

ACGME Program Requirements for Residency Education in Internal Medicine

Common Program Requirements are in BOLD

Effective: July 1, 2007

I. Institutions

A. Sponsoring Institution

One sponsoring institution must assume the ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.

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

The sponsoring institution must:

1. provide resident compensation and benefits, faculty, facilities, and resources for education, clinical care, and research required for accreditation;
2. provide at least 50% salary support for the program director;
3. provide 20 hours per week salary support for each associate program director required to meet these program requirements;
4. demonstrate a commitment to education and research sufficient to support the residency program; and,
5. establish the internal medicine residency within a department of internal medicine or an administrative unit whose primary mission is the advancement of internal medicine education and patient care;

B. Participating Sites

1. **There must be a program letter of agreement (PLA) between the program and each participating site providing an assignment. The PLA must be renewed at least every five years.**

The PLA should:

- a) **identity the faculty who will assume both educational and supervisory responsibilities for residents;**
 - b) **specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
 - c) **specify the duration and content of the educational experience; and,**
 - d) **state the policies and procedures that will govern resident education during the assignment.**
2. **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**
 3. **Participation by any site that provides six months or more of the training in the program must be approved by the Review Committee.**

II. Program Personnel and Resources

A. Program Director

1. **There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**
2. **The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
3. **Qualifications of the program director must include:**
 - a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee, including:**

- (1) at least five years of participation as an active faculty member in an ACGME-accredited internal medicine residency program; and,
 - (2) at least three years of graduate medical education administrative experience prior to appointment.
- b) current certification in Internal Medicine by the American Board of Internal Medicine, or specialty qualifications acceptable to the Review Committee; and,**
 - c) current medical licensure and appropriate medical staff appointment.**
- 4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**
- a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
 - b) approve a local director at each participating site who is accountable for resident education;**
 - c) approve the selection of program faculty as appropriate;**
 - d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
 - e) monitor resident supervision at all participating sites;**
 - f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
 - g) provide each resident with documented semiannual evaluation of performance with feedback;**
 - h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**

- i) provide verification of residency education for all residents, including those who leave the program prior to completion;**
- j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:**
 - (1) distribute these policies and procedures to the residents and faculty;**
 - (2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**
 - (3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,**
 - (4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.**
- k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;**
- l) comply with the sponsoring institution's written policies and procedures, including those specified in compliance with the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;**
- m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
- n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**
 - (1) all applications for ACGME accreditation of new programs;**
 - (2) changes in resident complement;**

- (3) major changes in program structure or length of training;**
 - (4) progress reports requested by the Review Committee;**
 - (5) responses to all proposed adverse actions;**
 - (6) requests for increases or any change to resident duty hours;**
 - (7) voluntary withdrawals of ACGME-accredited programs;**
 - (8) requests for appeal of an adverse action;**
 - (9) appeal presentations to a Board of Appeal or the ACGME; and,**
 - (10) proposals to ACGME for approval of innovative educational approaches.**
- o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
- (1) program citations, and/or**
 - (2) request for changes in the program that would have significant impact, including financial, on the program or institution.**
- p) notify the Review Committee within 60 days of changes in institutional governance, affiliation, or resources that affect the education program;**
- q) monitor resident stress, including mental or emotional conditions inhibiting performance or learning, and drug- or alcohol-related dysfunction. Both the program director and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Situations that demand excessive service or that consistently produce undesirable stress on residents must be evaluated and modified;**

- r) dedicate no less than 50% (at least 20 hours per week) of his or her professional effort to the internal medicine educational program and receive institutional support for this time. This effort must be devoted to administrative and educational activities of the internal medicine educational program;
- s) have primary responsibility and appropriate authority for the organization, implementation, and supervision of all aspects of the training program, including the selection and supervision of teaching faculty and other program personnel at each institution participating in the program;
- t) have the authority to ensure effective teaching, and obtain teaching commitments from other departments involved in the education of internal medicine residents;
- u) select residents for appointment to the program;
- v) ensure that the residency does not place excessive reliance on residents for service as opposed to education;
- w) establish a process to teach and document the residents' achievement of milestones in the competencies;
- x) monitor any internal medicine subspecialty training programs sponsored by the institution to ensure compliance with the ACGME accreditation standards;
- y) have supervisory authority over all educational tracks in the internal medicine residency program. The internal medicine component of special educational tracks must be conducted under the auspices of the Department of Internal Medicine. Although such tracks may differ in educational content, the core experience of residents must provide training in both inpatient and ambulatory general internal medicine to enable the graduates of such special tracks to function as general internists. The Review Committee evaluates the internal medicine components of the special educational tracks in the accreditation process;
- z) participate in academic societies and in educational programs designed to enhance his or her educational and administrative skills;

- aa) implement a program of continuous quality improvement in medical education for the faculty, especially as it pertains to the teaching and evaluation of the competencies; and,
- bb) be located at the principal clinical training institution.

B. Faculty

- 1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.**

The faculty must:

- a) **devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and**
 - b) **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**
- 2. The physician faculty must have current certification in the specialty by the American Board of Internal Medicine, or possess qualifications judged to be acceptable by the Review Committee.**
 - 3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
 - a) The physician faculty must meet professional standards of ethical behavior.
 - 4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
 - 5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
 - a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
 - b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**

- (1) **peer-reviewed funding;**
- (2) **publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
- (3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**
- (4) **participation in national committees or educational organizations.**

(a) Although not all faculty members must be investigators, collectively their activity must include all of the elements outlined above.

c) Faculty should encourage and support residents in scholarly activities.

6. All clinical faculty members should participate in prescribed faculty development programs designed to enhance the effectiveness of their teaching.
7. All clinical faculty members should review the written learning objectives and expectations for each rotation or assignment with residents at the beginning of the rotation or assignment.

C. Other Program Personnel

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

1. Associate Program Directors

Associate program directors are faculty who assist the program director in the administrative and clinical oversight of the educational program. Sponsoring organizations must provide associate program directors based on program size. At a minimum, associate program directors are required at resident complements of 24 or greater according to the following parameters: 24 to 40 residents, one associate program director; 41 to 79, two associate program directors; 80 to 119, three associate program directors; 120 to 159, four associate program directors; more than 159, five

associate program directors

- a) Qualifications of the associate program directors are as follows:
- (1) associate program directors must each be an institutionally-based faculty appointee;
 - (2) associate program directors must have current certification by the American Board of Internal Medicine or possess qualifications acceptable to the Review Committee;
 - (3) associate program directors must have documented clinical and academic experience to ensure effective implementation of the program requirements; and,
 - (4) associate program directors must be clinicians with broad knowledge of, experience with, and commitment to internal medicine as a discipline, and to the generalist training of residents, whether they themselves were trained as general internists or as subspecialists.
- b) Responsibilities for associate program directors are as follows:
- (1) associate program directors must dedicate an average of at least 20 hours per week to the administrative and educational aspects of the educational program, as delegated by the program director, and receive institutional support for this time;
 - (2) associate program directors must assist in the general administration of the program, including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents, as well as the maintenance of records related to program accreditation;
 - (3) associate program directors must report directly to the program director; and,
 - (4) associate program directors must participate in academic societies and in educational programs

designed to enhance their educational and administrative skills.

2. Key Clinical Faculty

The residency program must include institutionally-based key clinical faculty (KCF) in addition to the program director, associate program directors, and chief residents. KCF are attending physicians who dedicate significant effort to the educational program (see Section V). Sponsoring institutions must provide KCF based on program size. Four KCF are required at resident complements of 79 or fewer. At resident complements of 80 or greater, minimum KCF are required, according to the following parameters: 80 to 119 residents, six KCF; 120 to 159, eight KCF; more than 159, 10 KCF.

a) Qualifications

Key clinical faculty must:

- (1) be active clinicians with broad knowledge of, experience with, and commitment to internal medicine as a discipline, and to the generalist training of residents, and
- (2) have current certification by the American Board of Internal Medicine or possess qualifications acceptable to the Review Committee.

b) Responsibilities

Key clinical faculty must:

- (1) dedicate an average of at least 15 hours per week throughout the year to the internal medicine residency program;
- (2) provide teaching and supervision of residents in the clinical setting;
- (3) assist in the preparation of the written curriculum;
- (4) assist in the development and evaluation of the Competencies in the residents; and,

- (5) assist in monitoring resident stress, with the goal of identifying mental or emotional conditions inhibiting performance or learning (including drug or alcohol-related dysfunction), and advise the program director or associate program director(s) as indicated.

3. Subspecialty Education Coordinators

In conjunction with division chiefs, the program director must identify a Subspecialty Education Coordinator in each of the subspecialties of internal medicine (cardiology, critical care, endocrinology, hematology, gastroenterology, geriatric medicine, infectious diseases, nephrology, oncology, pulmonary disease, and rheumatology).

a) Qualifications

The Subspecialty Education Coordinator should have:

- (1) current certification by the American Board of Internal Medicine or possess qualifications acceptable to the Review Committee, and
- (2) a sufficient term of office to achieve the educational goals and objectives of the residency.

b) Responsibilities

The Subspecialty Education Coordinator must:

- (1) dedicate an adequate portion of his or her professional effort throughout the year to the internal medicine training program to accomplish the educational goals in each subspecialty, and
- (2) be accountable to the program director for coordination of the residents' subspecialty educational experiences. (N.B.: KCF may also serve as subspecialty education coordinators.)

4. Site Coordinating Faculty

At each participating inpatient institution where residents spend six or more months, the sponsor must ensure that a designated faculty member coordinates the activities of the residents. This faculty member must be based at that participating institution, and report to

the program director. At a minimum, the site coordinating faculty member must satisfy the qualifications and responsibilities of a KCF member.

D. Resources

- 1. The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.**
2. Adequate outpatient and inpatient facilities, support services, and space for teaching and patient care must be available. Residents must have clinical experiences in efficient, effective ambulatory and inpatient care settings.

a) Space and equipment

There must be space and equipment for the educational program, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids, and office space for teaching staff.

b) Facilities

- (1) To ensure that a spectrum of cardiovascular disorders is available for resident education, cardiac catheterization facilities should be present at the site(s) where the residents see the majority of their acutely ill, hospitalized patients.
- (2) Additional facilities must include those for: bronchoscopy, gastrointestinal endoscopy, noninvasive cardiology studies, pulmonary function studies, hemodialysis, and imaging studies, including radionuclide, ultrasound, fluoroscopy, angiography, computerized tomography, and magnetic resonance imaging.
- (3) Residents must have sleeping rooms, lounge, and food facilities during assigned duty hours.
- (4) When residents are assigned night duty in the hospital, they must be provided with on-call facilities that are convenient and that afford privacy, safety, and a restful environment with a secure space for their belongings.

3. Medical Records

Clinical records that document both inpatient and ambulatory care must be readily available at all times. (See Institutional Requirements)

4. Patient Population

- a) The patient population must have a variety of clinical problems and stages of disease.
- b) There must be patients of both sexes, with a broad age range, including geriatric patients. (N.B.: A resident's panel of patients must include at least 25% of patients of each gender.)

5. Death Reviews and Autopsies

- a) All deaths of patients who received care by residents must be reviewed and autopsies performed whenever possible.
- b) Residents must receive autopsy reports after autopsies are completed on their patients.

6. Support Services

- a) Support must include adequate professional and teaching staff in each of the major subspecialties of internal medicine.
- b) Administrative support must include adequate secretarial and administrative staff and technology to support the program director and associate program director(s).
- c) It is desirable that each program appoint a professional administrator/coordinator to oversee the program director's office staff and to assist in the administration of the residency program.
- d) Inpatient clinical support services must be available on a 24-hour basis to meet reasonable and expected demands, including intravenous services, phlebotomy services, messenger/transporter services, and laboratory and radiologic information retrieval systems that allow prompt access to results.

- e) Consultations from other clinical services in the hospital must be available in a timely manner. All consultations should be performed by or under the supervision of a qualified specialist.

E. Medical Information Access

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

III. Resident Appointment

A. Eligibility Criteria

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

1. The program should demonstrate the ability to retain qualified residents by graduating at the end of the residency at least 80% of the enrolled, first-year, categorical residents.

B. Number of Residents

The program director may not appoint more residents 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 residents appointed to the program.

1. A program must have a minimum of 12 residents enrolled and participating in the training program at all times.
2. The program director must obtain written approval from the Review Committee before changing the total number of approved residency positions.
3. A resident who has satisfactorily completed a preliminary training year should not be appointed to additional years as a preliminary resident.

C. Resident Transfer

1. **Before accepting a resident 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 resident.

- 2. A program director must provide timely verification of residency education and summative performance evaluation for residents who may leave the program prior to completion.**
3. Residents must not be accepted for advanced standing from programs not accredited by the ACGME. Exceptions will be permitted for physicians with at least three years of verified internal medicine training abroad or other training that has been approved by the American Board of Internal Medicine (ABIM).

D. Appointment of Fellows and Other Students

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The Program Director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

IV. Educational Program

Internal medicine is the discipline encompassing the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age, during health and all stages of illness. Intrinsic to the discipline are scientific knowledge, the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.

An accredited residency program in internal medicine must provide 36 months of supervised graduate education.

A. The curriculum must contain the following educational components:

- 1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;**
- 2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation. For each rotation or major learning experience, the**

written curriculum:

- a) should include the educational purpose; teaching methods; the mix of diseases, patient characteristics, and types of clinical encounters, procedures, and services; reading lists, pathological material, and other educational resources to be used; and a method of evaluation of resident competence;
- b) must define the level of residents' supervision by faculty members in all patient-care activities; and,
- c) should be reviewed and revised at least every 3 years by faculty members and residents to keep it current and relevant.

3. Regularly scheduled didactic sessions;

4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

a) Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

- (1) learn the practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age, during health and all stages of illness

b) Medical Knowledge

Residents 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. Residents are expected to:

- (1) learn the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values

c) Practice-based Learning and Improvement

Residents 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. Residents are expected to develop skills and habits to be able to meet the following goals:

- (1) identify strengths, deficiencies, and limits in one's knowledge and expertise;
- (2) set learning and improvement goals;
- (3) identify and perform appropriate learning activities;
- (4) systematically analyze practice, using quality improvement methods, and implement changes with the goal of practice improvement;
- (5) incorporate formative evaluation feedback into daily practice;
- (6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- (7) use information technology to optimize learning; and,
- (8) participate in the education of patients, families, students, residents and other health professionals.

d) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective

exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

- (1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;**
- (2) communicate effectively with physicians, other health professionals, and health related agencies;**
- (3) work effectively as a member or leader of a health care team or other professional group;**
- (4) act in a consultative role to other physicians and health professionals; and,**
- (5) maintain comprehensive, timely, and legible medical records, if applicable.**

e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- (1) compassion, integrity, and respect for others;**
- (2) responsiveness to patient needs that supersedes self-interest;**
- (3) respect for patient privacy and autonomy;**
- (4) accountability to patients, society and the profession; and,**
- (5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.**

f) Systems-based Practice

Residents 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. Residents are expected to:

- (1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;**
- (2) coordinate patient care within the health care system relevant to their clinical specialty;**
- (3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;**
- (4) advocate for quality patient care and optimal patient care systems;**
- (5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,**
- (6) participate in identifying system errors and implementing potential systems solutions.**

B. Residents' Scholarly Activities

- 1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.**
- 2. Residents should participate in scholarly activity.**
 - a) The program must provide an opportunity for residents to participate in research or other scholarly activities, such as: original research, comprehensive case reports, or review of assigned clinical and research topics.
- 3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.**

C. Didactics

1. Formal Teaching Program

a) Inpatient Teaching

(1) Teaching (attending) rounds

Teaching, or attending, rounds must be patient-based sessions in which current cases are presented as a basis for discussion of such points as interpretation of clinical data, pathophysiology, differential diagnosis, specific management of the patient, the appropriate use of technology, the incorporation of evidence and patient values in clinical decision making, and disease prevention.

(a) On all inpatient and consultative teaching services, teaching rounds must be regularly scheduled and formally conducted.

(b) Teaching rounds must include direct resident and attending interaction with the patient, and must include bedside teaching and the demonstration of interview and physical examination techniques.

(c) Teaching rounds must occur at least three days of the week for a minimum total of four and a half hours per week.

(2) Management (work) rounds by the physician of record

Management, or work, rounds involve the bedside review of patients and their clinical data and the development of the daily plan of care (therapeutic and diagnostic) by the physician of record with the residents. Such rounds are distinguished from teaching (attending) rounds by their focus on the care plan (resident order writing; record documentation; communication with nurses, pharmacists, families, etc.).

(a) Each physician of record has the responsibility to make management rounds on his or her

patients and to communicate effectively with the residents participating in the care of these patients at a frequency appropriate to the changing care needs of the patients.

- (b) To avoid interference with the residents' educational experience and ability to accomplish their daily tasks of patient care, including resident work rounds, residents should not be required to relate to an excessive number of physicians of record.
- (c) Note-writing and other coding/documentation activities by the physician of record must not infringe upon teaching rounds or resident education.

(3) Combined teaching and management rounds

Inpatient teaching rounds and management rounds may be functionally combined when:

- (a) there is a single physician of record for most or all patients on the teaching service;
- (b) that attending physician of record is also the teaching physician conducting teaching for those same patients; and,
- (c) the total time spent in combined inpatient rounds must exceed by a minimum of four and a half hours per week the time required to supervise the care of the patients, with this time dedicated to fulfill the requirements outlined above for teaching rounds.

b) Ambulatory teaching

In every half day session in the ambulatory setting, each resident should have at least 30 minutes of contact time with the supervising faculty physician.

2. Conferences and Seminars

In addition to morning report and rounds, the program must provide core conferences (e.g., CPC conferences, grand rounds, morbidity

and mortality review conferences, literature-review activities, and other seminars covering both general medicine and the internal medicine subspecialties), for a minimum of 150 hours per year of conference-based educational experience.

- a) The core conference series must:
 - (1) cover the major topics in general internal medicine (including issues arising in ambulatory and extended care settings) and the internal medicine subspecialties;
 - (2) be repeated often enough, or be made available for review on tape or electronically, to afford each resident an opportunity to attend or review most of the core conference topics;
 - (3) include the following interdisciplinary topics: adolescent medicine, clinical ethics, medical genetics, quality assessment, quality improvement, risk management, preventive medicine, medical informatics and decision-making skills, law and public policy, pain management, end-of-life care, domestic violence, physician impairment, and substance-use disorders; and,
 - (4) be made available to residents at each of the program's participating sites.
- b) Conferences should include information from the basic medical sciences, with emphasis on the pathophysiology of disease and reviews of recent advances in clinical medicine and biomedical research.
- c) The program must sponsor monthly conferences in which faculty members are involved. These must include:
 - (1) a journal club emphasizing critical appraisal of the medical literature and evidence-based medicine, and either:
 - (a) clinical pathologic conferences correlating current pathological material, including material from autopsies, surgical specimens, and other pathology material, with the clinical course and management of patients, or

- (b) clinical quality improvement (morbidity and mortality) conferences focusing on adverse clinical events on the teaching services. It should analyze the causes and consequences of each event, and should result in proposals for actions to avoid recurrence of similar events.
- d) It is suggested that each resident attend at least 60% of these conferences.

D. Clinical

1. Ambulatory Medicine

- a) At least one third of the residency training must be in the ambulatory care setting. In assessing the contribution of various clinical experiences with ambulatory patients to the 33% minimum, the following guidelines may be used: half day per week assigned to an ambulatory setting throughout all three years of training is equivalent to 10%; a one-month block rotation is equivalent to 3%; one full day per week throughout a single year of training is equivalent to 7%. Examples of settings that may be counted toward this requirement are general medicine continuity clinics, subspecialty clinics, ambulatory block rotations, physicians' offices, managed health-care systems, emergency medicine, walk-in clinics, neighborhood health clinics, and home-care visits.
 - (1) In an ambulatory setting, one faculty member must be responsible for no more than five residents or other learners.
 - (2) On-site faculty members' primary responsibilities must include the supervision and teaching of residents. On-site supervision, as well as the quality of the educational experience, must be documented.
 - (3) Residents must be able to obtain appropriate and timely consultation from other specialties for their ambulatory patients.
 - (4) There should be services available from other health-care professionals such as nurses, social workers,

language interpreters, and dietitians.

b) Ambulatory Medicine - Continuity Clinic

- (1) At the program director's discretion, residents may be excused from attending their continuity clinic when they are assigned to an intensive care unit, to emergency medicine, to an away-elective, or to night float.
- (2) Residents must attend a minimum of 108 weekly continuity clinic sessions during the 36 months of training.
- (3) The continuing patient-care experience should not be interrupted by more than one month, excluding a resident's vacation.
- (4) The number of patients seen by a first-year resident, when averaged over the year, must not be fewer than three or greater than five per scheduled half day session.
- (5) The number of patients seen by a second-year resident, when averaged over the year, must not be fewer than four or greater than six per scheduled half day session.
- (6) The number of patients seen by a third-year resident, when averaged over the year, must not be fewer than four per scheduled half day session.
- (7) During the continuity experience, arrangements should be made to minimize interruptions of the experience by residents' duties on inpatient and consultation services.
- (8) Each resident must follow patients with chronic diseases on a long-term basis.
- (9) Residents should be informed of the status of their continuity patients when they are hospitalized so the resident may make appropriate arrangements to maintain continuity of care.

c) Ambulatory Medicine - Emergency Medicine

- (1) Internal medicine residents assigned to emergency medicine must have first-contact responsibility for a sufficient number of unselected patients to meet the educational needs of internal medicine residents. Triage by other physicians prior to this contact is unacceptable.
- (2) Internal medicine residents must be assigned to emergency medicine for at least four weeks of direct experience in blocks of not less than two weeks.
- (3) Total required emergency medicine experience must not exceed three months in three years of training.
- (4) During emergency medicine assignments, continuous duty must not exceed 12 hours.
- (5) Residents must have direct patient responsibility, including participation in diagnosis, management, and admission decisions across the broad spectrum of medical, surgical, and psychiatric illnesses, such that the residents learn how to determine which patients require hospitalization.
- (6) Internal medicine residents assigned to rotations on emergency medicine must have on-site 24-hour supervision by qualified faculty members.
- (7) Timely, on-site consultations from other specialties must be available.

2. Inpatient Medicine

a) On Inpatient rotations:

- (1) A first-year resident must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services.
- (2) A first-year resident must not be assigned more than eight new patients in a 48-hour period.
- (3) A first-year resident must not be responsible for the ongoing care of more than 12 patients.

- (4) The program must demonstrate a minimum of 210 admissions per year to the medical teaching services for each first-year resident.
- (5) When supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48-hour period.
- (6) When supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 16 patients.
- (7) When supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 24 patients.
- (8) First-year residents should interact with second- or third-year internal medicine residents in the care of patients.
- (9) Second- or third-year internal medicine residents or other appropriate supervisory physicians (e.g., subspecialty residents or attendings) with documented experience appropriate to the acuity, complexity, and severity of patient illness must be available at all times on site to supervise first-year residents.
- (10) Residents should have continuing responsibility for most of the patients they admit.
- (11) Residents from other specialties must not supervise internal medicine residents on any internal medicine inpatient rotation.
- (12) Residents must write all orders for patients under their care, with appropriate supervision by the attending physician. In those unusual circumstances when an attending physician or subspecialty resident writes an order on a resident's patient, the attending or subspecialty resident must communicate his or her action to the resident in a timely manner.

- (13) There must be a resident on-call schedule and detailed check-out and check-in procedures, so residents will learn to work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients.
- (14) The on-call system must include a plan for backup to ensure that patient care is not jeopardized during or following assigned periods of duty.
- (15) A minimum of one third of the time in the three year training program must be spent in inpatient internal medicine teaching service assignments.
 - (a) There must be a minimum of six months of inpatient internal medicine teaching service assignments in the first year;
 - (b) There must be a minimum of six months of inpatient internal medicine teaching service assignments over the second and third years of training combined;
 - (c) The required 12 months of inpatient internal medicine must include a minimum of three months of inpatient general internal medicine teaching service assignments over the three years of training; and,
 - (d) Geographic concentration of inpatients assigned to a given resident is desirable because such concentration promotes effective teaching and fosters interaction with other health-care personnel.

b) Inpatient Medicine - Critical Care

- (1) Residents must be assigned to critical care rotations (e.g., medical or respiratory intensive care units, cardiac care units) no fewer than three months in three years of training.
- (2) Total required critical care experience must not exceed six months in three years of training. (N.B.: When elective experience occurs in the critical care unit, it must not result in more than a total of eight

months of critical care in three years of training for any resident.)

- (3) All critical care training must occur in critical care units that are directed by ABMS-certified critical care specialists.
- (4) All coronary intensive care unit training must occur in critical care units that are directed by ABIM-certified cardiologists.
- (5) Timely and appropriate consultations must be available from other internal medicine subspecialists and specialists from other disciplines.

3. Subspecialty Experience

- a) Clinical experience in each of the subspecialties of internal medicine must be included in the training program and may occur in either inpatient or ambulatory settings (see Section III.C.3.a)(1) of this document for the list of required specialties).
- b) Although it is not necessary that each resident be assigned to a dedicated rotation in every subspecialty, the curriculum must be designed to ensure that each resident has sufficient clinical exposure to the diagnostic and therapeutic methods of each of the recognized internal medicine subspecialties.
- c) Residents must have formal instruction and assigned clinical experience in geriatric medicine. The curriculum and clinical experience should be directed by an ABMS-certified geriatrician. These experiences may occur at 1 or more specifically designated geriatric inpatient units, geriatric consultation services, long-term care facilities, geriatric ambulatory clinics, and/or in home-care settings.
- d) Total required transplant rotations in dedicated units should not exceed one month in three years.

4. Other Specific Experiences and Skills

- a) Gender-specific health care

Residents should receive instruction and clinical experience in the prevention, counseling, detection, and diagnosis and

treatment of gender-specific diseases of women and men. (N.B.: This clinical experience may occur in general medicine clinics or other specialty clinics.)

b) Experiences in other specialties

- (1) The program must provide residents with instruction and sufficient clinical experience in neurology to acquire the knowledge needed to diagnose, follow, and treat patients with common neurologic disorders and to recognize those disorders that should be referred to a neurologist.
- (2) Residents should have sufficient instruction and clinical experience in psychiatry, dermatology, medical ophthalmology, office gynecology, otorhinolaryngology, non-operative orthopedics, and rehabilitation medicine to become familiar with those aspects of care in each specialty area that can be diagnosed and managed by general internists and those that should be referred to, or managed jointly with, other specialists. (N.B.: This experience may occur in clinical rotations or consultative interactions with specialists in these disciplines.)

c) Procedures and technical skills

(1) Procedures

- (a) All residents must be instructed in the indications, contraindications, complications, limitations, and interpretations of findings, and they must develop technical proficiency in performing the following procedures: advanced cardiac-life support (American Heart Association documentation of successful training within the teaching institution), abdominal paracentesis, arterial puncture, arthrocentesis, central venous line placement, lumbar puncture, nasogastric intubation, pap smear and endocervical culture, and thoracentesis.
- (b) Residents should have the opportunity to achieve competence in additional procedures that may be required in their future practice

settings. These may include arterial line placement, cryosurgical removal of skin lesions, elective cardioversion, endotracheal intubation, skin biopsies, soft tissue and joint injections, temporary pacemaker placement, and treadmill exercise testing.

(2) Interpretative skills

- (a) All residents must develop competency in interpretation of electrocardiograms.
- (b) All residents should develop competency in interpretation of chest roentgenograms, peripheral blood smears, Gram stains of sputum, microscopic examinations of urine, spirometry, and KOH and wet prep examinations of vaginal discharge.
- (c) Residents should have the opportunity to achieve competence in additional common interpretive skills required in the residents' expected practice settings. These include but are not limited to ambulatory electrocardiography, ambulatory blood pressure monitoring, and spirometry.

(3) Consultative experience

Residents must have a structured clinical experience to act, under supervision, as consultants to physicians in other specialties.

V. Evaluation

A. Resident

1. Formative Evaluation

- a) **The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.** The faculty must discuss this evaluation with the resident at the completion of the assignment.

- b) **The program must:**
- (1) **provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**
 - (2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**
 - (3) **document progressive resident performance improvement appropriate to educational level; and,**
 - (4) **provide each resident with documented semiannual evaluation of performance with feedback.** This includes formal evaluations of knowledge, skills, and professional growth of residents and required counseling by the program director or designee.
- c) **The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.**
- d) These evaluation, counseling sessions, and any others that occur must be maintained for each resident as permanent records in their file.
- (1) The record of evaluation should be based on close observation of residents performing specific tasks of patient management such as the interview and physical examination, choice of diagnostic studies, formulation of differential diagnosis or problem lists, development of plans for short-term and long-term medical management, communication of treatment plans, invasive procedures, and (when on inpatient services) discharge planning.
 - (2) The record of evaluation should document that residents have demonstrated an in-depth understanding of the basic mechanisms of human biology, and the application of current knowledge to practice, by the integration of pathophysiologic processes into the diagnosis, treatment, and

management of clinical disorders.

- (3) The record of evaluation should document that prior to the completion of training, each resident has demonstrated:
 - (a) acceptable scholarly activity such as: original research, comprehensive case reports, or review of assigned clinical and research topics;
 - (b) basic scientific literacy and understanding of the fundamental principles of clinical study design and evaluation of research findings; and,
 - (c) the effective application of knowledge and clinical skills (patient care), utilizing the synthetic skills of clinical judgment.
- (4) The record of evaluation should document that structured clinical evaluations were conducted during the first year (for examples see ACGME Website's Outcome Toolbox).
- (5) The record of evaluation should document that the review of residents' clinical documentation for format, quality of data entry, accuracy of the assessment, and appropriateness of the plan was completed on resident inpatient and outpatient records (including inpatient discharge summaries) during each rotation, with feedback to the residents. The program director should ensure that the review of medical records is incorporated into residents' evaluation.
- (6) The record of evaluation should document that records were maintained by documentation logbook or by an equivalent method to demonstrate that residents have achieved competence in the performance of invasive procedures. These records must state the indications and complications, and include the names of the supervising physicians. Such records must be of sufficient detail to permit use in future credentialing.

- (7) The record of evaluation should document that residents were evaluated in writing and their performance reviewed with them verbally on completion of each rotation period.
- (8) The record of evaluation should document that residents were evaluated in writing and their performance in continuity clinic reviewed with them verbally on at least a semiannual basis.

2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

- a) **document the resident's performance during the final period of education, and**
 - b) **verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.**
- (1) The program director must also prepare annually a written evaluation of the clinical competence of each resident. (N.B.: This evaluation is in addition to the completion of the ABIM tracking form.)
 - (2) The annual evaluation must stipulate the degree to which the resident has achieved the level of performance expected in each competency (i.e., patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice).

B. Faculty Evaluation

1. **At least annually, the program must evaluate faculty as it relates to the educational program.**
2. **The evaluations should include a review of faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**

3. **This evaluation must include at least annual written confidential evaluations by residents.** Provision must be made for residents to confidentially provide written evaluations of each teaching attending at the end of a rotation, and for the evaluations to be reviewed annually with faculty.
4. The residents must have the opportunity to assess formally the effectiveness of ambulatory teaching on an ongoing basis.
5. The results of the evaluations must be used for faculty-member counseling and for selecting faculty members for specific teaching assignments.

C. Program Evaluation and Improvement

1. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. **The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:**
 - a) **resident performance**, including resident performance and outcome assessment of the educational effectiveness of inpatient and ambulatory teaching;
 - b) **faculty development;**
 - c) **graduate performance, including performance of program graduates on the certification examination; and,**
 - (1) A program's graduates must achieve a pass rate on the certifying examination of the ABIM of at least 70% for first-time takers of the examination for the most recently defined 3-year period.
 - (2) At least 80% of those completing their training in the program for the most recently defined 3-year period must have taken the certifying examination.
 - d) **program quality. Specifically:**

- (1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
 - (2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.
2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

VI. Resident Duty Hours in the Learning and Working Environment

A. Principles

1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.
2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.
3. Didactic and clinical education must have priority in the allotment of residents' time and energy.
4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

B. Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

C. Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

- 1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
- 2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.**
- 3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**

E. On-Call Activities

- 1. In-house call must occur no more frequently than every third night, averaged over a four-week period.**
 - a) Internal Medicine residency programs are not allowed to average in-house call over a four-week period.
- 2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**
- 3. No new patients may be accepted after 24 hours of continuous duty.**
 - a) A new patient is defined as any patient to whom the resident has not previously provided care.
- 4. At-home call (or pager call)**
 - a) **The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at home-call must not be so frequent as to preclude rest and**

reasonable personal time for each resident.

- b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.**
- c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**

F. Moonlighting

- 1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**
- 2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.**

G. Duty Hour Exceptions

- 1. A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.**
- 2. In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.**
- 3. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.**
 - a) The Review Committee for Internal Medicine will not consider requests for exceptions to the limit to 80 hours per week, averaged monthly.**

H. Service versus Education

- 1. A sponsoring institution must not place excessive reliance on residents to meet the service needs of the participating training sites.**
- 2. To this end, the sponsoring institutions and participating sites must have written policies and procedures, and provide the resources to**

ensure the implementation of the following:

- a) Residents must not be required to provide routine intravenous, phlebotomy, or messenger/transporter services.
- b) Residents' service responsibilities must be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility. (N.B.: Teaching Service is defined as those patients for whom internal medicine residents [PGY 1, 2, or 3] routinely provide care.)
- c) The admission and continuing care of patients by residents must be limited to those patients on the teaching service.
- d) Residents must not be assigned more than one and a half months of night float during any year of training, or more than four months of night float over the three years of residency training. Residents must not be assigned to more than one month of consecutive night float rotation.
- e) For each rotation or major clinical assignment, the teaching ratio must not exceed a total of eight residents and students (excluding subspecialty residents in special care units) to one teaching attending.
- f) Emergency medicine or night float assignments should be separated by at least 10 hours without residency-related activities.

I. Graded Responsibility

- 1. The program must advance residents to positions of higher responsibility on the basis of their satisfactory demonstration of achievement of program-developed milestones in the competencies.
- 2. The program must ensure, with each year of training, that each resident has increasing responsibility in patient care, leadership, teaching, and administration.
- 3. Each resident must be assigned at least 24 months of the 36 months of residency education in settings where the resident personally provides, or supervises junior residents who provide, direct patient care in inpatient or ambulatory settings.

4. These inpatient and ambulatory assignments must include development of diagnostic strategies, planning, record keeping, order or prescription writing, management, discharge summary preparation, and decision making commensurate with residents' abilities and with appropriate supervision by the attending physician.
- J. Grievance procedures and due process
1. In the event of an adverse annual evaluation, a resident must be offered an opportunity to address a judgment of academic deficiencies or misconduct before a formally constituted clinical competence committee.
 2. There must be a written policy that ensures that academic due process is provided.

VII. Experimentation and Innovation

Requests for experimentation or innovative projects that may deviate from the institutional, common and 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 Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once an Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

- A. Performance Improvement Process
1. The program should identify and participate in at least two ongoing performance improvement (PI) activities which relate to the competencies.
 2. The PI activities must involve both residents and faculty in planning and implementing.
 3. The PI activities should result in measurable improvements in patient care or residency education.

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