

1 **ACGME Program Requirements for Graduate Medical Education**  
2 **in Hematology and Medical Oncology (Internal Medicine)**

3  
4 **Common Program Requirements are in BOLD**  
5 *General Subspecialty Requirements are ITALICIZED*

6  
7 Effective July 1, 2012

8  
9 **Introduction**

10  
11 **Int.A. Residency is an essential dimension of the transformation of the medical**  
12 **student to the independent practitioner along the continuum of medical**  
13 **education. It is physically, emotionally, and intellectually demanding, and**  
14 **requires longitudinally-concentrated effort on the part of the resident.**

15  
16 **The specialty education of physicians to practice independently is**  
17 **experiential, and necessarily occurs within the context of the health care**  
18 **delivery system. Developing the skills, knowledge, and attitudes leading to**  
19 **proficiency in all the domains of clinical competency requires the resident**  
20 **physician to assume personal responsibility for the care of individual**  
21 **patients. For the resident, the essential learning activity is interaction with**  
22 **patients under the guidance and supervision of faculty members who give**  
23 **value, context, and meaning to those interactions. As residents gain**  
24 **experience and demonstrate growth in their ability to care for patients, they**  
25 **assume roles that permit them to exercise those skills with greater**  
26 **independence. This concept—graded and progressive responsibility—is**  
27 **one of the core tenets of American graduate medical education.**  
28 **Supervision in the setting of graduate medical education has the goals of**  
29 **assuring the provision of safe and effective care to the individual patient;**  
30 **assuring each resident’s development of the skills, knowledge, and**  
31 **attitudes required to enter the unsupervised practice of medicine; and**  
32 **establishing a foundation for continued professional growth.**

33  
34 **Int.B. Hematology and medical oncology fellowships Subspecialty programs must**  
35 **provide advanced training education to allow the fellow to acquire competency in**  
36 **the subspecialty with sufficient expertise to act as an independent consultant.**

37  
38 **Int.C. ~~An~~ The educational program ~~accredited fellowship~~ in hematology and medical**  
39 **oncology must ~~provide~~ be 36 months of supervised graduate medical education**  
40 **in length.**

41  
42 **I. Institutions**

43  
44 **I.A. Sponsoring Institution**

45  
46 **One sponsoring institution must assume ultimate responsibility for the**  
47 **program, as described in the Institutional Requirements, and this**  
48 **responsibility extends to fellow assignments at all participating sites.**

49  
50 **The sponsoring institution and program must ensure that the program**  
51 **director has sufficient protected time and financial support for his or her**

52 **educational and administrative responsibilities to the program.**

53  
54 I.A.1. A-The hematology and medical oncology fellowship program must  
55 function as an integral part of an ACGME-accredited educational program  
56 in internal medicine.

57  
58 I.A.2. *The sponsoring institution must:*

59  
60 I.A.2.a) establish the hematology and medical oncology fellowship within a  
61 department of internal medicine or an administrative unit whose  
62 primary mission is the advancement of internal medicine  
63 subspecialty education and patient care; and,

64  
65 I.A.2.b) ~~provide ensure~~ the program director with adequate support for the  
66 administrative activities of the ~~internal medicine subspecialty-~~  
67 ~~program-fellowship.~~

68  
69 I.A.2.b).(1) *The program director must not be required to generate*  
70 *clinical or other income to provide this administrative*  
71 *support.*

72  
73 I.A.2.b).(2) ~~It is suggested~~ *This support should be 25-50% of the*  
74 *program director's salary, or protected time, depending on*  
75 *the size of the program.*

76  
77 I.A.3. *The sponsoring institution and participating sites must:*

78  
79 I.A.3.a) demonstrate that there is a culture of continuous quality  
80 improvement in the areas of patient care, patient safety, and  
81 education;

82  
83 I.A.3.b) demonstrate a commitment to quality patient-centered care and  
84 safety, education, research and scholarship sufficient to support  
85 the fellowship program; and,

86  
87 I.A.3.c) share appropriate inpatient and outpatient faculty performance  
88 data with the program director.

89  
90 I.A.1.a) ~~provide fellow compensation, and benefits, faculty, facilities, and~~  
91 ~~resources for education, clinical care, and research required for~~  
92 ~~accreditation;~~

93  
94 I.A.3.d) ~~notify the Review Committee within 60 days of changes in~~  
95 ~~institutional governance, affiliation, or resources that affect the~~  
96 ~~educational program as outlined in the Institutional Requirements;~~  
97 ~~and~~

98  
99 I.A.3.e) ~~provide fellowship positions in each training program that do not~~  
100 ~~number the number of accredited training in the program~~

101  
102 **I.B. Participating Sites**

- 103  
104 **I.B.1.** There must be a program letter of agreement (PLA) between the  
105 program and each participating site providing a required  
106 assignment. The PLA must be renewed at least every five years.  
107  
108 The PLA should:  
109  
110 **I.B.1.a)** identify the faculty who will assume both educational and  
111 supervisory responsibilities for fellows;  
112  
113 **I.B.1.b)** specify their responsibilities for teaching, supervision, and  
114 formal evaluation of fellows, as specified later in this  
115 document;  
116  
117 **I.B.1.c)** specify the duration and content of the educational  
118 experience; and,  
119  
120 **I.B.1.d)** state the policies and procedures that will govern fellow  
121 education during the assignment.  
122  
123 **I.B.2.** The program director must submit any additions or deletions of  
124 participating sites routinely providing an educational experience,  
125 required for all fellows, of one month full time equivalent (FTE) or  
126 more through the Accreditation Council for Graduate Medical  
127 Education (ACGME) Accreditation Data System (ADS).  
128  
129 **II. Program Personnel and Resources**  
130  
131 **II.A. Program Director**  
132  
133 **II.A.1.** There must be a single program director with authority and  
134 accountability for the operation of the program. The sponsoring  
135 institution's GMEC must approve a change in program director. After  
136 approval, the program director must submit this change to the  
137 ACGME via the ADS.  
138  
139 **II.A.2.** The program director should continue in his or her position for a  
140 length of time adequate to maintain continuity of leadership and  
141 program stability.  
142  
143 **II.A.3.** Qualifications of the program director must include:  
144  
145 **II.A.3.a)** requisite specialty expertise and documented educational  
146 and administrative experience acceptable to the Review  
147 Committee;  
148  
149 **II.A.3.a).(1)** The program director must have at least five years of  
150 participation as an active faculty member in an ACGME-  
151 accredited internal medicine residency, or hematology or  
152 medical oncology fellowship.

- 153  
154 **II.A.3.b)** **current certification in the subspecialty by the American**  
155 **Board of Internal Medicine (ABIM), or specialty qualifications**  
156 **acceptable to the Review Committee; and,**  
157
- 158 II.A.3.b).(1) The Review Committee only accepts current ABIM  
159 certification in hematology or medical oncology.  
160
- 161 II.A.3.b).(2) If the program director does not have appropriate  
162 credentials in both subspecialties, an appropriately-  
163 credentialed and full-time Key Clinical Faculty (KCF)  
164 member must be identified as responsible for the  
165 education program in the second specific area.  
166
- 167 **II.A.3.c)** **current medical licensure and appropriate medical staff**  
168 **appointment.**  
169
- 170 **II.A.4.** **The program director must administer and maintain an educational**  
171 **environment conducive to educating the fellows in each of the**  
172 **ACGME competency areas. The program director must:**  
173
- 174 **II.A.4.a)** **oversee and ensure the quality of didactic and clinical**  
175 **education in all sites that participate in the program;**  
176
- 177 **II.A.4.b)** **approve a local director at each participating site who is**  
178 **accountable for fellow education;**  
179
- 180 **II.A.4.c)** **approve the selection of program faculty as appropriate;**  
181
- 182 **II.A.4.d)** **evaluate program faculty and approve the continued**  
183 **participation of program faculty based on evaluation;**  
184
- 185 **II.A.4.e)** **monitor fellow supervision at all participating sites;**  
186
- 187 **II.A.4.f)** **prepare and submit all information required and requested by**  
188 **the ACGME, including but not limited to the program**  
189 **information forms and annual program fellow updates to the**  
190 **ADS, and ensure that the information submitted is accurate**  
191 **and complete;**  
192
- 193 **II.A.4.g)** **provide each fellow with documented semiannual evaluation**  
194 **of performance with feedback;**  
195
- 196 **II.A.4.h)** **ensure compliance with grievance and due process**  
197 **procedures, as set forth in the Institutional Requirements and**  
198 **implemented by the sponsoring institution;**  
199
- 200 **II.A.4.i)** **provide verification of fellowship education for all fellows,**  
201 **including those who leave the program prior to completion;**  
202

- 203 **II.A.4.j)** **implement policies and procedures consistent with the**  
204 **institutional and program requirements for fellow duty hours**  
205 **and the working environment, including moonlighting, and, to**  
206 **that end, must:**  
207
- 208 **II.A.4.j).(1)** **distribute these policies and procedures to the fellows**  
209 **and faculty;**  
210
- 211 **II.A.4.j).(2)** **monitor fellow duty hours, according to sponsoring**  
212 **institutional policies, with a frequency sufficient to**  
213 **ensure compliance with ACGME requirements;**  
214
- 215 **II.A.4.j).(3)** **adjust schedules as necessary to mitigate excessive**  
216 **service demands and/or fatigue; and,**  
217
- 218 **II.A.4.j).(4)** **if applicable, monitor the demands of at-home call and**  
219 **adjust schedules as necessary to mitigate excessive**  
220 **service demands and/or fatigue.**  
221
- 222 **II.A.4.k)** **monitor the need for and ensure the provision of back up**  
223 **support systems when patient care responsibilities are**  
224 **unusually difficult or prolonged;**  
225
- 226 **II.A.4.l)** **comply with the sponsoring institution's written policies and**  
227 **procedures, including those specified in Institutional**  
228 **Requirements, for selection, evaluation and promotion of**  
229 **fellows, disciplinary action, and supervision of fellows;**  
230
- 231 **II.A.4.m)** **be familiar with and comply with ACGME and Review**  
232 **Committee policies and procedures as outlined in the ACGME**  
233 **Manual of Policies and Procedures;**  
234
- 235 **II.A.4.n)** **obtain review and approval of the sponsoring institution's**  
236 **GMEC/DIO before submitting to the ACGME information or**  
237 **requests for the following:**  
238
- 239 **II.A.4.n).(1)** **all applications for ACGME accreditation of new**  
240 **programs;**  
241
- 242 **II.A.4.n).(2)** **changes in fellow complement;**  
243
- 244 **II.A.4.n).(3)** **major changes in program structure or length of**  
245 **training;**  
246
- 247 **II.A.4.n).(4)** **progress reports requested by the Review Committee;**  
248
- 249 **II.A.4.n).(5)** **responses to all proposed adverse actions;**  
250
- 251 **II.A.4.n).(6)** **requests for increases or any change to fellow duty**  
252 **hours;**

253  
254 **II.A.4.n).(7)** **voluntary withdrawals of ACGME-accredited**  
255 **programs;**  
256  
257 **II.A.4.n).(8)** **requests for appeal of an adverse action;**  
258  
259 **II.A.4.n).(9)** **appeal presentations to a Board of Appeal or the**  
260 **ACGME; and,**  
261  
262 **II.A.4.n).(10)** **proposals to ACGME for approval of innovative**  
263 **educational approaches.**  
264  
265 **II.A.4.o)** **obtain DIO review and co-signature on all program**  
266 **information forms, as well as any correspondence or**  
267 **document submitted to the ACGME that addresses:**  
268  
269 **II.A.4.o).(1)** **program citations; and/or**  
270  
271 **II.A.4.o).(2)** **request for changes in the program that would have**  
272 **significant impact, including financial, on the program**  
273 **or institution.**  
274  
275 *II.A.4.p)* *be responsible for monitoring fellow stress, including mental or*  
276 *emotional conditions inhibiting performance or learning, and drug-*  
277 *or alcohol-related dysfunction;*  
278  
279 *II.A.4.p).(1)* *Both-The program director and faculty should provide*  
280 *access to be sensitive to the need for timely provision of*  
281 *confidential counseling and psychological support services*  
282 *to fellows.*  
283  
284 *II.A.4.p).(2)* *Situations that demand excessive service or that*  
285 *consistently produce undesirable stress on fellows must be*  
286 *evaluated and modified.*  
287  
288 *II.A.4.q)* *ensure that fellows' service responsibilities are limited to patients*  
289 *for whom the teaching service has diagnostic and therapeutic*  
290 *responsibility.*  
291  
292 *II.A.4.r)* *dedicate an average of 20 hours per week of his or her*  
293 *professional effort to the internal medicine subspecialty program*  
294 *fellowship, including with sufficient time for administration of the*  
295 *program; and receive institutional support for that administrative*  
296 *time.*  
297  
298 *II.A.4.s)* *participate in academic societies and in educational programs*  
299 *designed to enhance his or her educational and administrative*  
300 *skills;*  
301  
302 *II.A.4.t)* *have a reporting relationship with the program director of the*  
303 *internal medicine residency program to ensure compliance with*

- 304 *the ACGME accreditation standards; and,*  
305  
306 II.A.4.u) *be available located at the primary principal clinical site.*  
307
- 308 **II.B. Faculty**  
309
- 310 **II.B.1. At each participating site, there must be a sufficient number of**  
311 **faculty with documented qualifications to instruct and supervise all**  
312 **fellows at that location.**  
313
- 314 **The faculty must:**  
315
- 316 **II.B.1.a) devote sufficient time to the educational program to fulfill**  
317 **their supervisory and teaching responsibilities; and to**  
318 **demonstrate a strong interest in the education of fellows;**  
319 **and,**  
320
- 321 **II.B.1.b) administer and maintain an educational environment**  
322 **conducive to educating fellows in each of the ACGME**  
323 **competency areas.**  
324
- 325 **II.B.2. The physician faculty must have current certification in the**  
326 **subspecialty by the American Board of Internal Medicine, or possess**  
327 **qualifications acceptable by the Review Committee.**  
328
- 329 **II.B.3. The physician faculty must possess current medical licensure and**  
330 **appropriate medical staff appointment.**  
331
- 332 **II.B.4. The nonphysician faculty must have appropriate qualifications in**  
333 **their field and hold appropriate institutional appointments.**  
334
- 335 **II.B.5. The faculty must establish and maintain an environment of inquiry**  
336 **and scholarship with an active research component.**  
337
- 338 **II.B.5.a) The faculty must regularly participate in organized clinical**  
339 **discussions, rounds, journal clubs, and conferences.**  
340
- 341 **II.B.5.b) Some members of the faculty should also demonstrate**  
342 **scholarship by one or more of the following:**  
343
- 344 **II.B.5.b).(1) peer-reviewed funding;**  
345
- 346 **II.B.5.b).(2) publication of original research or review articles in**  
347 **peer-reviewed journals or chapters in textbooks;**  
348
- 349 **II.B.5.b).(3) publication or presentation of case reports or clinical**  
350 **series at local, regional, or national professional and**  
351 **scientific society meetings; or,**  
352
- 353 **II.B.5.b).(4) participation in national committees or educational**

354 **organizations.**

355

356 **II.B.5.c) Faculty should encourage and support fellows in scholarly**

357 **activities.**

358

359 II.B.6. *The physician faculty must meet professional standards of ethical*

360 *behavior.*

361

362 II.B.7. Key Clinical Faculty

363

364 In addition to the program director, each program must have at least five

365 Key Clinical Faculty (KCF). KCF are attending physicians who dedicate,

366 on average, 10 hours per week throughout the year to the program. For

367 programs with more than nine fellows, enrolled during the accredited

368 portion of the program, a ratio of KCF to fellows of at least 1: there must

369 be at least one KCF for every 1.5 fellows. must be maintained.

370

371 II.B.7.a) Key Clinical Faculty Qualifications

372

373 II.B.7.a).(1) KCF must have current ABIM certification in hematology or

374 medical oncology. by the American Board of Internal

375 Medicine

376

377 II.B.7.a).(1).(a) At least three of the KCF must be certified have

378 current ABIM certification in hematology.

379

380 II.B.7.a).(1).(b) At least three of the KCF must be certified have

381 current ABIM certification in medical oncology.

382

383 II.B.7.a).(2) KCF must be active clinicians with ~~broad~~ knowledge of,

384 experience with, and commitment to hematology or

385 medical oncology as a discipline.

386

387 *II.B.7.b) Key Clinical Faculty Responsibilities*

388

389 *II.B.7.b).(1) In addition to the responsibilities of all individual faculty*

390 *members, the KCF ~~with and~~ the program director are*

391 *responsible for the planning, implementation, monitoring*

392 *and evaluation of the fellows' clinical and research*

393 *education training.*

394

395 II.B.7.b).(2) ~~The majority of~~ At least 50% of the KCF must demonstrate

396 evidence of productivity in ~~the scholarship, specifically,~~

397 peer-reviewed funding; publication of original research,

398 review articles, editorials, or case reports in peer-reviewed

399 journals; or chapters in textbooks. as defined in II.B.5.b.(1),

400 or (2) above.

401

402 II.B.7.b).(3) At least one KCF must:

403

404 be knowledgeable in the evaluation and

- 405 assessment of the ACGME competencies; and,  
406  
407 II.B.7.b).(3).(b) spend significant time in the evaluation of fellows,  
408 including the direct observation of fellows with  
409 patients.  
410  
411 II.B.7.b).(4) Appointment of one KCF to be an associate program  
412 director is suggested.  
413  
414 II.B.8. ~~All~~Clinical faculty members should participate in ~~prescribed~~faculty  
415 development programs designed to enhance the effectiveness of their  
416 teaching.  
417  
418 II.B.9. Faculty members who are ~~subspecialty certified by the American Board of~~  
419 ~~Internal Medicine~~ ABIM-certified in endocrinology, gastroenterology,  
420 infectious disease, nephrology, and pulmonary disease ~~must~~should be  
421 available to participate in the education of fellows in hematology and  
422 medical oncology.  
423  
424 II.C. **Other Program Personnel**  
425  
426 **The institution and the program must jointly ensure the availability of all**  
427 **necessary professional, technical, and clerical personnel for the effective**  
428 **administration the program.**  
429  
430 II.C.1. *There must be services available from other health care professionals,*  
431 *including dietitians, language interpreters, nurses, occupational*  
432 *therapists, physical therapists, and social workers.*  
433  
434 II.C.2. The fellowship must have access to surgeons in general surgery and  
435 surgical specialties, including ~~surgeons~~those with special interest in  
436 oncology.  
437  
438 II.C.3. The fellowship must have access to other clinical specialists, ~~specifically~~  
439 including those in dermatology, obstetrics and gynecology, neurology,  
440 ~~neurosurgery~~neurological surgery, orthopaedics, otolaryngology, and  
441 urology.  
442  
443 II.C.4. ~~There must be ensure the availability of~~ appropriate and timely  
444 consultation from other specialties.  
445  
446 II.C.5. ~~The following~~ Expertise and in the following disciplines should be  
447 available to the program to provide multidisciplinary patient care and  
448 fellow education:  
449  
450 II.C.5.a) genetic counseling;  
451  
452 II.C.5.b) hospice and palliative care;  
453  
454 II.C.5.c) oncologic nursing;  
455

- 456 II.C.5.d) pain management;  
 457  
 458 II.C.5.e) psychiatry; and,  
 459  
 460 II.C.5.f) rehabilitation medicine.  
 461  
 462 II.C.5.g) dietetics;  
 463  
 464 II.C.5.h) social services;

465  
 466 **II.D. Resources**

467  
 468 **The institution and the program must jointly ensure the availability of**  
 469 **adequate resources for fellow education, as defined in the specialty**  
 470 **program requirements.**  
 471

472 *II.D.1. Space and Equipment*

473  
 474 *There must be space and equipment for the educational program,*  
 475 *including meeting rooms, classrooms, examination rooms, computers,*  
 476 *visual and other educational aids, and work/study space.*

477  
 478 *II.D.2. Facilities*

479  
 480 *II.D.2.a) Inpatient and outpatient systems must be in place to prevent*  
 481 *fellows from performing routine clerical functions, including*  
 482 *scheduling tests and appointments, and retrieving records and*  
 483 *letters.*

484  
 485 *II.D.2.b) The sponsoring institution must provide the broad range of*  
 486 *facilities and clinical support services required to provide*  
 487 *comprehensive care of adult patients. ~~Fellows must have clinical~~*  
 488 *experiences in efficient, effective ambulatory and inpatient care*  
 489 *settings.*

490  
 491 *II.D.2.c) Fellows must have access to a lounge facility during assigned*  
 492 *duty hours.*

493  
 494 *II.D.2.d) When fellows are ~~assigned night duty~~ in the hospital, assigned*  
 495 *night duty, or called in from home, they must be provided with ~~on-~~*  
 496 *call facilities that are convenient and that afford privacy, safety,*  
 497 *and a restful environment with a secure space for their*  
 498 *belongings.*

499  
 500 *II.D.2.e) Radiation oncology facilities must be available ~~at the primary-~~*  
 501 *training site.*

502  
 503 *II.D.3. Laboratory Facilities and Imaging Services*

504  
 505 *II.D.3.a) A hematology laboratory must be located at the primary clinical*  
 506 *site.*

- 507  
508 II.D.3.b) Each of the following must be present at the primary clinical or  
509 participating site(s):  
510  
511 II.D.3.b).(1) ~~access to a specialized coagulation laboratory; must be~~  
512 ~~accessible.~~  
513  
514 II.D.3.b).(2) nuclear medicine imaging; ~~must be accessible for the~~  
515 ~~training program.~~  
516  
517 II.D.3.b).(3) cross-sectional imaging, including coaxial tomography  
518 (CT) and magnetic resonance imaging (MRI); and,  
519  
520 II.D.3.b).(4) positron emission tomography (PET) scan imaging.  
521  
522 II.D.4. Other Facilities, Resources, or Support Services  
523  
524 There must be advanced pathology services, including:  
525  
526 II.D.4.a) immunopathology;  
527  
528 II.D.4.b) blood banking ~~(N.B.: These may be located at institutions other~~  
529 ~~than the primary training site.); and,~~  
530  
531 II.D.4.c) transfusion and apheresis services facilities. ~~must be available at~~  
532 ~~the primary training site.~~  
533  
534 II.D.5. *Medical Records*  
535  
536 Access to an electronic health record should be provided. In the absence  
537 of an existing electronic health record, institutions must demonstrate  
538 institutional commitment to its development, and progress towards its  
539 implementation.  
540  
541 II.D.6. Patient Population  
542  
543 II.D.6.a) The patient population must have a variety of clinical problems  
544 and stages of diseases.  
545  
546 II.D.6.b) *There must be patients of each both sexes gender, with a broad*  
547 *age range, including geriatric patients.*  
548  
549 II.D.6.c) *A sufficient number of patients must be available to enable ensure*  
550 *adequate inpatient and ambulatory experience for each fellow to*  
551 *achieve the required educational outcomes.*  
552  
553 II.E. **Medical Information Access**  
554  
555 **Fellows must have ready access to specialty-specific and other appropriate**  
556 **reference material in print or electronic format. Electronic medical literature**  
557 **databases with search capabilities should be available.**

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**III. Fellow Appointments**

**III.A. Eligibility Criteria**

**The program director must comply with the criteria for fellow eligibility as specified in the Institutional Requirements.**

*III.A.1. ~~Prior to appointment in the fellowship program, fellows should have completed an ACGME-accredited internal medicine education program.~~*

*III.A.2. ~~Fellows from non-ACGME-accredited internal medicine education programs must have completed at least three years of internal medicine education prior to starting the fellowship.~~*

*III.A.3. ~~The program director must inform non-ACGME trained applicants from non-ACGME-accredited programs, prior to appointment, and in writing, of the ABIM policies and procedures that may will affect their the fellow's eligibility for ABIM certification.~~*

*III.A.4. ~~When averaged over any five-year period, a minimum of 75% of fellows in each subspecialty training program must be graduates of an ACGME-accredited internal medicine training program. Non-ACGME internal medicine trained fellows must have at least three years of internal medicine training prior to starting fellowship.~~*

**III.B. Number of Fellows**

**The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of fellows appointed to the program.**

*III.B.1. ~~The minimum number of available fellow positions in the training program must be at least one per year not be less than the number of accredited training years in the program.~~*

**III.C. Fellow Transfers**

**III.C.1. Before accepting a fellow who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring fellow.**

**III.C.2. A program director must provide timely verification of fellowship education and summative performance evaluations for fellows who leave the program prior to completion.**

**III.D. Appointment of Fellows and Other Learners**

**The presence of other learners (including, but not limited to, residents from**

609 other specialties, subspecialty fellows, PhD students, and nurse  
610 practitioners) in the program must not interfere with the appointed fellows'  
611 education. The program director must report the presence of other learners  
612 to the DIO and GMEC in accordance with sponsoring institution guidelines.  
613

614 **IV. Educational Program**

615 **IV.A. The curriculum must contain the following educational components:**

616 **IV.A.1. Overall educational goals for the program, which the program must**  
617 **distribute to fellows and faculty annually;**

618 **IV.A.2. Competency-based goals and objectives for each assignment at**  
619 **each educational level, which the program must distribute to fellows**  
620 **and faculty annually, in either written or electronic form. These**  
621 **should be reviewed by the fellow at the start of each rotation;**

622 **IV.A.3. Regularly scheduled didactic sessions;**

623 **IV.A.3.a) The core curriculum must include a didactic program based on the**  
624 **core knowledge content in the subspecialty area.**

625 **IV.A.3.a).(1) The program must afford each fellow an opportunity to**  
626 **review topics covered in conferences that he or she was**  
627 **unable to attend.**

628 **IV.A.3.a).(2) Fellows must participate in clinical case conferences,**  
629 **journal clubs, research conferences, and morbidity and**  
630 **mortality or quality improvement conferences.**

631 **IV.A.3.a).(3) All core conferences must have at least one faculty**  
632 **member present, and must be scheduled as to ensure**  
633 **peer-peer and peer-faculty interaction.**

634 **IV.A.3.b) Patient-based teaching must include direct interaction between**  
635 **fellows and attending faculty members, bedside teaching,**  
636 **discussion of pathophysiology, and the use of current evidence in**  
637 **diagnostic and therapeutic decisions. The teaching must be:**

638 **IV.A.3.b).(1) formally conducted on all inpatient, outpatient and**  
639 **consultative services; and,**

640 **IV.A.3.b).(2) conducted with a frequency and duration sufficient to that**  
641 **ensures a meaningful and continuous teaching relationship**  
642 **between the assigned supervising faculty member(s)-**  
643 **teaching attending and fellows.**

644 **IV.A.3.c) Fellows must receive instruction in practice management relevant**  
645 **to hematology and medical oncology.**

646 **IV.A.4. Delineation of fellow responsibilities for patient care, progressive**

660 responsibility for patient management, and supervision of fellows  
661 over the continuum of the program.

662  
663 **IV.A.5. ACGME Competencies**

664  
665 **The program must integrate the following ACGME competencies**  
666 **into the curriculum:**

667  
668 **IV.A.5.a) Patient Care**

669  
670 **Fellows must be able to provide patient care that is**  
671 **compassionate, appropriate, and effective for the treatment of**  
672 **health problems and the promotion of health. Fellows:**

673  
674 *IV.A.5.a).(1) must demonstrate competence in the practice of health*  
675 *promotion, disease prevention, diagnosis, care, and*  
676 *treatment of ~~men and women~~ patients of each gender,*  
677 *from adolescence to old age, during health and all stages*  
678 *of illness;*

679  
680 *IV.A.5.a).(2) must demonstrate competency as a consultant;*

681  
682 *IV.A.5.a).(3) must ~~have formal instruction, clinical experience, and~~*  
683 *demonstrate competence in the:*

684  
685 *IV.A.5.a).(3).(a) prevention, evaluation, diagnosis, cancer staging,*  
686 *and management of patients with hematologic and*  
687 *neoplastic disorders of the:*

688  
689 *IV.A.5.a).(3).(a).(i) lung;*

690  
691 *IV.A.5.a).(3).(a).(ii) gastrointestinal tract (esophagus, stomach,*  
692 *colon, rectum, anus);*

693  
694 *IV.A.5.a).(3).(a).(iii) breast;*

695  
696 *IV.A.5.a).(3).(a).(iv) pancreas;*

697  
698 *IV.A.5.a).(3).(a).(v) liver;*

699  
700 *IV.A.5.a).(3).(a).(vi) testes;*

701  
702 *IV.A.5.a).(3).(a).(vii) lymphoid organs;*

703  
704 *IV.A.5.a).(3).(a).(viii) hematopoietic system;*

705  
706 *IV.A.5.a).(3).(a).(ix) central nervous system;*

707  
708 *IV.A.5.a).(3).(a).(x) head and neck;*

709  
710 *IV.A.5.a).(3).(a).(xi) thyroid and other endocrine organs,*

711		including multiple endocrine neoplasia
712		(MEN) syndromes;
713		
714	IV.A.5.a).(3).(a).(xii)	skin, including melanoma;
715		
716	IV.A.5.a).(3).(a).(xiii)	genitourinary tract;
717		
718	IV.A.5.a).(3).(a).(xiv)	cancer family syndromes; and,
719		
720	IV.A.5.a).(3).(a).(xv)	gynecologic malignancies.
721		
722	IV.A.5.a).(3).(b)	indications for and application of imaging
723		techniques in patients with neoplastic and blood
724		disorders;
725		
726	IV.A.5.a).(3).(c)	use of chemotherapeutic drugs, biologic products,
727		and growth factors; their mechanisms of action,
728		pharmacokinetics, clinical indications, and
729		limitations, including their effects, toxicity, and
730		interactions;
731		
732	IV.A.5.a).(3).(d)	<del>the</del> use of multiagent chemotherapeutic protocols
733		and combined modality therapy of neoplastic
734		disorders;
735		
736	IV.A.5.a).(3).(e)	management and care of indwelling access
737		catheters;
738		
739	IV.A.5.a).(3).(f)	<del>the role and</del> use of hematologic, infection, and
740		nutrition support;
741		
742	IV.A.5.a).(3).(g)	management of the neutropenic and the
743		immunocompromised patient;
744		
745	IV.A.5.a).(3).(h)	management of pain, anxiety, and depression in
746		patients with cancer and hematologic disorders;
747		
748	IV.A.5.a).(3).(i)	rehabilitation and psychosocial care of patients with
749		cancer and hematologic disorders;
750		
751	IV.A.5.a).(3).(j)	palliative care, including hospice and home care;
752		
753	IV.A.5.a).(3).(k)	<del>the</del> treatment and diagnosis of paraneoplastic
754		disorders;
755		
756	IV.A.5.a).(3).(l)	specific cancer prevention and screening, including
757		competency in genetic testing <del>and</del> for high-risk
758		individuals;
759		
760	IV.A.5.a).(3).(m)	care of patients with HIV-related malignancies;
761		

762	IV.A.5.a).(3).(n)	care and management of the geriatric patient with malignancy and hematologic disorders;
763		
764		
765	IV.A.5.a).(3).(o)	correlation of clinical information with cytology, histology, and immunodiagnostic imaging techniques;
766		
767		
768		
769	IV.A.5.a).(3).(p)	tests of hemostasis and thrombosis for both congenital and acquired disorders and regulation of antithrombotic therapy;
770		
771		
772		
773	IV.A.5.a).(3).(q)	use of chemotherapeutic agents and biological products through all therapeutic routes;
774		
775		
776	IV.A.5.a).(3).(r)	assessment of tumor burden and response as measured by physical and radiologic exam, and tumor markers;
777		
778		
779		
780	IV.A.5.a).(3).(s)	assessment of hematologic disorders by computed tomography, <del>magnetic resonance MRI</del> , <del>positron emission tomography (PET)</del> scanning, and nuclear imaging techniques;
781		
782		
783		
784		
785	IV.A.5.a).(3).(t)	assessment and interpretation of <del>the following</del> , complete blood count, including platelets and white cell differential, by means of automated or manual techniques, with appropriate quality control;
786		
787		
788		
789		
790	IV.A.5.a).(3).(u)	preparation staining and interpretation of blood smears, bone marrow aspirates, and touch preparations, as well as interpretation of bone marrow biopsies;
791		
792		
793		
794		
795	IV.A.5.a).(3).(v)	<u>performance and interpretation of lumbar puncture and interpretation of cerebrospinal fluid evaluation;</u>
796		
797		
798	IV.A.5.a).(3).(w)	access <u>and care</u> of Ommaya <u>reservoir</u> ;
799		
800	IV.A.5.a).(3).(x)	intrathecal administration of chemotherapeutic agents; and,
801		
802		
803	IV.A.5.a).(3).(y)	care and management of venous access devices.
804		

**IV.A.5.b)**

**Medical Knowledge**

**Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows:**

811  
812 IV.A.5.b).(1) *must demonstrate knowledge of the scientific method of*

813		<i>problem solving and evidence-based decision making;</i>
814		<i>commitment to lifelong learning, and an attitude of caring</i>
815		<i>that is derived from humanistic and professional values.</i>
816		
817	IV.A.5.b).(2)	<i>must <del>develop</del> demonstrate knowledge <u>understanding</u> of</i>
818		<i>indications, contraindications, limitations, complications,</i>
819		<i>techniques, and interpretation of results of those diagnostic</i>
820		<i>and therapeutic procedures integral to the discipline,</i>
821		<i><u>including the appropriate indications for and use of</u></i>
822		<i><u>screening tests/procedures</u>;</i>
823		
824	IV.A.5.b).(3)	must demonstrate knowledge of pathogenesis, diagnosis,
825		and treatment of disease, including:
826		
827	IV.A.5.b).(3).(a)	basic molecular and pathophysiologic mechanisms,
828		diagnosis, and therapy of diseases of the blood,
829		including anemias, diseases of white blood cells
830		and stem cells, and disorders of hemostasis and
831		thrombosis; and,
832		
833	IV.A.5.b).(3).(b)	etiology, epidemiology, natural history, diagnosis,
834		pathology, staging, and management of neoplastic
835		diseases of the blood, blood-forming organs, and
836		lymphatic tissues.
837		
838	IV.A.5.b).(4)	must demonstrate knowledge of genetics and
839		developmental biology, including:
840		
841	IV.A.5.b).(4).(a)	molecular genetics;
842		
843	IV.A.5.b).(4).(b)	prenatal diagnosis;
844		
845	IV.A.5.b).(4).(c)	the nature of oncogenes and their products; and,
846		
847	IV.A.5.b).(4).(d)	cytogenetics.
848		
849	IV.A.5.b).(5)	must demonstrate knowledge of physiology and
850		pathophysiology, including:
851		
852	IV.A.5.b).(5).(a)	cell and molecular biology;
853		
854	IV.A.5.b).(5).(b)	hematopoiesis;
855		
856	IV.A.5.b).(5).(c)	principles of oncogenesis;
857		
858	IV.A.5.b).(5).(d)	tumor immunology;
859		
860	IV.A.5.b).(5).(e)	molecular mechanisms of hematopoietic and
861		lymphopoietic malignancies;
862		
863	IV.A.5.b).(5).(f)	basic and clinical pharmacology, pharmacokinetics,

864		and toxicity; and,
865		
866	IV.A.5.b).(5).(g)	pathophysiology and patterns of tumor metastases.
867		
868	IV.A.5.b).(6)	must demonstrate knowledge of clinical epidemiology and
869		<del>medical studies</del> <u>biostatistics, including clinical study and</u>
870		<u>experimental protocol design, data collection, and analysis;</u>
871		
872	<del>IV.A.5.b).(6).(a)</del>	<del>clinical epidemiology and medical statistics;</del>
873		
874	IV.A.5.b).(6).(b)	<del>clinical study and experimental protocol design,</del>
875		<del>data collection, and analysis.</del>
876		
877	IV.A.5.b).(7)	must demonstrate knowledge of:
878		
879	IV.A.5.b).(7).(a)	basic principles of laboratory and clinical testing,
880		quality control, quality assurance, and proficiency
881		standards;
882		
883	IV.A.5.b).(7).(b)	<del>must demonstrate knowledge of</del> immune markers,
884		immunophenotyping, flow cytometry, cytochemical
885		studies, and cytogenetic and DNA analysis of
886		neoplastic disorders;
887		
888	IV.A.5.b).(7).(c)	<del>must demonstrate knowledge of</del> malignant and
889		hematologic complications of organ transplantation;
890		
891	IV.A.5.b).(7).(d)	<del>must demonstrate knowledge of</del> gene therapy;
892		
893	IV.A.5.b).(7).(e)	effects of systemic disorders and drugs on the
894		blood, blood-forming organs, and lymphatic tissues;
895		
896	IV.A.5.b).(7).(f)	transfusion medicine, including the evaluation of
897		antibodies, blood compatibility, and the indications
898		for and complications of blood component therapy
899		and apheresis procedures;
900		
901	IV.A.5.b).(7).(g)	acquired and congenital disorders of red cells,
902		white cells, platelets and stem cells;
903		
904	IV.A.5.b).(7).(h)	hematopoietic and lymphopoietic malignancies,
905		including disorders of plasma cells;
906		
907	IV.A.5.b).(7).(i)	principles of multidisciplinary management of
908		organ-specific cancers; and,
909		
910	IV.A.5.b).(7).(j)	<del>the use of chemotherapeutic drugs, biologic</del>
911		<del>products, and growth factors;</del> their mechanisms of
912		action, pharmacokinetics, clinical indications, and
913		limitations <u>of chemotherapeutic drugs, biologic</u>
914		<u>products, and growth factors,</u> including their effects,

915		toxicity, and interactions.
916		
917	IV.A.5.b).(8)	<u>must demonstrate knowledge of</u> principles of, indications for, and limitations of:
918		
919		
920	IV.A.5.b).(8).(a)	surgery in the treatment of cancer; and,
921		
922	IV.A.5.b).(8).(b)	radiation therapy in the treatment of cancer.
923		
924	IV.A.5.b).(9)	<u>must demonstrate knowledge of</u> principles of, indications for, and complications of autologous and allogeneic bone marrow or peripheral blood stem cell transplantation;
925		
926		
927		
928	IV.A.5.b).(10)	<u>must demonstrate knowledge of principles, indications for,</u> and complications of peripheral stem cell harvests;
929		
930		
931	IV.A.5.b).(11)	<u>must demonstrate knowledge of the</u> management of post-transplant complications; and,
932		
933		
934	IV.A.5.b).(12)	<del>All trainees should</del> <u>must understand demonstrate</u> knowledge of the indications <del>for,</del> complications, <del>of</del> and risks and limitations <u>associated with</u> <del>to</del> :
935		
936		
937		
938	IV.A.5.b).(12).(a)	thoracentesis;
939		
940	IV.A.5.b).(12).(b)	paracentesis;
941		
942	IV.A.5.b).(12).(c)	skin biopsies; and,
943		
944	IV.A.5.b).(12).(d)	lesion biopsies.
945		
946	<b>IV.A.5.c)</b>	<b>Practice-based Learning and Improvement</b>
947		
948		<b>Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Fellows are expected to develop skills and habits to be able to meet the following goals:</b>
949		
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952		
953		
954		
955	<b>IV.A.5.c).(1)</b>	<b>identify strengths, deficiencies, and limits in one's knowledge and expertise;</b>
956		
957		
958	<b>IV.A.5.c).(2)</b>	<b>set learning and improvement goals;</b>
959		
960	<b>IV.A.5.c).(3)</b>	<b>identify and perform appropriate learning activities;</b>
961		
962	<b>IV.A.5.c).(4)</b>	<b>systematically analyze practice, using quality improvement methods, and implement changes with the goal of practice improvement;</b>
963		
964		
965		

966	<b>IV.A.5.c).(5)</b>	<b>incorporate formative evaluation feedback into daily practice;</b>
967		
968		
969	<b>IV.A.5.c).(6)</b>	<b>locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;</b>
970		
971		
972		
973	<b>IV.A.5.c).(7)</b>	<b>use information technology to optimize learning;</b>
974		
975	<b>IV.A.5.c).(8)</b>	<b>participate in the education of patients, families, students, fellows and other health professionals;</b>
976		
977		
978	IV.A.5.c).(9)	competently educate patients about the rationale, techniques, and complications of procedures; and,
979		
980		
981	IV.A.5.c).(10)	<del>incompetently</del> obtaining procedure-specific informed consent.
982		
983		
984	<b>IV.A.5.d)</b>	<b>Interpersonal and Communication Skills</b>
985		
986		<b>Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Fellows are expected to:</b>
987		
988		
989		
990		
991	<b>IV.A.5.d).(1)</b>	<b>communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;</b>
992		
993		
994		
995	<b>IV.A.5.d).(2)</b>	<b>communicate effectively with physicians, other health professionals, and health related agencies;</b>
996		
997		
998	<b>IV.A.5.d).(3)</b>	<b>work effectively as a member or leader of a health care team or other professional group;</b>
999		
1000		
1001	<b>IV.A.5.d).(4)</b>	<b>act in a consultative role to other physicians and health professionals;</b>
1002		
1003		
1004	<b>IV.A.5.d).(5)</b>	<b>maintain comprehensive, timely, and legible medical records, if applicable; and,</b>
1005		
1006		
1007	IV.A.5.d).(6)	<u>demonstrate team leadership skills and ability to work with an interdisciplinary team by:</u>
1008		
1009		
1010	IV.A.5.d).(6).(a)	<u>identifying essential team members;</u>
1011		
1012	IV.A.5.d).(6).(b)	<u>defining the roles of team members; and,</u>
1013		
1014	IV.A.5.d).(6).(c)	<u>evaluating the role of the interdisciplinary team.</u>
1015		

1016	<b>IV.A.5.e)</b>	<b>Professionalism</b>
1017		
1018		<b>Fellows must demonstrate a commitment to carrying out</b>
1019		<b>professional responsibilities and an adherence to ethical</b>
1020		<b>principles. Fellows are expected to demonstrate:</b>
1021		
1022	<b>IV.A.5.e).(1)</b>	<b>compassion, integrity, and respect for others;</b>
1023		
1024	<b>IV.A.5.e).(2)</b>	<b>responsiveness to patient needs that supersedes self-</b>
1025		<b>interest;</b>
1026		
1027	<b>IV.A.5.e).(3)</b>	<b>respect for patient privacy and autonomy;</b>
1028		
1029	<b>IV.A.5.e).(4)</b>	<b>accountability to patients, society and the profession;</b>
1030		
1031	<b>IV.A.5.e).(5)</b>	<b>sensitivity and responsiveness to a diverse patient</b>
1032		<b>population, including but not limited to diversity in</b>
1033		<b>gender, age, culture, race, religion, disabilities, and</b>
1034		<b>sexual orientation;</b>
1035		
1036	<i>IV.A.5.e).(6)</i>	<i><u>high standards of ethical behavior, including maintaining</u></i>
1037		<i><u>appropriate professional boundaries and relationships with</u></i>
1038		<i><u>other physicians and other health care team members, and</u></i>
1039		<i><u>avoiding conflicts of interest;</u></i>
1040		
1041	<i>IV.A.5.e).(7)</i>	<i>a commitment to lifelong learning, and an attitude of caring</i>
1042		<i>derived from humanistic and professional values; and,</i>
1043		
1044	<i>IV.A.5.e).(8)</i>	<i>personal development, attitudes, and coping skills of</i>
1045		<i>physicians and other health-care professionals who care</i>
1046		<i>for critically-ill patients.</i>
1047		
1048	<b>IV.A.5.f)</b>	<b>Systems-based Practice</b>
1049		
1050		<b>Fellows must demonstrate an awareness of and</b>
1051		<b>responsiveness to the larger context and system of health</b>
1052		<b>care, as well as the ability to call effectively on other</b>
1053		<b>resources in the system to provide optimal health care.</b>
1054		<b>Fellows are expected to:</b>
1055		
1056	<b>IV.A.5.f).(1)</b>	<b>work effectively in various health care delivery</b>
1057		<b>settings and systems relevant to their clinical</b>
1058		<b>specialty;</b>
1059		
1060	<b>IV.A.5.f).(2)</b>	<b>coordinate patient care within the health care system</b>
1061		<b>relevant to their clinical specialty;</b>
1062		
1063	<b>IV.A.5.f).(3)</b>	<b>incorporate considerations of cost awareness and</b>
1064		<b>risk-benefit analysis in patient and/or population-</b>
1065		<b>based care as appropriate;</b>

1066		
1067	<b>IV.A.5.f).(4)</b>	<b>advocate for quality patient care and optimal patient care systems;</b>
1068		
1069		
1070	<b>IV.A.5.f).(5)</b>	<b>work in interprofessional teams to enhance patient safety and improve patient care quality; and,</b>
1071		
1072		
1073	<b>IV.A.5.f).(6)</b>	<b>participate in identifying system errors and implementing potential systems solutions.</b>
1074		
1075		
1076	IV.A.6.	<u>Curriculum Organization and Fellow Experiences</u>
1077		
1078	IV.A.6.a)	A minimum of 18 months must be devoted to clinical experience.
1079		
1080	IV.A.6.a).(1)	<u>Of this time, nine months must be in hematology and nine months must be in medical oncology.</u>
1081		
1082		
1083	IV.A.6.a).(2)	<u>At least 50% of the medical oncology clinical experience must occur in the outpatient setting.</u>
1084		
1085		
1086	IV.A.6.a).(3)	The program must provide at least one month of clinical experience in autologous and allogeneic bone marrow transplantation.
1087		
1088		
1089		
1090	IV.A.6.b)	<u>Fellows must participate in training using simulation.</u>
1091		
1092	IV.A.6.c)	Inpatient assignments should be of sufficient duration to permit continuing care of a majority of the patients throughout their hospitalization.
1093		
1094		
1095		
1096	IV.A.6.d)	<del>The program Fellows must also participate in a multidisciplinary case management or tumor board conferences,</del> and in protocol studies.
1097		
1098		
1099		
1100	IV.A.6.e)	Fellows must assume continuing responsibility for acutely- and chronically-ill patients in order to observe and manage both inpatients and outpatients with a wide variety of blood and neoplastic disorders, and the benefits and adverse effects of therapy.
1101		
1102		
1103		
1104		
1105		
1106	IV.A.6.f)	<u>Fellows must participate in a multidisciplinary case management conference or discussion.</u>
1107		
1108		
1109	IV.A.6.g)	<u>Fellows should participate in the care of patients undergoing:</u>
1110		
1111	IV.A.6.g).(1)	apheresis procedures; and,
1112		
1113	IV.A.6.g).(2)	bone marrow or peripheral stem cell harvest for transplantation.
1114		
1115		
1116	IV.A.6.h)	<u>Fellows must be educated about, and should have experience</u>

1117		<u>with:</u>
1118		
1119	IV.A.6.h).(1)	performance and interpretation of partial thromboplastin
1120		time, prothrombin time, platelet aggregation, and bleeding
1121		time, as well as other standard <u>and specialized</u> coagulation
1122		assays; and,
1123		
1124	IV.A.6.h).(2)	test of hemostasis.
1125		
1126	IV.A.6.i)	Experience with Continuity Ambulatory Patients
1127		
1128		<i>Fellows must have continuity ambulatory clinic experience to</i>
1129		<i>develop a continuous healing relationship with patients for whom</i>
1130		<i>they provide hematology or medical oncology care. This continuity</i>
1131		<i>experience should expose that exposes them fellows to the</i>
1132		<i>breadth and depth of hematology and medical oncology.</i>
1133		
1134	IV.A.6.i).(1)	<del>Overall</del> -This experience should average one half-day each
1135		week.
1136		
1137	IV.A.6.i).(2)	<del>Overall</del> -This experience must include an appropriate
1138		distribution of patients of <u>each both sexes</u> gender and a
1139		diversity of ages, <u>and</u> . This should be accomplished <del>by</del>
1140		<u>through either:</u>
1141		
1142	IV.A.6.i).(2).(a)	a continuity clinic which provides fellows the
1143		opportunity to learn the course of disease; or,
1144		
1145	IV.A.6.i).(2).(b)	selected blocks of at least six months which
1146		address specific areas of blood and neoplastic
1147		disorders.
1148		
1149	IV.A.6.i).(3)	Each fellow should, on average, be responsible for four to
1150		eight patients during each half-day session.
1151		
1152	IV.A.6.i).(4)	The continuity patient care experience should not be
1153		interrupted by more than one month, excluding a fellow's
1154		vacation.
1155		
1156	IV.A.6.i).(5)	<del>It is suggested that</del> Fellows should be informed of the
1157		status of their continuity patients when <u>they such patients</u>
1158		are hospitalized, <u>as clinically appropriate</u> . <del>so the fellows</del>
1159		<del>can make appropriate arrangements to maintain continuity</del>
1160		<del>of care.</del>
1161		
1162	IV.A.6.j)	Procedures and Technical Skills
1163		
1164	IV.A.6.j).(1)	<u>Direct faculty</u> supervision of procedures performed by each
1165		fellow must occur until proficiency has been acquired and
1166		documented by the program director.
1167		

1168 IV.A.6.j).(2) ~~A skilled preceptor Faculty must be available to teach and~~  
1169 ~~supervise the fellows in the performance and interpretation~~  
1170 ~~of these procedures. Procedures which must be~~  
1171 ~~documented in each fellow's record, including indications,~~  
1172 ~~outcomes, diagnoses, and supervisor(s).~~

1174 IV.A.6.j).(3) It is suggested that fellows have the opportunity to develop  
1175 proficiency-competence in performing thoracentesis,  
1176 paracentesis, skin biopsies, and lesion biopsies.  
1177

#### 1178 **IV.B. Fellows' Scholarly Activities**

1179  
1180 **IV.B.1. The curriculum must advance fellows' knowledge of the basic**  
1181 **principles of research, including how research is conducted,**  
1182 **evaluated, explained to patients, and applied to patient care.**  
1183

1184 **IV.B.2. Fellows should participate in scholarly activity.**

1185  
1186 IV.B.2.a) *The majority of fellows must demonstrate evidence of scholarship*  
1187 *~~recent research productivity conducted during the fellowship~~*  
1188 *through one or more of the following:*  
1189

1190 *IV.B.2.a).(1) publication of articles, book chapters, abstracts, or case*  
1191 *reports in peer-reviewed journals;*  
1192

1193 *IV.B.2.a).(2) publication of peer-reviewed performance improvement or*  
1194 *education research;*  
1195

1196 *IV.B.2.a).(3) peer-reviewed funding; or,*  
1197

1198 *IV.B.2.a).(4) peer-reviewed abstracts presented at regional, state, or*  
1199 *national specialty meetings.*  
1200

1201 **IV.B.3. The sponsoring institution and program should allocate adequate**  
1202 **educational resources to facilitate fellow involvement in scholarly**  
1203 **activities.**  
1204

#### 1205 **V. Evaluation**

##### 1206 **V.A. Fellow**

##### 1207 **V.A.1. Formative Evaluation**

1208  
1209 **V.A.1.a) The faculty must evaluate fellow performance in a timely**  
1210 **manner during each rotation or similar educational**  
1211 **assignment, and document this evaluation at completion of**  
1212 **the assignment.**  
1213  
1214

1215  
1216 *V.A.1.a).(1) The faculty must discuss this evaluation with ~~the~~ each*  
1217 *fellow at the completion of ~~the~~ each assignment.*  
1218

1219	V.A. 1.a).(2)	<u>Assessment of procedural competence should include a formal evaluation process and not be based solely on a minimum number of procedures performed.</u>
1220		
1221		
1222		
1223	<b>V.A.1.b)</b>	<b>The program must:</b>
1224		
1225	<b>V.A.1.b).(1)</b>	<b>provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;</b>
1226		
1227		
1228		
1229		
1230		
1231	V.A. 1.b).(1).(a)	<u>Patient Care</u>
1232		
1233		<u>The program must assess the fellow in data gathering, clinical reasoning, patient management, and procedures in both the inpatient and outpatient setting. This assessment must involve direct observation of fellow-patient encounters.</u>
1234		
1235		
1236		
1237		
1238		
1239	V.A. 1.b).(1).(a).(i)	<u>Each program must define a standard criteria for proficiency-competence for all required and elective procedures.</u>
1240		
1241		
1242		
1243	V.A. 1.b).(1).(a).(ii)	<u>The record of evaluation must include the fellow's logbook or an equivalent method to demonstrate that each fellow has achieved competence in the performance of required procedures.</u>
1244		
1245		
1246		
1247		
1248		
1249	V.A. 1.b).(1).(b)	<u>Medical Knowledge</u>
1250		
1251		<u>The program must use an objective formative assessment method. The same formative assessment method must be administered at least twice during the program.</u>
1252		
1253		
1254		
1255		
1256	V.A. 1.b).(1).(c)	<u>Practice-based Learning and Improvement</u>
1257		
1258		<u>The program must use performance data to assess the fellow in:</u>
1259		
1260		
1261	V.A. 1.b).(1).(c).(i)	<u>application of evidence to patient care;</u>
1262		
1263	V.A. 1.b).(1).(c).(ii)	<u>practice improvement;</u>
1264		
1265	V.A. 1.b).(1).(c).(iii)	<u>teaching skills involving peers and patients;</u>
1266		<u>and,</u>
1267		
1268	V.A. 1.b).(1).(c).(iv)	<u>scholarship.</u>
1269		

1270	V.A. 1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
1271		
1272		<u>The program must use both direct observation and</u>
1273		<u>multi-source evaluation, including patients, peers</u>
1274		<u>and non-physician team members, to assess fellow</u>
1275		<u>performance in:</u>
1276		
1277	V.A. 1.b).(1).(d).(i)	<u>communication with patient and family;</u>
1278		
1279	V.A. 1.b).(1).(d).(ii)	<u>teamwork;</u>
1280		
1281	V.A. 1.b).(1).(d).(iii)	<u>communication with peers, including</u>
1282		<u>transitions in care; and,</u>
1283		
1284	V.A. 1.b).(1).(d).(iv)	<u>record keeping.</u>
1285		
1286	V.A. 1.b).(1).(e)	<u>Professionalism</u>
1287		
1288		<u>The program must use multi-source evaluation,</u>
1289		<u>including patients, peers, and non-physician team</u>
1290		<u>members, to assess each fellow's:</u>
1291		
1292	V.A. 1.b).(1).(e).(i)	<u>honesty and integrity;</u>
1293		
1294	V.A. 1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
1295		
1296	V.A. 1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
1297		<u>relationships with patients and colleagues;</u>
1298		<u>and,</u>
1299		
1300	V.A. 1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
1301		
1302	V.A. 1.b).(1).(f)	<u>Systems-based Practice</u>
1303		
1304		<u>The program must use multi-source evaluation,</u>
1305		<u>including peers, and non-physician team members,</u>
1306		<u>to assess each fellow's:</u>
1307		
1308	V.A. 1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
1309		<u>including transition of care;</u>
1310		
1311	V.A. 1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
1312		
1313	V.A. 1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
1314		
1315	V.A. 1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
1316		<u>participate in improvement activities.</u>
1317		
1318	<b>V.A.1.b).(2)</b>	<b>use multiple evaluators (e.g., faculty, peers, patients,</b>
1319		<b>self, and other professional staff);</b>
1320		

- 1321 **V.A.1.b).(3)** document progressive fellow performance  
 1322 improvement appropriate to educational level; and,  
 1323
- 1324 **V.A.1.b).(4)** provide each fellow with documented semiannual  
 1325 evaluation of performance with feedback.  
 1326
- 1327 **V.A.1.b).(4).(a)** *Fellows' performance in continuity clinic must be*  
 1328 *reviewed with them verbally and in writing at least*  
 1329 *semiannually.*  
 1330
- 1331 **V.A.1.c)** The evaluations of fellow performance must be accessible for  
 1332 review by the fellow, in accordance with institutional policy.  
 1333
- 1334 **V.A.2.** **Summative Evaluation**  
 1335
- 1336 The program director must provide a summative evaluation for each  
 1337 fellow upon completion of the program. This evaluation must  
 1338 become part of the fellow's permanent record maintained by the  
 1339 institution, and must be accessible for review by the fellow in  
 1340 accordance with institutional policy. This evaluation must:  
 1341
- 1342 **V.A.2.a)** document the fellow's performance during the final period of  
 1343 education; and,  
 1344
- 1345 **V.A.2.b)** verify that the fellow has demonstrated sufficient competence  
 1346 to enter practice without direct supervision.  
 1347
- 1348 **V.B.** **Faculty Evaluation**  
 1349
- 1350 **V.B.1.** At least annually, the program must evaluate faculty performance as  
 1351 it relates to the educational program.  
 1352
- 1353 **V.B.2.** These evaluations should include a review of faculty's clinical  
 1354 teaching abilities, commitment to the educational program, clinical  
 1355 knowledge, professionalism, and scholarly activities.  
 1356
- 1357 **V.B.3.** This evaluation must include at least annual written confidential  
 1358 evaluations by fellows.  
 1359
- 1360 **V.B.3.a)** *~~In addition,~~ Fellows must have the opportunity to provide*  
 1361 *confidential written evaluations of each supervising faculty*  
 1362 *member at the end of a rotation.*  
 1363
- 1364 **V.B.3.b)** *~~The program must be reviewed~~ These evaluations must be*  
 1365 *reviewed with each ~~attending~~ faculty member annually.*  
 1366
- 1367 **V.C.** **Program Evaluation and Improvement**  
 1368
- 1369 **V.C.1.** The program must document formal, systematic evaluation of the  
 1370 curriculum at least annually. The program must monitor and track

- 1371 each of the following areas:
- 1372
- 1373 **V.C.1.a)** fellow performance;
- 1374
- 1375 **V.C.1.b)** faculty development;
- 1376
- 1377 **V.C.1.c)** graduate performance, including performance of program
- 1378 graduates on the certification examination; and,
- 1379
- 1380 V.C.1.c).(1) *At least 80% of program's graduating fellows from those*
- 1381 *eligible to take an ABIM subspecialty certifying*
- 1382 *examination upon completion of their training for the most*
- 1383 *recently defined five year period who are eligible should*
- 1384 *must have taken an the ABIM subspecialty certifying*
- 1385 *examination. (Note: Five-year rolling pass rate for first-time*
- 1386 *takers of the ABIM certifying examination will be examined*
- 1387 *at each program review).*
- 1388
- 1389 V.C.1.c).(2) *At least 80% of a program's graduates taking the ABIM*
- 1390 *certifying examination for the first time during the most*
- 1391 *recently defined five year period should pass.*
- 1392
- 1393 **V.C.1.d)** program quality. Specifically:
- 1394
- 1395 **V.C.1.d).(1)** **Fellows and faculty must have the opportunity to**
- 1396 **evaluate the program confidentially and in writing at**
- 1397 **least annually.**
- 1398
- 1399 **V.C.1.d).(2)** **The program must use the results of fellows'**
- 1400 **assessments of the program together with other**
- 1401 **program evaluation results to improve the program.**
- 1402
- 1403 V.C.1.d).(3) *At least 80% of the entering fellows should have*
- 1404 *completed the program when averaged over a five-year*
- 1405 *period.*
- 1406
- 1407 **V.C.2.** **If deficiencies are found, the program should prepare a written plan**
- 1408 **of action to document initiatives to improve performance in the**
- 1409 **areas listed in section V.C.1. The action plan should be reviewed**
- 1410 **and approved by the teaching faculty and documented in meeting**
- 1411 **minutes.**
- 1412
- 1413 V.C.3. *Representative program personnel, at a minimum to include the program*
- 1414 *director, representative faculty, and one fellow, must review program*
- 1415 *goals and objectives, and the effectiveness with which they are achieved.*
- 1416
- 1417 **VI. Fellow Duty Hours in the Learning and Working Environment**
- 1418
- 1419 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
- 1420

- 1421 VI.A.1. Programs and sponsoring institutions must educate fellows and  
 1422 faculty members concerning the professional responsibilities of  
 1423 physicians to appear for duty appropriately rested and fit to provide  
 1424 the services required by their patients.  
 1425
- 1426 VI.A.2. The program must be committed to and responsible for promoting  
 1427 patient safety and fellow well-being in a supportive educational  
 1428 environment.  
 1429
- 1430 VI.A.3. The program director must ensure that fellows are integrated and  
 1431 actively participate in interdisciplinary clinical quality improvement  
 1432 and patient safety programs.  
 1433
- 1434 VI.A.4. The learning objectives of the program must:
- 1435
- 1436 VI.A.4.a) be accomplished through an appropriate blend of supervised  
 1437 patient care responsibilities, clinical teaching, and didactic  
 1438 educational events; and,  
 1439
- 1440 VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill  
 1441 non-physician service obligations.  
 1442
- 1443 *VI.A.4.b).(1) ~~Fellows' service responsibilities must be limited to patients~~*  
 1444 *~~for whom the teaching service has diagnostic and~~*  
 1445 *~~therapeutic responsibility.~~*  
 1446
- 1447 VI.A.5. The program director and institution must ensure a culture of  
 1448 professionalism that supports patient safety and personal  
 1449 responsibility. Fellows and faculty members must demonstrate an  
 1450 understanding and acceptance of their personal role in the  
 1451 following:  
 1452
- 1453 VI.A.5.a) assurance of the safety and welfare of patients entrusted to  
 1454 their care;  
 1455
- 1456 VI.A.5.b) provision of patient- and family-centered care;  
 1457
- 1458 VI.A.5.c) assurance of their fitness for duty;  
 1459
- 1460 VI.A.5.d) management of their time before, during, and after clinical  
 1461 assignments;  
 1462
- 1463 VI.A.5.e) recognition of impairment, including illness and fatigue, in  
 1464 themselves and in their peers;  
 1465
- 1466 VI.A.5.f) attention to lifelong learning;  
 1467
- 1468 VI.A.5.g) the monitoring of their patient care performance improvement  
 1469 indicators; and,  
 1470

- 1471 **VI.A.5.h)** **honest and accurate reporting of duty hours, patient**  
1472 **outcomes, and clinical experience data.**  
1473
- 1474 **VI.A.6.** **All fellows and faculty members must demonstrate responsiveness**  
1475 **to patient needs that supersedes self-interest. Physicians must**  
1476 **recognize that under certain circumstances, the best interests of the**  
1477 **patient may be served by transitioning that patient's care to another**  
1478 **qualified and rested provider.**  
1479
- 1480 **VI.B. Transitions of Care**  
1481
- 1482 **VI.B.1.** **Programs must design clinical assignments to minimize the number**  
1483 **of transitions in patient care.**  
1484
- 1485 **VI.B.2.** **Sponsoring institutions and programs must ensure and monitor**  
1486 **effective, structured hand-over processes to facilitate both**  
1487 **continuity of care and patient safety.**  
1488
- 1489 **VI.B.3.** **Programs must ensure that fellows are competent in communicating**  
1490 **with team members in the hand-over process.**  
1491
- 1492 **VI.B.4.** **The sponsoring institution must ensure the availability of schedules**  
1493 **that inform all members of the health care team of attending**  
1494 **physicians and fellows currently responsible for each patient's care.**  
1495
- 1496 **VI.C. Alertness Management/Fatigue Mitigation**  
1497
- 1498 **VI.C.1. The program must:**  
1499
- 1500 **VI.C.1.a)** **educate all faculty members and fellows to recognize the**  
1501 **signs of fatigue and sleep deprivation;**  
1502
- 1503 **VI.C.1.b)** **educate all faculty members and fellows in alertness**  
1504 **management and fatigue mitigation processes; and,**  
1505
- 1506 **VI.C.1.c)** **adopt fatigue mitigation processes to manage the potential**  
1507 **negative effects of fatigue on patient care and learning, such**  
1508 **as naps or back-up call schedules.**  
1509
- 1510 **VI.C.2.** **Each program must have a process to ensure continuity of patient**  
1511 **care in the event that a fellow may be unable to perform his/her**  
1512 **patient care duties.**  
1513
- 1514 **VI.C.3.** **The sponsoring institution must provide adequate sleep facilities**  
1515 **and/or safe transportation options for fellows who may be too**  
1516 **fatigued to safely return home.**  
1517
- 1518 **VI.D. Supervision of Fellows**  
1519
- 1520 **VI.D.1.** **In the clinical learning environment, each patient must have an**

1521 identifiable, appropriately-credentialed and privileged attending  
1522 physician (or licensed independent practitioner as approved by each  
1523 Review Committee) who is ultimately responsible for that patient's  
1524 care.

1525

1526 **VI.D.1.a)** This information should be available to fellows, faculty  
1527 members, and patients.

1528

1529 **VI.D.1.b)** Fellows and faculty members should inform patients of their  
1530 respective roles in each patient's care.  
1531

1532 **VI.D.2.** The program must demonstrate that the appropriate level of  
1533 supervision is in place for all fellows who care for patients.  
1534

1535 Supervision may be exercised through a variety of methods. Some  
1536 activities require the physical presence of the supervising faculty  
1537 member. For many aspects of patient care, the supervising  
1538 physician may be a more advanced resident or fellow. Other  
1539 portions of care provided by the fellow can be adequately  
1540 supervised by the immediate availability of the supervising faculty  
1541 member or resident physician, either in the institution, or by means  
1542 of telephonic and/or electronic modalities. In some circumstances,  
1543 supervision may include post-hoc review of fellow-delivered care  
1544 with feedback as to the appropriateness of that care.  
1545

1546 **VI.D.3.** Levels of Supervision

1547

1548 To ensure oversight of fellow supervision and graded authority and  
1549 responsibility, the program must use the following classification of  
1550 supervision:  
1551

1552 **VI.D.3.a)** Direct Supervision – the supervising physician is physically  
1553 present with the fellow and patient.  
1554

1555 **VI.D.3.b)** Indirect Supervision:

1556

1557 **VI.D.3.b).(1)** with direct supervision immediately available – the  
1558 supervising physician is physically within the hospital  
1559 or other site of patient care, and is immediately  
1560 available to provide Direct Supervision.  
1561

1562 **VI.D.3.b).(2)** with direct supervision available – the supervising  
1563 physician is not physically present within the hospital  
1564 or other site of patient care, but is immediately  
1565 available by means of telephonic and/or electronic  
1566 modalities, and is available to provide Direct  
1567 Supervision.  
1568

1569 **VI.D.3.c)** Oversight – the supervising physician is available to provide  
1570 review of procedures/encounters with feedback provided

1571 after care is delivered.

1572

1573 **VI.D.4.** The privilege of progressive authority and responsibility, conditional

1574 independence, and a supervisory role in patient care delegated to

1575 each fellow must be assigned by the program director and faculty

1576 members.

1577

1578 **VI.D.4.a)** The program director must evaluate each fellow's abilities

1579 based on specific criteria. When available, evaluation should

1580 be guided by specific national standards-based criteria.

1581

1582 **VI.D.4.b)** Faculty members functioning as supervising physicians

1583 should delegate portions of care to fellows, based on the

1584 needs of the patient and the skills of the fellows.

1585

1586 **VI.D.4.c)** Senior residents or fellows should serve in a supervisory role

1587 of junior residents in recognition of their progress toward

1588 independence, based on the needs of each patient and the

1589 skills of the individual resident or fellow.

1590

1591 **VI.D.5.** Programs must set guidelines for circumstances and events in

1592 which fellows must communicate with appropriate supervising

1593 faculty members, such as the transfer of a patient to an intensive

1594 care unit, or end-of-life decisions.

1595

1596 **VI.D.5.a)** Each fellow must know the limits of his/her scope of

1597 authority, and the circumstances under which he/she is

1598 permitted to act with conditional independence.

1599

1600 **VI.D.5.a).(1)** In particular, PGY-1 residents should be supervised

1601 either directly or indirectly with direct supervision

1602 immediately available.

1603

1604 **VI.D.6.** Faculty supervision assignments should be of sufficient duration to

1605 assess the knowledge and skills of each fellow and delegate to

1606 him/her the appropriate level of patient care authority and

1607 responsibility.

1608

1609 **VI.E.** **Clinical Responsibilities**

1610

1611 The clinical responsibilities for each fellow must be based on PGY-level,

1612 patient safety, fellow education, severity and complexity of patient

1613 illness/condition and available support services.

1614

1615 **VI.F.** **Teamwork**

1616

1617 Fellows must care for patients in an environment that maximizes effective

1618 communication. This must include the opportunity to work as a member of

1619 effective interprofessional teams that are appropriate to the delivery of care

1620 in the specialty.

1621		
1622	<b>VI.G.</b>	<b>Fellow Duty Hours</b>
1623		
1624	<b>VI.G.1.</b>	<b>Maximum Hours of Work per Week</b>
1625		
1626		<b>Duty hours must be limited to 80 hours per week, averaged over a</b>
1627		<b>four-week period, inclusive of all in-house call activities and all</b>
1628		<b>moonlighting.</b>
1629		
1630	<b>VI.G.1.a)</b>	<b>Duty Hour Exceptions</b>
1631		
1632		<b>A Review Committee may grant exceptions for up to 10% or a</b>
1633		<b>maximum of 88 hours to individual programs based on a</b>
1634		<b>sound educational rationale.</b>
1635		
1636		<i>The Review Committee for Internal Medicine will not consider</i>
1637		<i>requests for exceptions to the 80-hour limit to the fellows' work</i>
1638		<i>week.</i>
1639		
1640	<b>VI.G.1.a).(1)</b>	<b>In preparing a request for an exception the program</b>
1641		<b>director must follow the duty hour exception policy</b>
1642		<b>from the ACGME Manual on Policies and Procedures.</b>
1643		
1644	<b>VI.G.1.a).(2)</b>	<b>Prior to submitting the request to the Review</b>
1645		<b>Committee, the program director must obtain approval</b>
1646		<b>of the institution's GMEC and DIO.</b>
1647		
1648	<b>VI.G.2.</b>	<b>Moonlighting</b>
1649		
1650	<b>VI.G.2.a)</b>	<b>Moonlighting must not interfere with the ability of the fellow</b>
1651		<b>to achieve the goals and objectives of the educational</b>
1652		<b>program.</b>
1653		
1654	<b>VI.G.2.b)</b>	<b>Time spent by fellows in Internal and External Moonlighting</b>
1655		<b>(as defined in the ACGME Glossary of Terms) must be</b>
1656		<b>counted towards the 80-hour Maximum Weekly Hour Limit.</b>
1657		
1658	<b>VI.G.2.c)</b>	<b>PGY-1 residents are not permitted to moonlight.</b>
1659		
1660	<b>VI.G.3.</b>	<b>Mandatory Time Free of Duty</b>
1661		
1662		<b>Fellows must be scheduled for a minimum of one day free of duty</b>
1663		<b>every week (when averaged over four weeks). At-home call cannot</b>
1664		<b>be assigned on these free days.</b>
1665		
1666	<b>VI.G.4.</b>	<b>Maximum Duty Period Length</b>
1667		
1668	<b>VI.G.4.a)</b>	<b>Duty periods of PGY-1 residents must not exceed 16 hours in</b>
1669		<b>duration.</b>
1670		

- 1671 **VI.G.4.b)** **Duty periods of PGY-2 residents and above may be**  
 1672 **scheduled to a maximum of 24 hours of continuous duty in**  
 1673 **the hospital. Programs must encourage fellows to use**  
 1674 **alertness management strategies in the context of patient**  
 1675 **care responsibilities. Strategic napping, especially after 16**  
 1676 **hours of continuous duty and between the hours of 10:00**  
 1677 **p.m. and 8:00 a.m., is strongly suggested.**  
 1678
- 1679 **VI.G.4.b).(1)** **It is essential for patient safety and fellow education**  
 1680 **that effective transitions in care occur. Fellows may be**  
 1681 **allowed to remain on-site in order to accomplish these**  
 1682 **tasks; however, this period of time must be no longer**  
 1683 **than an additional four hours.**  
 1684
- 1685 **VI.G.4.b).(2)** **Fellows must not be assigned additional clinical**  
 1686 **responsibilities after 24 hours of continuous in-house**  
 1687 **duty.**  
 1688
- 1689 **VI.G.4.b).(3)** **In unusual circumstances, fellows, on their own**  
 1690 **initiative, may remain beyond their scheduled period**  
 1691 **of duty to continue to provide care to a single patient.**  
 1692 **Justifications for such extensions of duty are limited**  
 1693 **to reasons of required continuity for a severely ill or**  
 1694 **unstable patient, academic importance of the events**  
 1695 **transpiring, or humanistic attention to the needs of a**  
 1696 **patient or family.**  
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- 1698 **VI.G.4.b).(3).(a)** **Under those circumstances, the fellow must:**  
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- 1700 **VI.G.4.b).(3).(a).(i)** **appropriately hand over the care of all**  
 1701 **other patients to the team responsible**  
 1702 **for their continuing care; and,**  
 1703
- 1704 **VI.G.4.b).(3).(a).(ii)** **document the reasons for remaining to**  
 1705 **care for the patient in question and**  
 1706 **submit that documentation in every**  
 1707 **circumstance to the program director.**  
 1708
- 1709 **VI.G.4.b).(3).(b)** **The program director must review each**  
 1710 **submission of additional service, and track**  
 1711 **both individual fellow and program-wide**  
 1712 **episodes of additional duty.**  
 1713
- 1714 **VI.G.5. Minimum Time Off between Scheduled Duty Periods**  
 1715
- 1716 **VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight**  
 1717 **hours, free of duty between scheduled duty periods.**  
 1718
- 1719 **VI.G.5.b) Intermediate-level residents should have 10 hours free of**  
 1720 **duty, and must have eight hours between scheduled duty**

1721		<b>periods. They must have at least 14 hours free of duty after 24</b>
1722		<b>hours of in-house duty.</b>
1723		
1724		<u>Internal medicine subspecialty fellows are considered to be in the</u>
1725		<u>final years of education.</u>
1726		
1727	<b>VI.G.5.c)</b>	<b>Residents in the final years of education must be prepared to</b>
1728		<b>enter the unsupervised practice of medicine and care for</b>
1729		<b>patients over irregular or extended periods.</b>
1730		
1731		<u>Internal medicine subspecialty fellows are considered to be in the</u>
1732		<u>final years of education.</u>
1733		
1734	<b>VI.G.5.c).(1)</b>	<b>This preparation must occur within the context of the</b>
1735		<b>80-hour, maximum duty period length, and one-day-</b>
1736		<b>off-in-seven standards. While it is desirable that</b>
1737		<b>fellows in their final years of education have eight</b>
1738		<b>hours free of duty between scheduled duty periods,</b>
1739		<b>there may be circumstances when these fellows must</b>
1740		<b>stay on duty to care for their patients or return to the</b>
1741		<b>hospital with fewer than eight hours free of duty.</b>
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1743	<b>VI.G.5.c).(1).(a)</b>	<b>Circumstances of return-to-hospital activities</b>
1744		<b>with fewer than eight hours away from the</b>
1745		<b>hospital by fellows in their final years of</b>
1746		<b>education must be monitored by the program</b>
1747		<b>director.</b>
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1749	<b>VI.G.5.c).(1).(b)</b>	<u>In unusual circumstances, fellows may remain</u>
1750		<u>beyond their scheduled period of duty or return</u>
1751		<u>after their scheduled period of duty to provide care</u>
1752		<u>to a single patient. Justifications for such</u>
1753		<u>extensions of duty are limited to reasons of</u>
1754		<u>required continuity of care for a severely ill or</u>
1755		<u>unstable patient, academic importance of the</u>
1756		<u>events transpiring, or humanistic attention to the</u>
1757		<u>needs of the patient or family. Such episodes</u>
1758		<u>should be rare, must be of the fellows' own</u>
1759		<u>initiative, and need not initiate a new 'off-duty</u>
1760		<u>period' nor require a change in the scheduled 'off-</u>
1761		<u>duty period.'</u>
1762		
1763	<b>VI.G.5.c).(1).(c)</b>	<u>Under such circumstances, the fellow must</u>
1764		<u>appropriately hand over care of all other patients to</u>
1765		<u>the team responsible for their continuing care, and</u>
1766		<u>document the reasons for remaining or returning to</u>
1767		<u>care for the patient in question and submit that</u>
1768		<u>documentation to the program director.</u>
1769		
1770	<b>VI.G.5.c).(1).(d)</b>	<u>The program director must review each submission</u>
1771		<u>of additional service and track both individual</u>

fellows' and program-wide episodes of additional duty.

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**VI.G.6.**  
**VI.G.7.**

**Maximum Frequency of In-House Night Float**  
**Fellows must not be scheduled for more than six consecutive nights of night float.**

**Maximum In-House On-Call Frequency**  
**PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).**

**VI.G.7.a)**

*Internal Medicine ~~residency programs are~~ fellowships must not ~~allowed to~~ average in-house call over a four-week period.*

**VI.G.8.**

**At-Home Call**

**VI.G.8.a)**

**Time spent in the hospital by fellows on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.**

**VI.G.8.a).(1)**

**At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.**

**VI.G.8.b)**

**Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".**

**VII. Innovative Projects**

**Requests for innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to fellows for the duration of such a project.**

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