

1 **ACGME Program Requirements for Graduate Medical Education**  
2 **in Pulmonary Disease and Critical Care Medicine (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. Pulmonary medicine focuses on the etiology, diagnosis, prevention, and**  
35 **treatment of diseases affecting the lungs and related organs. Critical care**  
36 **medicine is concerned with the diagnosis, management, and prevention of**  
37 **complications in patients who are severely ill and who usually require intensive**  
38 **monitoring and/or organ system support. Pulmonary disease and critical care**  
39 **medicine fellowships must provide advanced education to allow the fellow to**  
40 **acquire competency in these subspecialties with sufficient expertise to act as an**  
41 **independent consultant.**

42  
43 **Int.C. ~~An~~The educational program ~~accredited fellowship~~ in pulmonary disease and**  
44 **critical care medicine must ~~provide~~ be 36 months of supervised graduate medical**  
45 **education in length.**

46  
47 **I. Institutions**

48  
49 **I.A. Sponsoring Institution**

50  
51 **One sponsoring institution must assume ultimate responsibility for the**

52 program, as described in the Institutional Requirements, and this  
53 responsibility extends to fellow assignments at all participating sites.

54  
55 The sponsoring institution and program must ensure that the program  
56 director has sufficient protected time and financial support for his or her  
57 educational and administrative responsibilities to the program.

58  
59 I.A.1. A pulmonary disease and critical care medicine fellowship must function  
60 as an integral part of an ACGME-accredited residency program in internal  
61 medicine.

62  
63 I.A.2. Located at the primary clinical site, there should be at least three ~~In order-~~  
64 ~~to provide opportunities for peer interaction in the care of critically ill-~~  
65 ~~patients, the primary site should sponsor at least two~~ ACGME-accredited  
66 internal medicine subspecialty programs from the following disciplines:  
67 cardiovascular disease, gastroenterology, infectious diseases, or  
68 nephrology ~~(these should be located at the primary clinical site).~~

69  
70 I.A.3. The sponsoring institution must should sponsor an ACGME-accredited  
71 residency program in general surgery.

72  
73 I.A.4. *The sponsoring institution must:*

74  
75 I.A.4.a) establish the pulmonary disease and critical care medicine  
76 fellowship within a department of internal medicine or an  
77 administrative unit whose primary mission is the advancement of  
78 internal medicine subspecialty education and patient care; and,

79  
80 I.A.4.b) ~~ensure that provide the program director is provided with~~  
81 ~~adequate salary support for the administrative activities of the~~  
82 ~~fellowship.~~

83  
84 I.A.4.b).(1) *The program director must not be required to generate*  
85 *clinical or other income to provide this administrative*  
86 *support.*

87  
88 I.A.4.b).(2) ~~It is suggested~~ This support should be 25-50% of the  
89 program director's salary, or protected time, depending on  
90 the size of the program.

91  
92 I.A.5. *The sponsoring institution and participating sites must:*

93  
94 I.A.5.a) demonstrate that there is a culture of continuous quality  
95 improvement in the areas of patient care, patient safety, and  
96 education;

97  
98 I.A.5.b) demonstrate a commitment to quality patient-centered care and  
99 safety, education, research and scholarship sufficient to support  
100 the fellowship program; and,

101  
102 I.A.5.c) share appropriate inpatient and outpatient faculty performance

- 103 *data with the program director.*
- 104
- 105 I.A.1.a) *provide fellow compensation, and benefits, faculty, facilities, and*
- 106 *resources for education, clinical care, and research required for*
- 107 *accreditation;*
- 108
- 109 I.A.5.d) *notify the Review Committee within 60 days of changes in*
- 110 *institutional governance, affiliation, or resources that affect the*
- 111 *educational program as outlined in the Institutional Requirements;*
- 112 *and*
- 113
- 114 I.A.5.e) *provide fellowship positions in each training program that do not*
- 115 *number the number of accredited training years in the program;*
- 116
- 117 **I.B. Participating Sites**
- 118
- 119 **I.B.1. There must be a program letter of agreement (PLA) between the**
- 120 **program and each participating site providing a required**
- 121 **assignment. The PLA must be renewed at least every five years.**
- 122
- 123 **The PLA should:**
- 124
- 125 **I.B.1.a) identify the faculty who will assume both educational and**
- 126 **supervisory responsibilities for fellows;**
- 127
- 128 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
- 129 **formal evaluation of fellows, as specified later in this**
- 130 **document;**
- 131
- 132 **I.B.1.c) specify the duration and content of the educational**
- 133 **experience; and,**
- 134
- 135 **I.B.1.d) state the policies and procedures that will govern fellow**
- 136 **education during the assignment.**
- 137
- 138 **I.B.2. The program director must submit any additions or deletions of**
- 139 **participating sites routinely providing an educational experience,**
- 140 **required for all fellows, of one month full time equivalent (FTE) or**
- 141 **more through the Accreditation Council for Graduate Medical**
- 142 **Education (ACGME) Accreditation Data System (ADS).**
- 143
- 144 **II. Program Personnel and Resources**
- 145
- 146 **II.A. Program Director**
- 147
- 148 **II.A.1. There must be a single program director with authority and**
- 149 **accountability for the operation of the program. The sponsoring**
- 150 **institution's GMEC must approve a change in program director. After**
- 151 **approval, the program director must submit this change to the**
- 152 **ACGME via the ADS.**

- 153  
154 **II.A.2.**                   **The program director should continue in his or her position for a**  
155 **length of time adequate to maintain continuity of leadership and**  
156 **program stability.**  
157
- 158 **II.A.3.**                   **Qualifications of the program director must include:**  
159
- 160 **II.A.3.a)**                   **requisite specialty expertise and documented educational**  
161 **and administrative experience acceptable to the Review**  
162 **Committee;**  
163
- 164 **II.A.3.a).(1)**                   The program director must have at least five years of  
165 participation as an active faculty member in an ACGME-  
166 accredited **internal medicine residency, or pulmonary**  
167 **disease or critical care medicine fellowship.**  
168
- 169 **II.A.3.b)**                   **current certification in the subspecialty by the American**  
170 **Board of Internal Medicine (ABIM), or specialty qualifications**  
171 **acceptable to the Review Committee; and,**  
172
- 173 **II.A.3.b).(1)**                   The Review Committee only accepts current ABIM  
174 certification in **pulmonary disease or critical care medicine.**  
175
- 176 **II.A.3.b).(2)**                   If the program director does not have appropriate  
177 credentials in both subspecialties, an appropriately-  
178 credentialed and full-time **Key Clinical Faculty (KCF)**  
179 member must be identified as responsible for the  
180 education program in the second specific area.  
181
- 182 **II.A.3.c)**                   **current medical licensure and appropriate medical staff**  
183 **appointment.**  
184
- 185 **II.A.4.**                   **The program director must administer and maintain an educational**  
186 **environment conducive to educating the fellows in each of the**  
187 **ACGME competency areas. The program director must:**  
188
- 189 **II.A.4.a)**                   **oversee and ensure the quality of didactic and clinical**  
190 **education in all sites that participate in the program;**  
191
- 192 **II.A.4.b)**                   **approve a local director at each participating site who is**  
193 **accountable for fellow education;**  
194
- 195 **II.A.4.c)**                   **approve the selection of program faculty as appropriate;**  
196
- 197 **II.A.4.d)**                   **evaluate program faculty and approve the continued**  
198 **participation of program faculty based on evaluation;**  
199
- 200 **II.A.4.e)**                   **monitor fellow supervision at all participating sites;**  
201
- 202 **II.A.4.f)**                   **prepare and submit all information required and requested by**

203 the ACGME, including but not limited to the program  
204 information forms and annual program fellow updates to the  
205 ADS, and ensure that the information submitted is accurate  
206 and complete;

207

208 **II.A.4.g)** provide each fellow with documented semiannual evaluation  
209 of performance with feedback;

210

211 **II.A.4.h)** ensure compliance with grievance and due process  
212 procedures, as set forth in the Institutional Requirements and  
213 implemented by the sponsoring institution;

214

215 **II.A.4.i)** provide verification of fellowship education for all fellows,  
216 including those who leave the program prior to completion;

217

218 **II.A.4.j)** implement policies and procedures consistent with the  
219 institutional and program requirements for fellow duty hours  
220 and the working environment, including moonlighting, and, to  
221 that end, must:

222

223 **II.A.4.j).(1)** distribute these policies and procedures to the fellows  
224 and faculty;

225

226 **II.A.4.j).(2)** monitor fellow duty hours, according to sponsoring  
227 institutional policies, with a frequency sufficient to  
228 ensure compliance with ACGME requirements;

229

230 **II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive  
231 service demands and/or fatigue; and,

232

233 **II.A.4.j).(4)** if applicable, monitor the demands of at-home call and  
234 adjust schedules as necessary to mitigate excessive  
235 service demands and/or fatigue.

236

237 **II.A.4.k)** monitor the need for and ensure the provision of back up  
238 support systems when patient care responsibilities are  
239 unusually difficult or prolonged;

240

241 **II.A.4.l)** comply with the sponsoring institution's written policies and  
242 procedures, including those specified in Institutional  
243 Requirements, for selection, evaluation and promotion of  
244 fellows, disciplinary action, and supervision of fellows;

245

246 **II.A.4.m)** be familiar with and comply with ACGME and Review  
247 Committee policies and procedures as outlined in the ACGME  
248 Manual of Policies and Procedures;

249

250 **II.A.4.n)** obtain review and approval of the sponsoring institution's  
251 GMEC/DIO before submitting to the ACGME information or  
252 requests for the following:

253		
254	II.A.4.n).(1)	all applications for ACGME accreditation of new
255		programs;
256		
257	II.A.4.n).(2)	changes in fellow complement;
258		
259	II.A.4.n).(3)	major changes in program structure or length of
260		training;
261		
262	II.A.4.n).(4)	progress reports requested by the Review Committee;
263		
264	II.A.4.n).(5)	responses to all proposed adverse actions;
265		
266	II.A.4.n).(6)	requests for increases or any change to fellow duty
267		hours;
268		
269	II.A.4.n).(7)	voluntary withdrawals of ACGME-accredited
270		programs;
271		
272	II.A.4.n).(8)	requests for appeal of an adverse action;
273		
274	II.A.4.n).(9)	appeal presentations to a Board of Appeal or the
275		ACGME; and,
276		
277	II.A.4.n).(10)	proposals to ACGME for approval of innovative
278		educational approaches.
279		
280	II.A.4.o)	obtain DIO review and co-signature on all program
281		information forms, as well as any correspondence or
282		document submitted to the ACGME that addresses:
283		
284	II.A.4.o).(1)	program citations; and/or,
285		
286	II.A.4.o).(2)	request for changes in the program that would have
287		significant impact, including financial, on the program
288		or institution.
289		
290	II.A.4.p)	<i>be responsible for monitoring fellow stress, including mental or</i>
291		<i>emotional conditions inhibiting performance or learning, and drug-</i>
292		<i>or alcohol-related dysfunction.</i>
293		
294	II.A.4.p).(1)	<del><i>Both The program director and faculty should provide</i></del>
295		<del><i>access to be sensitive to the need for timely provision of</i></del>
296		<del><i>confidential counseling and psychological support services</i></del>
297		<del><i>to fellows.</i></del>
298		
299	II.A.4.p).(2)	<i>Situations that demand excessive service or that</i>
300		<i>consistently produce undesirable stress on fellows must be</i>
301		<i>evaluated and modified.</i>
302		

- 303 *II.A.4.q) ensure that fellows' service responsibilities are limited to patients*  
 304 *for whom the teaching service has diagnostic and therapeutic*  
 305 *responsibility.*  
 306  
 307 *II.A.4.r) dedicate an average of 20 hours per week of his or her*  
 308 *professional effort to the ~~internal medicine subspecialty program~~*  
 309 *fellowship, ~~including with sufficient time for administration of the~~*  
 310 *program; ~~and receive institutional support for that administrative~~*  
 311 *time.*  
 312  
 313 *II.A.4.s) participate in academic societies and in educational programs*  
 314 *designed to enhance his or her educational and administrative*  
 315 *skills;*  
 316  
 317 *II.A.4.t) have a reporting relationship with program director of the internal*  
 318 *medicine residency program to ensure compliance with ~~the~~*  
 319 *ACGME accreditation standards; and,*  
 320  
 321 *II.A.4.u) be available ~~located~~ at the primary principal clinical site.*  
 322

323 **II.B. Faculty**

- 324  
 325 **II.B.1. At each participating site, there must be a sufficient number of**  
 326 **faculty with documented qualifications to instruct and supervise all**  
 327 **fellows at that location.**  
 328  
 329 **The faculty must:**  
 330  
 331 **II.B.1.a) devote sufficient time to the educational program to fulfill**  
 332 **their supervisory and teaching responsibilities; and to**  
 333 **demonstrate a strong interest in the education of fellows;**  
 334 **and,**  
 335  
 336 **II.B.1.b) administer and maintain an educational environment**  
 337 **conducive to educating fellows in each of the ACGME**  
 338 **competency areas.**  
 339  
 340 **II.B.2. The physician faculty must have current certification in the**  
 341 **subspecialty by the American Board of Internal Medicine, or possess**  
 342 **qualifications acceptable by the Review Committee.**  
 343  
 344 **II.B.3. The physician faculty must possess current medical licensure and**  
 345 **appropriate medical staff appointment.**  
 346  
 347 **II.B.4. The nonphysician faculty must have appropriate qualifications in**  
 348 **their field and hold appropriate institutional appointments.**  
 349  
 350 **II.B.5. The faculty must establish and maintain an environment of inquiry**  
 351 **and scholarship with an active research component.**  
 352

- 353 **II.B.5.a)** **The faculty must regularly participate in organized clinical**  
354 **discussions, rounds, journal clubs, and conferences.**  
355
- 356 **II.B.5.b)** **Some members of the faculty should also demonstrate**  
357 **scholarship by one or more of the following:**  
358
- 359 **II.B.5.b).(1)** **peer-reviewed funding;**  
360
- 361 **II.B.5.b).(2)** **publication of original research or review articles in**  
362 **peer-reviewed journals or chapters in textbooks;**  
363
- 364 **II.B.5.b).(3)** **publication or presentation of case reports or clinical**  
365 **series at local, regional, or national professional and**  
366 **scientific society meetings; or,**  
367
- 368 **II.B.5.b).(4)** **participation in national committees or educational**  
369 **organizations.**  
370
- 371 **II.B.5.c)** **Faculty should encourage and support fellows in scholarly**  
372 **activities.**  
373
- 374 *II.B.6. The physician faculty must meet professional standards of ethical*  
375 *behavior.*  
376
- 377 **II.B.7.** **Key Clinical Faculty**  
378
- 379 In addition to the program director, each program must have at least five  
380 Key Clinical Faculty (KCF). KCF are attending physicians who dedicate,  
381 on average, 10 hours per week throughout the year to the program. For  
382 programs with more than nine fellows, ~~enrolled during the accredited~~  
383 ~~portion of the program, a ratio of KCF to fellows of at least 1: there must~~  
384 ~~be at least one KCF for every 1.5 fellows. must be maintained.~~  
385
- 386 **II.B.7.a)** **Key Clinical Faculty Qualifications**  
387
- 388 **II.B.7.a).(1)** **KCF must be active clinicians with ~~broad~~ knowledge of,**  
389 **experience with, and commitment to pulmonary disease or**  
390 **critical care medicine as a discipline.**  
391
- 392 **II.B.7.a).(2)** **KCF must have current ABIM certification in pulmonary**  
393 **disease or critical care medicine.**  
394
- 395 **II.B.7.a).(3)** **At least three KCF must be ABIM-certified in pulmonary**  
396 **disease and at least three KCF must be ABIM-certified in**  
397 **critical care medicine.**  
398
- 399 *II.B.7.b) Key Clinical Faculty Responsibilities*  
400
- 401 *II.B.7.b).(1) In addition to the responsibilities of all individual faculty\_*  
402 *members, the KCF ~~with~~ and the program director are*

403 responsible for the planning, implementation, monitoring,  
404 and evaluation of the fellows' clinical and research ~~training~~  
405 education.

406  
407 *II.B.7.b).(2)* ~~The majority of key clinical faculty~~ (At least 50% of the  
408 KCF must demonstrate evidence of productivity in the  
409 scholarship, specifically, peer-reviewed funding;  
410 publication of original research, review articles, editorials,  
411 or case reports in peer-reviewed journals; or chapters in  
412 textbooks, as defined in II.B.5.b.(1) or (2) above

413  
414 *II.B.7.b).(3)* At least one of the KCF must:

415  
416 *II.B.7.b).(3).(a)* be knowledgeable in the evaluation and  
417 assessment of the ACGME competencies; and,

418  
419 *II.B.7.b).(3).(b)* spend significant time in the evaluation of fellows,  
420 including the direct observation of fellows with  
421 patients.

422  
423 *II.B.7.b).(4)* Appointment of one KCF to be an associate program  
424 director is suggested.

425  
426 *II.B.8.* ~~All~~ Clinical faculty members should participate in prescribed faculty  
427 development programs designed to enhance the effectiveness of their  
428 teaching.

429  
430 *II.B.9.* Other Faculty

431  
432 *II.B.9.a)* ~~There must be~~ ABIM-certified clinical faculty members in  
433 nephrology, gastroenterology, cardiology, infectious disease,  
434 hematology, and oncology ~~and geriatric medicine who are certified~~  
435 ~~in their specialty by the American Board of Internal Medicine~~  
436 ~~(ABIM); these faculty members must participate in the educational~~  
437 ~~program.~~

438  
439 *II.B.9.b)* Faculty from several related disciplines, ~~such as~~ including general  
440 surgery, thoracic surgery, urology, orthopaedic surgery, obstetrics,  
441 and gynecology, neurology, neurological surgery, emergency  
442 medicine, anesthesiology, cardiovascular surgery, and vascular  
443 surgery must be available to participate in the program.

444  
445 **II.C. Other Program Personnel**

446  
447 **The institution and the program must jointly ensure the availability of all**  
448 **necessary professional, technical, and clerical personnel for the effective**  
449 **administration the program.**

450  
451 *II.C.1.* There must be services available from other health care professionals,  
452 including dietitians, language interpreters, nurses, occupational  
453 therapists, physical therapists, and social workers.

454  
455 II.C.2. Personnel must include ~~specialty-trained~~ nurses and technicians skilled in  
456 critical care instrumentation, respiratory function, and laboratory  
457 medicine.

458  
459 *II.C.3. ~~There must be~~ ensure the availability of appropriate and timely*  
460 *consultation from other specialties.*

461  
462 **II.D. Resources**

463  
464 **The institution and the program must jointly ensure the availability of**  
465 **adequate resources for fellow education, as defined in the specialty**  
466 **program requirements.**

467  
468 *II.D.1. Space and Equipment*

469  
470 *There must be space and equipment for the ~~educational~~ program,*  
471 *including meeting rooms, ~~classrooms~~, examination rooms, computers,*  
472 *visual and other educational aids, and work/study space.*

473  
474 *II.D.2. Facilities*

475  
476 *II.D.2.a) Inpatient and outpatient systems must be in place to prevent*  
477 *fellows from performing routine clerical functions, such as*  
478 *scheduling tests and appointments, and retrieving records and*  
479 *letters.*

480  
481 *II.D.2.b) The sponsoring institution must provide the broad range of*  
482 *facilities and clinical support services required to provide*  
483 *comprehensive care of adult patients. ~~Fellows must have clinical~~*  
484 *experiences in efficient, effective ambulatory and inpatient care*  
485 *settings.*

486  
487 *II.D.2.c) Fellows must have access to a lounge facility during assigned*  
488 *duty hours.*

489  
490 *II.D.2.d) When fellows are ~~assigned night duty~~ in the hospital, assigned*  
491 *night duty, or called in from home, they must be provided with ~~on-~~*  
492 *call facilities that are convenient and that afford privacy, safety,*  
493 *and a restful environment with a secure space for their*  
494 *belongings.*

495  
496 *II.D.3. Laboratory and Imaging Services*

497  
498 *The following must be available at the primary clinical site:*

499  
500 *II.D.3.a) a supporting laboratory ~~must be available to provide~~ that provides*  
501 *complete and prompt laboratory evaluation;*

502  
503 *II.D.3.b) ~~There must be~~ a pulmonary function testing laboratory;*  
504

- 505 II.D.3.c) timely bedside imaging services ~~available to~~ for patients in the  
506 critical care units;
- 507
- 508 II.D.3.d) computed tomography (CT) imaging, including CT angiography;  
509 and, must be available
- 510
- 511 II.D.3.e) a bronchoscopy suite, including appropriate space and staffing for  
512 pulmonary procedures.
- 513
- 514 II.D.4. ~~Other Facilities, Resources, or Support Services~~
- 515
- 516 II.D.4.a) The following must be available:
- 517
- 518 II.D.4.a).(1) an active open heart surgery program;
- 519
- 520 II.D.4.a).(2) ~~an accredited residency program in general surgery;~~
- 521
- 522 II.D.4.a).(3) a diagnostic laboratory for sleep disorders
- 523
- 524 II.D.4.a).(4) pathology services, including exfoliative cytology;
- 525
- 526 II.D.4.a).(5) thoracic surgery service;
- 527
- 528 II.D.4.a).(6) an active emergency service ~~must be available;~~
- 529
- 530 II.D.4.a).(7) postoperative care and respiratory care services ~~must be~~  
531 ~~available;~~ and,
- 532
- 533 II.D.4.a).(8) nutritional support services. ~~must be available;~~
- 534
- 535 II.D.4.b) ~~The~~ Critical care unit(s) must be located in a designated area  
536 within the hospital, and must be constructed and designed  
537 specifically for the care of critically-ill patients.
- 538
- 539 II.D.4.b).(1) Whether operating in separate locations or in combined  
540 facilities, the program must provide the equivalent of a  
541 medical intensive care unit (MICU), a surgical intensive  
542 care unit (SICU), and a coronary intensive care unit  
543 (CICU).
- 544
- 545 II.D.4.b).(2) The MICU or its equivalent must be at the primary clinical  
546 site, and should be the focus of a teaching service ~~in which~~  
547 ~~the program director or designee is responsible for the~~  
548 ~~educational program.~~
- 549
- 550 II.D.4.c) There must be facilities ~~must be adequate~~ to care for patients with  
551 acute myocardial infarction, severe trauma, shock, recent open  
552 heart surgery, recent major thoracic or abdominal surgery, and  
553 severe neurologic and neurosurgical conditions.
- 554
- 555 II.D.4.d) ~~There should be a close liaison with~~ Other services should be

556 available, including anesthesiology, immunology, laboratory  
557 medicine, microbiology, occupational medicine, otolaryngology,  
558 pathology, physical medicine and rehabilitation, and radiology,  
559 ~~and rehabilitation.~~

560  
561 II.D.5. Medical Records

562  
563 Access to an electronic health record should be provided. In the absence  
564 of an existing electronic health record, institutions must demonstrate  
565 institutional commitment to its development, and progress towards its  
566 implementation.

567  
568 II.D.6. Patient Population

569  
570 II.D.6.a) The patient population must have a variety of clinical problems  
571 and stages of diseases.

572  
573 II.D.6.b) There must be patients of ~~each~~ both gender, with a broad age  
574 range, including geriatric patients.

575  
576 II.D.6.c) A sufficient number of patients must be available to ~~enable~~ ensure  
577 adequate inpatient and ambulatory experience for each fellow to  
578 achieve the required educational outcomes.

579  
580 II.D.6.d) Because critical care medicine is multidisciplinary in nature, the  
581 program must provide opportunities to manage adult patients with  
582 a wide variety of serious illnesses and injuries requiring treatment  
583 in a critical care setting.

584  
585 II.D.6.e) ~~Provide fellows-~~ There must be an average daily census of at least  
586 five patients per fellow during assignments to critical care units.

587  
588 II.E. Medical Information Access

589  
590 **Fellows must have ready access to specialty-specific and other appropriate**  
591 **reference material in print or electronic format. Electronic medical literature**  
592 **databases with search capabilities should be available.**

593  
594 III. Fellow Appointments

595  
596 III.A. Eligibility Criteria

597  
598 **The program director must comply with the criteria for fellow eligibility as**  
599 **specified in the Institutional Requirements.**

600  
601 III.A.1. Prior to appointment in the fellowship ~~program~~, fellows should have  
602 completed an ACGME-accredited internal medicine ~~education~~ program.

603  
604 III.A.2. Fellows from non-ACGME-accredited internal medicine ~~education~~  
605 programs must have at least three years of internal medicine education  
606 prior to starting the fellowship.

- 607  
608 III.A.3. *When averaged over any five-year period, a minimum of 75% of fellows in*  
609 *each ~~subspecialty training program~~ must be graduates of an ACGME-*  
610 *accredited internal medicine ~~training program~~. ~~Non-ACGME internal~~*  
611 *medicine trained fellows must have at least three years of internal*  
612 *medicine training prior to starting fellowship.*  
613  
614 III.A.4. *The program director must inform ~~non-ACGME trained~~ applicants from*  
615 *non-ACGME-accredited programs, prior to appointment, and in writing, of*  
616 *the ABIM policies and procedures that ~~may~~ will affect ~~the fellow's~~ their*  
617 *eligibility for ABIM certification.*  
618  
619 **III.B. Number of Fellows**  
620  
621 **The program director may not appoint more fellows than approved by the**  
622 **Review Committee, unless otherwise stated in the specialty-specific**  
623 **requirements. The program's educational resources must be adequate to**  
624 **support the number of fellows appointed to the program.**  
625  
626 III.B.1. *The ~~minimum~~ number of available fellow positions in the training program*  
627 *must be at least one per year ~~not be less than the number of accredited~~*  
628 *~~training years in the program.~~*  
629  
630 **III.C. Fellow Transfers**  
631  
632 **III.C.1. Before accepting a fellow who is transferring from another program,**  
633 **the program director must obtain written or electronic verification of**  
634 **previous educational experiences and a summative competency-**  
635 **based performance evaluation of the transferring fellow.**  
636  
637 **III.C.2. A program director must provide timely verification of fellowship**  
638 **education and summative performance evaluations for fellows who**  
639 **leave the program prior to completion.**  
640  
641 **III.D. Appointment of Fellows and Other Learners**  
642  
643 **The presence of other learners (including, but not limited to, residents from**  
644 **other specialties, subspecialty fellows, PhD students, and nurse**  
645 **practitioners) in the program must not interfere with the appointed fellows'**  
646 **education. The program director must report the presence of other learners**  
647 **to the DIO and GMEC in accordance with sponsoring institution guidelines.**  
648  
649 **IV. Educational Program**  
650  
651 **IV.A. The curriculum must contain the following educational components:**  
652  
653 **IV.A.1. Overall educational goals for the program, which the program must**  
654 **distribute to fellows and faculty annually;**  
655  
656 **IV.A.2. Competency-based goals and objectives for each assignment at**

657 each educational level, which the program must distribute to fellows  
658 and faculty annually, in either written or electronic form. These  
659 should be reviewed by the fellow at the start of each rotation;  
660

661 **IV.A.3. Regularly scheduled didactic sessions; and**

662  
663 *IV.A.3.a) The core curriculum must include a didactic program based upon*  
664 *the core knowledge content in the subspecialty area.*

665  
666 *IV.A.3.a).(1) The program must afford each fellow an opportunity to*  
667 *review topics covered in conferences that he or she was*  
668 *unable to attend.*

669  
670 *IV.A.3.a).(2) Fellows must participate in clinical case conferences,*  
671 *journal clubs, research conferences, and morbidity and*  
672 *mortality or quality improvement conferences.*

673  
674 *IV.A.3.a).(3) All core conferences must have at least one faculty*  
675 *member present, and must be scheduled as to ensure*  
676 *peer-peer and peer-faculty interaction.*

677  
678 *IV.A.3.b) Patient-based teaching must include direct interaction between*  
679 *fellows and attendingsfaculty members, bedside teaching,*  
680 *discussion of pathophysiology, and the use of current evidence in*  
681 *diagnostic and therapeutic decisions. The teaching must be:*

682  
683 *IV.A.3.b).(1) formally conducted on all inpatient, outpatient, and*  
684 *consultative services; and,*

685  
686 *IV.A.3.b).(2) conducted with a frequency and duration sufficient to that*  
687 *ensures a meaningful and continuous teaching relationship*  
688 *between the assigned supervising faculty member(s)*  
689 *teaching attending and fellows.*

690  
691 *IV.A.3.c) Fellows must receive instruction in practice management relevant*  
692 *to pulmonary disease and critical care medicine.*

693  
694 **IV.A.4. Delineation of fellow responsibilities for patient care, progressive**  
695 **responsibility for patient management, and supervision of fellows**  
696 **over the continuum of the program.**

697  
698 **IV.A.5. ACGME Competencies**

699  
700 **The program must integrate the following ACGME competencies**  
701 **into the curriculum:**

702  
703 **IV.A.5.a) Patient Care**

704  
705 **Fellows must be able to provide patient care that is**  
706 **compassionate, appropriate, and effective for the treatment of**  
707 **health problems and the promotion of health. Fellows**

708		
709	IV.A.5.a).(1)	<i>must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care, and treatment of <del>men and women</del> patients of each gender, from adolescence to old age, during health and all stages of illness;</i>
710		
711		
712		
713		
714		
715	IV.A.5.a).(2)	must demonstrate competence in the prevention, evaluation and management of both inpatients and outpatients with the following:
716		
717		
718		
719	IV.A.5.a).(2).(a)	acute lung injury, including radiation, inhalation, and trauma;
720		
721		
722	IV.A.5.a).(2).(b)	acute metabolic disturbances, including overdoses and intoxication syndromes;
723		
724		
725	IV.A.5.a).(2).(c)	anaphylaxis and acute allergic reactions in the critical care unit;
726		
727		
728	IV.A.5.a).(2).(d)	cardiovascular diseases in the critical care unit;
729		
730	IV.A.5.a).(2).(e)	circulatory failure;
731		
732	IV.A.5.a).(2).(f)	detection and prevention of iatrogenic and nosocomial problems in critical care medicine;
733		
734		
735	IV.A.5.a).(2).(g)	diffuse interstitial lung disease;
736		
737	IV.A.5.a).(2).(h)	disorders of the pleura and the mediastinum;
738		
739	IV.A.5.a).(2).(i)	end of life issues and palliative care;
740		
741	IV.A.5.a).(2).(j)	hypertensive emergencies;
742		
743	IV.A.5.a).(2).(k)	iatrogenic respiratory diseases, including drug-induced disease;
744		
745		
746	IV.A.5.a).(2).(l)	immunosuppressed conditions in the critical care unit;
747		
748		
749	IV.A.5.a).(2).(m)	metabolic, nutritional and endocrine effects of critical illness, <u>and</u> hematologic and coagulation disorders associated with critical illness;
750		
751		
752		
753	IV.A.5.a).(2).(n)	multi-organ system failure;
754		
755	IV.A.5.a).(2).(o)	obstructive lung diseases, including asthma, bronchitis, emphysema, <u>and</u> bronchiectasis;
756		
757		
758	IV.A.5.a).(2).(p)	occupational and environmental lung diseases;

759		
760	IV.A.5.a).(2).(q)	perioperative critically-ill patients, <del>to include</del> hemodynamic and ventilatory support;
761		
762		
763	IV.A.5.a).(2).(r)	psychosocial and emotional effects of critical illness on patients and their families;
764		
765		
766	IV.A.5.a).(2).(s)	pulmonary embolism and pulmonary embolic disease;
767		
768		
769	IV.A.5.a).(2).(t)	pulmonary infections, including tuberculous, fungal, and <del>these infections</del> in the immunocompromised host (e.g., HIV-related infections);
770		
771		
772		
773	IV.A.5.a).(2).(u)	pulmonary malignancy—primary and metastatic;
774		
775	IV.A.5.a).(2).(v)	pulmonary manifestations of systemic diseases, including collagen vascular disease and diseases that are primary in other organs;
776		
777		
778		
779	IV.A.5.a).(2).(w)	pulmonary vascular disease, including primary and secondary pulmonary hypertension and the vasculitis and pulmonary hemorrhage syndromes;
780		
781		
782		
783	IV.A.5.a).(2).(x)	renal disorders in the critical care unit, including electrolyte and acid-base disturbance and acute renal failure;
784		
785		
786		
787	IV.A.5.a).(2).(y)	respiratory failure, including the acute respiratory distress syndrome, acute and chronic respiratory failure in obstructive lung diseases, and neuromuscular respiratory drive disorders;
788		
789		
790		
791		
792	IV.A.5.a).(2).(z)	sepsis and sepsis syndrome;
793		
794	IV.A.5.a).(2).(aa)	severe organ dysfunction resulting in critical illness to include disorders of the gastrointestinal, neurologic, endocrine, hematologic, musculoskeletal, and immune systems as well as infections and malignancies;
795		
796		
797		
798		
799		
800	IV.A.5.a).(2).(bb)	shock syndromes;
801		
802	IV.A.5.a).(2).(cc)	sleep-disordered breathing; and,
803		
804	IV.A.5.a).(2).(dd)	the use of paralytic agents and sedative and analgesic drugs in the critical care unit.
805		
806		
807	IV.A.5.a).(3)	must demonstrate competence in <del>the requisite procedural and technical skills, including the ability to interpret</del> data derived from various bedside devices commonly employed
808		
809		

810 to monitor patients, ~~and data from the interpretation of~~  
811 laboratory studies related to sputum, bronchopulmonary  
812 secretions, pleural fluid;

813

814 IV.A.5.a).(4) Fellows must demonstrate competence in procedural and  
815 technical skills, including:

816

817 IV.A.5.a).(4).(a) airway management;

818

819 IV.A.5.a).(4).(b) the use of a variety of positive pressure ventilatory  
820 modes, including:

821

822 IV.A.5.a).(4).(b).(i) initiation and maintenance, ~~weaning of~~  
823 ventilatory support;

824

825 IV.A.5.a).(4).(b).(ii) respiratory care techniques; and,

826

827 IV.A.5.a).(4).(b).(iii) withdrawal of mechanical ventilatory  
828 support.

829

830 IV.A.5.a).(4).(c) the use of reservoir masks and continuous positive  
831 airway pressure masks for delivery of supplemental  
832 oxygen, humidifiers, nebulizers, and incentive  
833 spirometry;

834

835 IV.A.5.a).(4).(d) flexible fiber-optic bronchoscopy procedures,  
836 including those where endobronchial and  
837 transbronchial biopsies, and transbronchial needle  
838 aspiration are performed (each fellow must perform  
839 a minimum of 50-100 such procedures);

840

841 IV.A.5.a).(4).(e) pulmonary function tests to assess respiratory  
842 mechanics and gas exchange, including  
843 spirometry, flow volume studies, lung volumes,  
844 diffusing capacity, arterial blood gas analysis,  
845 exercise studies, and interpretation of the results of  
846 bronchoprovocation testing using methacholine or  
847 histamine;

848

849 IV.A.5.a).(4).(f) diagnostic and therapeutic procedures, including  
850 paracentesis, lumbar puncture, thoracentesis,  
851 endotracheal intubation, and related procedures;

852

853 IV.A.5.a).(4).(g) use of chest tubes and drainage systems;

854

855 IV.A.5.a).(4).(h) insertion of arterial, central venous, and pulmonary  
856 artery balloon flotation catheters;

857

858 IV.A.5.a).(4).(i) operation of bedside hemodynamic monitoring  
859 systems;

860

- 861 IV.A.5.a).(4).(j) emergency cardioversion;  
 862  
 863 IV.A.5.a).(4).(k) interpretation of intracranial pressure monitoring;  
 864  
 865 IV.A.5.a).(4).(l) nutritional support;  
 866  
 867 IV.A.5.a).(4).(m) use of ultrasound techniques to perform  
 868 thoracentesis and place intravascular and  
 869 intracavitary tubes and catheters; and,  
 870  
 871 IV.A.5.a).(4).(n) use of transcutaneous pacemakers.  
 872

873 **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:**

- 879  
 880 IV.A.5.b).(1) *must demonstrate knowledge of the scientific method of*  
 881 *problem solving, and evidence-based decision making.*  
 882  
 883 IV.A.5.b).(2) *must develop-demonstrate knowledge-understanding of*  
 884 *indications, contraindications, limitations, complications,*  
 885 *techniques, and interpretation of results of those diagnostic*  
 886 *and therapeutic procedures integral to the discipline,*  
 887 *including the appropriate indication for and use of*  
 888 *screening tests/procedures, and.*  
 889  
 890 IV.A.5.b).(2).(a) must demonstrate knowledge in the indications,  
 891 contraindications and complications of placement  
 892 of percutaneous tracheostomies.  
 893  
 894 IV.A.5.b).(3) must demonstrate knowledge of: ~~appropriate to the~~  
 895 ~~practice of pulmonary disease and critical care medicine in~~  
 896 ~~each of the following areas:~~  
 897  
 898 IV.A.5.b).(3).(a) imaging techniques commonly employed in the  
 899 evaluation of patients with pulmonary disease or  
 900 critical illness, including the use of ultrasound;  
 901  
 902 IV.A.5.b).(3).(b) monitoring and supervising special services,  
 903 including:  
 904  
 905 IV.A.5.b).(3).(b).(i) respiratory care units;  
 906  
 907 IV.A.5.b).(3).(b).(ii) pulmonary function laboratories, including  
 908 quality control, quality assurance, and  
 909 proficiency standards; and,  
 910  
 911 IV.A.5.b).(3).(b).(iii) respiratory care techniques and services.

912		
913	IV.A.5.b).(3).(c)	the basic sciences, with particular emphasis on:
914		
915	IV.A.5.b).(3).(c).(i)	genetics and molecular biology as they
916		relate to pulmonary diseases;
917		
918	IV.A.5.b).(3).(c).(ii)	developmental biology;
919		
920	IV.A.5.b).(3).(c).(iii)	pulmonary physiology and pathophysiology
921		in systemic diseases; and,
922		
923	IV.A.5.b).(3).(c).(iv)	biochemistry and physiology, including cell
924		and molecular biology and immunology, as
925		they relate to pulmonary disease.
926		
927	IV.A.5.b).(3).(d)	indications, complications, and outcomes of lung
928		transplantation;
929		
930	IV.A.5.b).(3).(e)	pericardiocentesis;
931		
932	IV.A.5.b).(3).(f)	percutaneous needle biopsies;
933		
934	IV.A.5.b).(3).(g)	renal replacement therapy;
935		
936	IV.A.5.b).(3).(h)	pharmacokinetics, pharmacodynamics, and drug
937		metabolism and excretion in critical illness;
938		
939	IV.A.5.b).(3).(i)	principles and techniques of administration and
940		management of a MICU;
941		
942	IV.A.5.b).(3).(j)	ethical, economic, and legal aspects of critical
943		illness;
944		
945	IV.A.5.b).(3).(k)	recognition and management of the critically-ill from
946		disasters, including those caused by chemical and
947		biological agents; and,
948		
949	IV.A.5.b).(3).(l)	the psychosocial and emotional effects of critical
950		illness on patients and their families.
951		

**IV.A.5.c)**

**Practice-based Learning and Improvement**

**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:**

**IV.A.5.c).(1)**

**identify strengths, deficiencies, and limits in one's knowledge and expertise;**

963		
964	<b>IV.A.5.c).(2)</b>	<b>set learning and improvement goals;</b>
965		
966	<b>IV.A.5.c).(3)</b>	<b>identify and perform appropriate learning activities;</b>
967		
968	<b>IV.A.5.c).(4)</b>	<b>systematically analyze practice, using quality</b>
969		<b>improvement methods, and implement changes with</b>
970		<b>the goal of practice improvement;</b>
971		
972	<b>IV.A.5.c).(5)</b>	<b>incorporate formative evaluation feedback into daily</b>
973		<b>practice;</b>
974		
975	<b>IV.A.5.c).(6)</b>	<b>locate, appraise, and assimilate evidence from</b>
976		<b>scientific studies related to their patients' health</b>
977		<b>problems;</b>
978		
979	<b>IV.A.5.c).(7)</b>	<b>use information technology to optimize learning;</b>
980		
981	<b>IV.A.5.c).(8)</b>	<b>participate in the education of patients, families,</b>
982		<b>students, fellows and other health professionals; and,</b>
983		
984	<i>IV.A.5.c).(9)</i>	obtain procedure-specific informed consent by competently
985		educating patients about rationale, technique, and
986		complications of procedures.
987		
988	<b>IV.A.5.d)</b>	<b>Interpersonal and Communication Skills</b>
989		
990		<b>Fellows must demonstrate interpersonal and communication</b>
991		<b>skills that result in the effective exchange of information and</b>
992		<b>collaboration with patients, their families, and health</b>
993		<b>professionals. Fellows are expected to:</b>
994		
995	<b>IV.A.5.d).(1)</b>	<b>communicate effectively with patients, families, and</b>
996		<b>the public, as appropriate, across a broad range of</b>
997		<b>socioeconomic and cultural backgrounds;</b>
998		
999	<b>IV.A.5.d).(2)</b>	<b>communicate effectively with physicians, other health</b>
1000		<b>professionals, and health related agencies;</b>
1001		
1002	<b>IV.A.5.d).(3)</b>	<b>work effectively as a member or leader of a health care</b>
1003		<b>team or other professional group;</b>
1004		
1005	<b>IV.A.5.d).(4)</b>	<b>act in a consultative role to other physicians and</b>
1006		<b>health professionals; and,</b>
1007		
1008	<b>IV.A.5.d).(5)</b>	<b>maintain comprehensive, timely, and legible medical</b>
1009		<b>records, if applicable.</b>
1010		
1011	<b>IV.A.5.e)</b>	<b>Professionalism</b>
1012		

1013		<b>Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Fellows are expected to demonstrate:</b>
1014		
1015		
1016		
1017	<b>IV.A.5.e).(1)</b>	<b>compassion, integrity, and respect for others;</b>
1018		
1019	<b>IV.A.5.e).(2)</b>	<b>responsiveness to patient needs that supersedes self-interest;</b>
1020		
1021		
1022	<b>IV.A.5.e).(3)</b>	<b>respect for patient privacy and autonomy;</b>
1023		
1024	<b>IV.A.5.e).(4)</b>	<b>accountability to patients, society and the profession;</b>
1025		
1026	<b>IV.A.5.e).(5)</b>	<b>sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation;</b>
1027		
1028		
1029		
1030		
1031	<i>IV.A.5.e).(6)</i>	<i><u>high standards of ethical behavior, including maintaining appropriate professional boundaries and relationships with other physicians and other health care team members, and avoiding conflicts of interest; and.</u></i>
1032		
1033		
1034		
1035		
1036	<i>IV.A.5.e).(7)</i>	<i>a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values.</i>
1037		
1038		
1039	<b>IV.A.5.f)</b>	<b>Systems-based Practice</b>
1040		
1041		<b>Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.</b>
1042		
1043		
1044		
1045		<b>Fellows are expected to:</b>
1046		
1047	<b>IV.A.5.f).(1)</b>	<b>work effectively in various health care delivery settings and systems relevant to their clinical specialty;</b>
1048		
1049		
1050		
1051	<b>IV.A.5.f).(2)</b>	<b>coordinate patient care within the health care system relevant to their clinical specialty;</b>
1052		
1053		
1054	<b>IV.A.5.f).(3)</b>	<b>incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;</b>
1055		
1056		
1057		
1058	<b>IV.A.5.f).(4)</b>	<b>advocate for quality patient care and optimal patient care systems;</b>
1059		
1060		
1061	<b>IV.A.5.f).(5)</b>	<b>work in interprofessional teams to enhance patient safety and improve patient care quality;</b>
1062		

1063		
1064	<b>IV.A.5.f).(6)</b>	<b>participate in identifying system errors and implementing potential systems solutions;</b>
1065		
1066		
1067	IV.A.5.f).(7)	<del>skills required to acquire the skills to organize, administer, and direct a critical care unit; and, and to work effectively as a member of a multidisciplinary team;</del>
1068		
1069		
1070		
1071	IV.A.5.f).(8)	<del>skills required to acquire the skills to organize, administer and direct a respiratory therapy section. and to work effectively as a member of a multidisciplinary team; and</del>
1072		
1073		
1074		
1075	IV.A.6.	<u>Curriculum Organization and Fellow Experiences</u>
1076		
1077	IV.A.6.a)	Fellows must have at least 18 months of clinical <u>experiencetraining</u> . This must include:
1078		
1079		
1080	IV.A.6.a).(1)	at least nine months of <del>meaningful</del> patient care responsibility for inpatients and outpatients with a wide variety of pulmonary diseases, with an educational emphasis on pulmonary physiology and its correlation with clinical disorders;
1081		
1082		
1083		
1084		
1085		
1086	IV.A.6.a).(2)	at least nine months of <del>clinical training</del> in critical care medicine, of which at least six months must be devoted to the care of critically-ill medical patients ( <del>i.e.,</del> MICU/CICU or equivalent);
1087		
1088		
1089		
1090		
1091	IV.A.6.a).(2).(a)	at least three months <del>must be</del> devoted to the care of critically-ill non-medical patients ( <del>i.e.,</del> SICU, Burn Unit, Transplant Unit, Neurointensive Care, or equivalent). <del>This</del> These experience should consist of at least one month of direct patient care activity, with the remainder being fulfilled with either consultative activities or with direct care of such patients; and
1092		
1093		
1094		
1095		
1096		
1097		
1098		
1099		
1100	IV.A.6.a).(3)	not more than 15 months of required intensive care unit experiences in the three years of <u>education training</u> .
1101		
1102		
1103	IV.A.6.b)	24 months of clinical <u>experience training</u> is suggested.
1104		
1105	IV.A.6.c)	<u>Fellows must participate in training using simulation.</u>
1106		
1107	IV.A.6.d)	<u>Clinical training Fellow experiences</u> must include:
1108		
1109	IV.A.6.d).(1)	<del>provide fellows opportunities in pulmonary training to assume</del> continuing responsibility for both acutely_ and chronically-ill <u>pulmonary</u> patients in order to learn both the natural history of pulmonary disease <del>as well as and</del> the effectiveness of therapeutic programs;
1110		
1111		
1112		
1113		

1114		
1115	IV.A.6.d).(2)	<del>provide fellows opportunities in critical care training to</del>
1116		<del>manage</del> <u>managing</u> adult patients with a wide variety of
1117		serious illnesses and injuries requiring treatment in a
1118		critical care setting;
1119		
1120	IV.A.6.d).(3)	<del>provide additional clinical experience with other critically ill-</del>
1121		<del>patients; and which may include surgical, shock/trauma,</del>
1122		<del>neurologic/neurosurgical intensive care units and</del>
1123		<del>neurologic/neurosurgical intensive care units; pediatric</del>
1124		<del>intensive care unit; burn unit; dialysis unit; anesthesia</del>
1125		<del>service; cardiac catheterization laboratory; and, high-risk</del>
1126		<del>pregnancy intensive care unit; and transplant unit; and</del>
1127		
1128	IV.A.6.d).(4)	clinical experience in the evaluation and management of
1129		patients:
1130		
1131	IV.A.6.d).(4).(a)	with genetic and developmental disorders of the
1132		respiratory system, including cystic fibrosis;
1133		
1134	IV.A.6.d).(4).(b)	undergoing pulmonary rehabilitation;
1135		
1136	IV.A.6.d).(4).(c)	with trauma;
1137		
1138	IV.A.6.d).(4).(d)	with neurosurgical emergencies;
1139		
1140	IV.A.6.d).(4).(e)	with critical obstetric and gynecologic disorders;
1141		and,
1142		
1143	IV.A.6.d).(4).(f)	after discharge from the critical care unit.
1144		
1145	IV.A.6.e)	Fellows must have clinical experience in examination and
1146		interpretation of lung tissue for infectious agents, cytology, and
1147		histopathology.
1148		
1149	IV.A.6.f)	Experience with Continuity Ambulatory Patients
1150		
1151		<del>Fellows must have a continuity ambulatory clinic experience to</del>
1152		<del>develop a continuous healing relationship with patients for whom</del>
1153		<del>they provide pulmonary disease or critical care medicine care.</del>
1154		<del>This continuity experience should expose that exposes them</del>
1155		<del>fellows to the breadth and depth of pulmonary disease and critical</del>
1156		<del>care medicine.</del>
1157		
1158	IV.A.6.f).(1)	The ambulatory care clinic experience must occur
1159		throughout the 36 months of the fellowship.
1160		
1161	IV.A.6.f).(1).(a)	<u>For programs with at least 24 months of clinical</u>
1162		<u>rotations, fellows must complete a minimum of 24</u>
1163		<u>months of one half-day weekly ambulatory care</u>
1164		<u>clinic during the 36-month fellowship.</u>

1165  
1166 IV.A.6.f).(1).(b) For programs with 18-23 months of required clinical  
1167 rotations, fellows must complete a minimum of 30  
1168 months of one half-day weekly ambulatory care  
1169 clinic during the 36-month fellowship.  
1170  
1171 IV.A.6.f).(2) ~~Overall~~-This experience must include an appropriate  
1172 distribution of patients of each ~~both~~ gender and a diversity  
1173 of ages, and should be accomplished through either. ~~This~~  
1174 ~~should be accomplished by:~~  
1175  
1176 IV.A.6.f).(2).(a) a continuity clinic which provides fellows the  
1177 opportunity to learn the course of disease; or,  
1178  
1179 IV.A.6.f).(2).(b) ~~As an alternative to a continuity clinic which occurs~~  
1180 ~~throughout the entire duration of the fellowship, a~~  
1181 ~~program may offer consecutive selected blocks of~~  
1182 ~~at least six months duration for the length of the~~  
1183 ~~accredited fellowship.~~  
1184  
1185 IV.A.6.f).(2).(b).(i) If the above clinic blocks are interrupted by  
1186 other clinical rotations, they must be  
1187 extended so that their total duration is at  
1188 least six months.  
1189  
1190 IV.A.6.f).(3) Each fellow should be responsible, on average, for four to  
1191 eight patients during each half day session.  
1192  
1193 IV.A.6.f).(4) ~~The continuing patient care experience should not be~~  
1194 ~~interrupted by more than one month, excluding a fellow's~~  
1195 ~~vacation.~~  
1196  
1197 IV.A.6.f).(5) Up to six months may be exempted from ambulatory  
1198 experiences during MICU rotations, other time-intensive  
1199 rotations, or vacation.  
1200  
1201 IV.A.6.f).(6) ~~It is suggested that~~ Fellows should be informed of the  
1202 status of their continuity patients when they ~~such~~ patients  
1203 are hospitalized, as clinically appropriate. ~~so the fellows~~  
1204 ~~can make appropriate arrangements to maintain continuity~~  
1205 ~~of care.~~  
1206  
1207 IV.A.6.g) Procedures and Technical Skills  
1208  
1209 IV.A.6.g).(1) Direct faculty supervision of procedures performed by each  
1210 fellow must occur until proficiency has been acquired and  
1211 documented by the program director.  
1212  
1213 IV.A.6.g).(2) ~~A skilled preceptor~~ Faculty ~~must be available to teach and~~  
1214 ~~supervise the fellows in the performance~~ and interpretation  
1215 ~~of these procedures,~~ Procedures which must be

1216 documented in each fellow's record, including indications,  
1217 outcomes, diagnoses, and supervisor(s).  
1218

1219 IV.A.6.g).(3) It is suggested that fellows have clinical experience in the  
1220 placement of percutaneous tracheostomies.

1221  
1222 IV.A.6.g).(4) ~~The Fellows must have experience~~ ~~be given opportunities~~  
1223 ~~to function~~ in the role of a pulmonary disease consultant  
1224 in both the inpatient and outpatient settings and as a  
1225 critical care medicine consultant in the inpatient setting.  
1226

## 1227 **IV.B. Fellows' Scholarly Activities**

1228  
1229 **IV.B.1. The curriculum must advance fellows' knowledge of the basic**  
1230 **principles of research, including how research is conducted,**  
1231 **evaluated, explained to patients, and applied to patient care.**  
1232

1233 **IV.B.2. Fellows should participate in scholarly activity.**

1234  
1235 *IV.B.2.a) The majority of fellows must demonstrate evidence of scholarship*  
1236 *recent research productivity conducted during the fellowship*  
1237 *through one or more of the following:*  
1238

1239 *IV.B.2.a).(1) publication of articles, book chapters, abstracts, or case*  
1240 *reports in peer-reviewed journals;*

1241  
1242 *IV.B.2.a).(2) publication of peer-reviewed performance improvement or*  
1243 *education research;*

1244  
1245 *IV.B.2.a).(3) peer-reviewed funding; or,*

1246  
1247 *IV.B.2.a).(4) peer-reviewed abstracts presented at regional, state, or*  
1248 *national specialty meetings.*  
1249

1250 **IV.B.3. The sponsoring institution and program should allocate adequate**  
1251 **educational resources to facilitate fellow involvement in scholarly**  
1252 **activities.**

## 1253 **V. Evaluation**

### 1254 **V.A. Fellow**

#### 1255 **V.A.1. Formative Evaluation**

1256  
1257  
1258  
1259 **V.A.1.a) The faculty must evaluate fellow performance in a timely**  
1260 **manner during each rotation or similar educational**  
1261 **assignment, and document this evaluation at completion of**  
1262 **the assignment.**  
1263

1264 *V.A.1.a).(1) The faculty must discuss this evaluation with the each*  
1265 *fellow at the completion of the each assignment.*  
1266

1267	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>
1268		
1269		
1270		
1271	<b>V.A.1.b)</b>	<b>The program must:</b>
1272		
1273	<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>
1274		
1275		
1276		
1277		
1278		
1279	V.A. 1.b).(1).(a)	<u>Patient Care</u>
1280		
1281		<u>The program must assess each 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>
1282		
1283		
1284		
1285		
1286		
1287	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>
1288		
1289		
1290		
1291	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>
1292		
1293		
1294		
1295		
1296		
1297	V.A. 1.b).(1).(b)	<u>Medical Knowledge</u>
1298		
1299		<u>The program must use an objective formative assessment method. The same formative assessment method must be administered at least twice.</u>
1300		
1301		
1302		
1303		
1304	V.A. 1.b).(1).(c)	<u>Practice-based Learning and Improvement</u>
1305		
1306		<u>The program must use performance data to assess each fellow in:</u>
1307		
1308		
1309	V.A. 1.b).(1).(c).(i)	<u>application of evidence to patient care;</u>
1310		
1311	V.A. 1.b).(1).(c).(ii)	<u>practice improvement;</u>
1312		
1313	V.A. 1.b).(1).(c).(iii)	<u>teaching skills involving peers and patients;</u>
1314		<u>and,</u>
1315		
1316	V.A. 1.b).(1).(c).(iv)	<u>scholarship.</u>
1317		

1318	V.A. 1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
1319		
1320		<u>The program must use both direct observation and</u>
1321		<u>multi-source evaluation, including patients, peers</u>
1322		<u>and non-physician team members, to assess each</u>
1323		<u>fellow's performance in:</u>
1324		
1325	V.A. 1.b).(1).(d).(i)	<u>communication with patient and family;</u>
1326		
1327	V.A. 1.b).(1).(d).(ii)	<u>teamwork;</u>
1328		
1329	V.A. 1.b).(1).(d).(iii)	<u>communication with peers, including</u>
1330		<u>transitions in care; and,</u>
1331		
1332	V.A. 1.b).(1).(d).(iv)	<u>record keeping.</u>
1333		
1334	V.A. 1.b).(1).(e)	<u>Professionalism</u>
1335		
1336		<u>The program must use multi-source evaluation,</u>
1337		<u>including patients, peers, and non-physician team</u>
1338		<u>members, to assess each fellow's:</u>
1339		
1340	V.A. 1.b).(1).(e).(i)	<u>honesty and integrity;</u>
1341		
1342	V.A. 1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
1343		
1344	V.A. 1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
1345		<u>relationships with patients and colleagues;</u>
1346		<u>and,</u>
1347		
1348	V.A. 1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
1349		
1350	V.A. 1.b).(1).(f)	<u>Systems-based Practice</u>
1351		
1352		<u>The program must use multi-source evaluation,</u>
1353		<u>including peers, and non-physician team members,</u>
1354		<u>to assess each fellow's:</u>
1355		
1356	V.A. 1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
1357		<u>including transition of care;</u>
1358		
1359	V.A. 1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
1360		
1361	V.A. 1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
1362		
1363	V.A. 1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
1364		<u>participate in improvement activities.</u>
1365		
1366	<b>V.A.1.b).(2)</b>	<b>use multiple evaluators (e.g., faculty, peers, patients,</b>
1367		<b>self, and other professional staff);</b>
1368		

- 1369 **V.A.1.b).(3)** document progressive fellow performance  
 1370 improvement appropriate to educational level; and,  
 1371
- 1372 **V.A.1.b).(4)** provide each fellow with documented semiannual  
 1373 evaluation of performance with feedback.  
 1374
- 1375 *V.A.1.b).(4).(a) Fellows' performance in continuity clinic must be*  
 1376 *reviewed with them verbally and in writing at least*  
 1377 *semiannually.*  
 1378
- 1379 **V.A.1.c)** The evaluations of fellow performance must be accessible for  
 1380 review by the fellow, in accordance with institutional policy.  
 1381
- 1382 **V.A.2. Summative Evaluation**  
 1383  
 1384 The program director must provide a summative evaluation for each  
 1385 fellow upon completion of the program. This evaluation must  
 1386 become part of the fellow's permanent record maintained by the  
 1387 institution, and must be accessible for review by the fellow in  
 1388 accordance with institutional policy. This evaluation must:  
 1389
- 1390 **V.A.2.a)** document the fellow's performance during the final period of  
 1391 education; and,  
 1392
- 1393 **V.A.2.b)** verify that the fellow has demonstrated sufficient competence  
 1394 to enter practice without direct supervision.  
 1395
- 1396 **V.B. Faculty Evaluation**  
 1397
- 1398 **V.B.1.** At least annually, the program must evaluate faculty performance as  
 1399 it relates to the educational program.  
 1400
- 1401 **V.B.2.** These evaluations should include a review of faculty's clinical  
 1402 teaching abilities, commitment to the educational program, clinical  
 1403 knowledge, professionalism, and scholarly activities.  
 1404
- 1405 **V.B.3.** This evaluation must include at least annual written confidential  
 1406 evaluations by fellows.  
 1407
- 1408 *V.B.3.a) ~~In addition, Fellows must have the opportunity to provide~~*  
 1409 *confidential written evaluations of each supervising faculty\_*  
 1410 *member teaching-attending at the end of a each rotation.*  
 1411
- 1412 *V.B.3.b) ~~The program director must be reviewed~~ These evaluations must*  
 1413 *be reviewed with each ~~attending~~ faculty member annually.*  
 1414
- 1415 **V.C. Program Evaluation and Improvement**  
 1416
- 1417 **V.C.1.** The program must document formal, systematic evaluation of the  
 1418 curriculum at least annually. The program must monitor and track

- 1419 each of the following areas:
- 1420
- 1421 **V.C.1.a)** fellow performance;
- 1422
- 1423 **V.C.1.b)** faculty development;
- 1424
- 1425 **V.C.1.c)** graduate performance, including performance of program
- 1426 graduates on the certification examination; and,
- 1427
- 1428 V.C.1.c).(1) *At least 80% of program's graduating fellows from those*
- 1429 *eligible to take an ABIM subspecialty certifying*
- 1430 *examination upon completion of their training for the most*
- 1431 *recently defined five year period who are eligible should*
- 1432 *must have taken an the ABIM subspecialty certifying*
- 1433 *examination. (Note: Five-year rolling pass rate for first-time*
- 1434 *takers of the ABIM certifying examination will be examined*
- 1435 *at each program review).*
- 1436
- 1437 V.C.1.c).(2) *At least 80% of a program's graduates taking the ABIM*
- 1438 *certifying examination for the first time during the most*
- 1439 *recently defined five year period should pass.*
- 1440
- 1441 **V.C.1.d)** program quality. Specifically:
- 1442
- 1443 **V.C.1.d).(1)** **Fellows and faculty must have the opportunity to**
- 1444 **evaluate the program confidentially and in writing at**
- 1445 **least annually.**
- 1446
- 1447 **V.C.1.d).(2)** **The program must use the results of fellows'**
- 1448 **assessments of the program together with other**
- 1449 **program evaluation results to improve the program.**
- 1450
- 1451 V.C.1.d).(3) *At least 80% of the entering fellows should have*
- 1452 *completed the program when averaged over a five-year*
- 1453 *period.*
- 1454
- 1455 **V.C.2.** **If deficiencies are found, the program should prepare a written plan**
- 1456 **of action to document initiatives to improve performance in the**
- 1457 **areas listed in section V.C.1. The action plan should be reviewed**
- 1458 **and approved by the teaching faculty and documented in meeting**
- 1459 **minutes.**
- 1460
- 1461 V.C.3. *Representative program personnel, at a minimum to include the program*
- 1462 *director, representative faculty, and one fellow, must review program*
- 1463 *goals and objectives, and the effectiveness with which they are achieved.*
- 1464
- 1465 **VI. Fellow Duty Hours in the Learning and Working Environment**
- 1466
- 1467 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
- 1468

- 1469 **VI.A.1.** Programs and sponsoring institutions must educate fellows and  
 1470 faculty members concerning the professional responsibilities of  
 1471 physicians to appear for duty appropriately rested and fit to provide  
 1472 the services required by their patients.  
 1473
- 1474 **VI.A.2.** The program must be committed to and responsible for promoting  
 1475 patient safety and fellow well-being in a supportive educational  
 1476 environment.  
 1477
- 1478 **VI.A.3.** The program director must ensure that fellows are integrated and  
 1479 actively participate in interdisciplinary clinical quality improvement  
 1480 and patient safety programs.  
 1481
- 1482 **VI.A.4.** The learning objectives of the program must:
- 1483
- 1484 **VI.A.4.a)** be accomplished through an appropriate blend of supervised  
 1485 patient care responsibilities, clinical teaching, and didactic  
 1486 educational events; and,  
 1487
- 1488 **VI.A.4.b)** not be compromised by excessive reliance on fellows to fulfill  
 1489 non-physician service obligations.  
 1490
- 1491 ~~VI.A.4.b).(1)~~ *Fellows' service responsibilities must be limited to patients*  
 1492 *for whom the teaching service has diagnostic and*  
 1493 *therapeutic responsibility.*  
 1494
- 1495 **VI.A.5.** The program director and institution must ensure a culture of  
 1496 professionalism that supports patient safety and personal  
 1497 responsibility. Fellows and faculty members must demonstrate an  
 1498 understanding and acceptance of their personal role in the  
 1499 following:  
 1500
- 1501 **VI.A.5.a)** assurance of the safety and welfare of patients entrusted to  
 1502 their care;  
 1503
- 1504 **VI.A.5.b)** provision of patient- and family-centered care;  
 1505
- 1506 **VI.A.5.c)** assurance of their fitness for duty;  
 1507
- 1508 **VI.A.5.d)** management of their time before, during, and after clinical  
 1509 assignments;  
 1510
- 1511 **VI.A.5.e)** recognition of impairment, including illness and fatigue, in  
 1512 themselves and in their peers;  
 1513
- 1514 **VI.A.5.f)** attention to lifelong learning;  
 1515
- 1516 **VI.A.5.g)** the monitoring of their patient care performance improvement  
 1517 indicators; and,  
 1518

- 1519 VI.A.5.h) honest and accurate reporting of duty hours, patient  
1520 outcomes, and clinical experience data.  
1521
- 1522 VI.A.6. All fellows and faculty members must demonstrate responsiveness  
1523 to patient needs that supersedes self-interest. Physicians must  
1524 recognize that under certain circumstances, the best interests of the  
1525 patient may be served by transitioning that patient's care to another  
1526 qualified and rested provider.  
1527
- 1528 VI.B. Transitions of Care  
1529
- 1530 VI.B.1. Programs must design clinical assignments to minimize the number  
1531 of transitions in patient care.  
1532
- 1533 VI.B.2. Sponsoring institutions and programs must ensure and monitor  
1534 effective, structured hand-over processes to facilitate both  
1535 continuity of care and patient safety.  
1536
- 1537 VI.B.3. Programs must ensure that fellows are competent in communicating  
1538 with team members in the hand-over process.  
1539
- 1540 VI.B.4. The sponsoring institution must ensure the availability of schedules  
1541 that inform all members of the health care team of attending  
1542 physicians and fellows currently responsible for each patient's care.  
1543
- 1544 VI.C. Alertness Management/Fatigue Mitigation  
1545
- 1546 VI.C.1. The program must:  
1547
- 1548 VI.C.1.a) educate all faculty members and fellows to recognize the  
1549 signs of fatigue and sleep deprivation;  
1550
- 1551 VI.C.1.b) educate all faculty members and fellows in alertness  
1552 management and fatigue mitigation processes; and,  
1553
- 1554 VI.C.1.c) adopt fatigue mitigation processes to manage the potential  
1555 negative effects of fatigue on patient care and learning, such  
1556 as naps or back-up call schedules.  
1557
- 1558 VI.C.2. Each program must have a process to ensure continuity of patient  
1559 care in the event that a fellow may be unable to perform his/her  
1560 patient care duties.  
1561
- 1562 VI.C.3. The sponsoring institution must provide adequate sleep facilities  
1563 and/or safe transportation options for fellows who may be too  
1564 fatigued to safely return home.  
1565
- 1566 VI.D. Supervision of Fellows  
1567
- 1568 VI.D.1. In the clinical learning environment, each patient must have an

1569 identifiable, appropriately-credentialed and privileged attending  
1570 physician (or licensed independent practitioner as approved by each  
1571 Review Committee) who is ultimately responsible for that patient's  
1572 care.

1573

1574 **VI.D.1.a)** This information should be available to fellows, faculty  
1575 members, and patients.

1576

1577 **VI.D.1.b)** Fellows and faculty members should inform patients of their  
1578 respective roles in each patient's care.

1579

1580 **VI.D.2.** The program must demonstrate that the appropriate level of  
1581 supervision is in place for all fellows who care for patients.

1582

1583 Supervision may be exercised through a variety of methods. Some  
1584 activities require the physical presence of the supervising faculty  
1585 member. For many aspects of patient care, the supervising  
1586 physician may be a more advanced resident or fellow. Other  
1587 portions of care provided by the fellow can be adequately  
1588 supervised by the immediate availability of the supervising faculty  
1589 member or resident physician, either in the institution, or by means  
1590 of telephonic and/or electronic modalities. In some circumstances,  
1591 supervision may include post-hoc review of fellow-delivered care  
1592 with feedback as to the appropriateness of that care.

1593

1594 **VI.D.3.** Levels of Supervision

1595

1596 To ensure oversight of fellow supervision and graded authority and  
1597 responsibility, the program must use the following classification of  
1598 supervision:

1599

1600 **VI.D.3.a)** Direct Supervision – the supervising physician is physically  
1601 present with the fellow and patient.

1602

1603 **VI.D.3.b)** Indirect Supervision:

1604

1605 **VI.D.3.b).(1)** with direct supervision immediately available – the  
1606 supervising physician is physically within the hospital  
1607 or other site of patient care, and is immediately  
1608 available to provide Direct Supervision.

1609

1610 **VI.D.3.b).(2)** with direct supervision available – the supervising  
1611 physician is not physically present within the hospital  
1612 or other site of patient care, but is immediately  
1613 available by means of telephonic and/or electronic  
1614 modalities, and is available to provide Direct  
1615 Supervision.

1616

1617 **VI.D.3.c)** Oversight – the supervising physician is available to provide  
1618 review of procedures/encounters with feedback provided

1619 after care is delivered.

1620

1621 **VI.D.4.** The privilege of progressive authority and responsibility, conditional

1622 independence, and a supervisory role in patient care delegated to

1623 each fellow must be assigned by the program director and faculty

1624 members.

1625

1626 **VI.D.4.a)** The program director must evaluate each fellow's abilities

1627 based on specific criteria. When available, evaluation should

1628 be guided by specific national standards-based criteria.

1629

1630 **VI.D.4.b)** Faculty members functioning as supervising physicians

1631 should delegate portions of care to fellows, based on the

1632 needs of the patient and the skills of the fellows.

1633

1634 **VI.D.4.c)** Senior residents or fellows should serve in a supervisory role

1635 of junior residents in recognition of their progress toward

1636 independence, based on the needs of each patient and the

1637 skills of the individual resident or fellow.

1638

1639 **VI.D.5.** Programs must set guidelines for circumstances and events in

1640 which fellows must communicate with appropriate supervising

1641 faculty members, such as the transfer of a patient to an intensive

1642 care unit, or end-of-life decisions.

1643

1644 **VI.D.5.a)** Each fellow must know the limits of his/her scope of

1645 authority, and the circumstances under which he/she is

1646 permitted to act with conditional independence.

1647

1648 **VI.D.5.a).(1)** In particular, PGY-1 residents should be supervised

1649 either directly or indirectly with direct supervision

1650 immediately available.

1651

1652 **VI.D.6.** Faculty supervision assignments should be of sufficient duration to

1653 assess the knowledge and skills of each fellow and delegate to

1654 him/her the appropriate level of patient care authority and

1655 responsibility.

1656

1657 **VI.E.** **Clinical Responsibilities**

1658

1659 The clinical responsibilities for each fellow must be based on PGY-level,

1660 patient safety, fellow education, severity and complexity of patient

1661 illness/condition and available support services.

1662

1663 **VI.F.** **Teamwork**

1664

1665 Fellows must care for patients in an environment that maximizes effective

1666 communication. This must include the opportunity to work as a member of

1667 effective interprofessional teams that are appropriate to the delivery of care

1668 in the specialty.

1669		
1670	<b>VI.G.</b>	<b>Fellow Duty Hours</b>
1671		
1672	<b>VI.G.1.</b>	<b>Maximum Hours of Work per Week</b>
1673		
1674		<b>Duty hours must be limited to 80 hours per week, averaged over a</b>
1675		<b>four-week period, inclusive of all in-house call activities and all</b>
1676		<b>moonlighting.</b>
1677		
1678	<b>VI.G.1.a)</b>	<b>Duty Hour Exceptions</b>
1679		
1680		<b>A Review Committee may grant exceptions for up to 10% or a</b>
1681		<b>maximum of 88 hours to individual programs based on a</b>
1682		<b>sound educational rationale.</b>
1683		
1684		<i>The Review Committee for Internal Medicine will not consider</i>
1685		<i>requests for exceptions to the 80-hour limit to the fellows' work</i>
1686		<i>week.</i>
1687		
1688	<b>VI.G.1.a).(1)</b>	<b>In preparing a request for an exception the program</b>
1689		<b>director must follow the duty hour exception policy</b>
1690		<b>from the ACGME Manual on Policies and Procedures.</b>
1691		
1692	<b>VI.G.1.a).(2)</b>	<b>Prior to submitting the request to the Review</b>
1693		<b>Committee, the program director must obtain approval</b>
1694		<b>of the institution's GMEC and DIO.</b>
1695		
1696	<b>VI.G.2.</b>	<b>Moonlighting</b>
1697		
1698	<b>VI.G.2.a)</b>	<b>Moonlighting must not interfere with the ability of the fellow</b>
1699		<b>to achieve the goals and objectives of the educational</b>
1700		<b>program.</b>
1701		
1702	<b>VI.G.2.b)</b>	<b>Time spent by fellows in Internal and External Moonlighting</b>
1703		<b>(as defined in the ACGME Glossary of Terms) must be</b>
1704		<b>counted towards the 80-hour Maximum Weekly Hour Limit.</b>
1705		
1706	<b>VI.G.2.c)</b>	<b>PGY-1 residents are not permitted to moonlight.</b>
1707		
1708	<b>VI.G.3.</b>	<b>Mandatory Time Free of Duty</b>
1709		
1710		<b>Fellows must be scheduled for a minimum of one day free of duty</b>
1711		<b>every week (when averaged over four weeks). At-home call cannot</b>
1712		<b>be assigned on these free days.</b>
1713		
1714	<b>VI.G.4.</b>	<b>Maximum Duty Period Length</b>
1715		
1716	<b>VI.G.4.a)</b>	<b>Duty periods of PGY-1 residents must not exceed 16 hours in</b>
1717		<b>duration.</b>
1718		

- 1719 **VI.G.4.b)** **Duty periods of PGY-2 residents and above may be**  
 1720 **scheduled to a maximum of 24 hours of continuous duty in**  
 1721 **the hospital. Programs must encourage fellows to use**  
 1722 **alertness management strategies in the context of patient**  
 1723 **care responsibilities. Strategic napping, especially after 16**  
 1724 **hours of continuous duty and between the hours of 10:00**  
 1725 **p.m. and 8:00 a.m., is strongly suggested.**
- 1726
- 1727 **VI.G.4.b).(1)** **It is essential for patient safety and fellow education**  
 1728 **that effective transitions in care occur. Fellows may be**  
 1729 **allowed to remain on-site in order to accomplish these**  
 1730 **tasks; however, this period of time must be no longer**  
 1731 **than an additional four hours.**
- 1732
- 1733 **VI.G.4.b).(2)** **Fellows must not be assigned additional clinical**  
 1734 **responsibilities after 24 hours of continuous in-house**  
 1735 **duty.**
- 1736
- 1737 **VI.G.4.b).(3)** **In unusual circumstances, fellows, on their own**  
 1738 **initiative, may remain beyond their scheduled period**  
 1739 **of duty to continue to provide care to a single patient.**  
 1740 **Justifications for such extensions of duty are limited**  
 1741 **to reasons of required continuity for a severely ill or**  
 1742 **unstable patient, academic importance of the events**  
 1743 **transpiring, or humanistic attention to the needs of a**  
 1744 **patient or family.**
- 1745
- 1746 **VI.G.4.b).(3).(a)** **Under those circumstances, the fellow must:**
- 1747
- 1748 **VI.G.4.b).(3).(a).(i)** **appropriately hand over the care of all**  
 1749 **other patients to the team responsible**  
 1750 **for their continuing care; and,**
- 1751
- 1752 **VI.G.4.b).(3).(a).(ii)** **document the reasons for remaining to**  
 1753 **care for the patient in question and**  
 1754 **submit that documentation in every**  
 1755 **circumstance to the program director.**
- 1756
- 1757 **VI.G.4.b).(3).(b)** **The program director must review each**  
 1758 **submission of additional service, and track**  
 1759 **both individual fellow and program-wide**  
 1760 **episodes of additional duty.**
- 1761
- 1762 **VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**
- 1763
- 1764 **VI.G.5.a)** **PGY-1 residents should have 10 hours, and must have eight**  
 1765 **hours, free of duty between scheduled duty periods.**
- 1766
- 1767 **VI.G.5.b)** **Intermediate-level residents should have 10 hours free of**  
 1768 **duty, and must have eight hours between scheduled duty**

1769 periods. They must have at least 14 hours free of duty after 24  
1770 hours of in-house duty.

1771  
1772 Internal medicine subspecialty fellows are considered to be in the  
1773 final years of education.  
1774

1775 **VI.G.5.c)** Residents in the final years of education must be prepared to  
1776 enter the unsupervised practice of medicine and care for  
1777 patients over irregular or extended periods.

1778  
1779 Internal medicine subspecialty fellows are considered to be in the  
1780 final years of education.  
1781

1782 **VI.G.5.c).(1)** This preparation must occur within the context of the  
1783 80-hour, maximum duty period length, and one-day-  
1784 off-in-seven standards. While it is desirable that  
1785 fellows in their final years of education have eight  
1786 hours free of duty between scheduled duty periods,  
1787 there may be circumstances when these fellows must  
1788 stay on duty to care for their patients or return to the  
1789 hospital with fewer than eight hours free of duty.

1790  
1791 **VI.G.5.c).(1).(a)** Circumstances of return-to-hospital activities  
1792 with fewer than eight hours away from the  
1793 hospital by fellows in their final years of  
1794 education must be monitored by the program  
1795 director.  
1796

1797 **VI.G.5.c).(1).(b)** In unusual circumstances, fellows may remain  
1798 beyond their scheduled period of duty or return  
1799 after their scheduled period of duty to provide care  
1800 to a single patient. Justifications for such  
1801 extensions of duty are limited to reasons of  
1802 required continuity of care for a severely ill or  
1803 unstable patient, academic importance of the  
1804 events transpiring, or humanistic attention to the  
1805 needs of the patient or family. Such episodes  
1806 should be rare, must be of the fellows' own  
1807 initiative, and need not initiate a new 'off-duty  
1808 period' nor require a change in the scheduled 'off-  
1809 duty period.'  
1810

1811 **VI.G.5.c).(1).(c)** Under such circumstances, the fellow must  
1812 appropriately hand over care of all other patients to  
1813 the team responsible for their continuing care, and  
1814 document the reasons for remaining or returning to  
1815 care for the patient in question and submit that  
1816 documentation to the program director.  
1817

1818 **VI.G.5.c).(1).(d)** The program director must review each submission  
1819 of additional service and track both individual

fellows' and program-wide episodes of additional duty.

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**VI.G.6. Maximum Frequency of In-House Night Float**

**Fellows must not be scheduled for more than six consecutive nights of night float.**

**VI.G.7. 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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