



**Accreditation Council for
Graduate Medical Education**

**ACGME Program Requirements for
Graduate Medical Education
in Pulmonary Disease and Critical Care Medicine
(Internal Medicine)**

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ACGME Program Requirements for Graduate Medical Education in Pulmonary Disease and Critical Care Medicine (Internal Medicine)

Common Program Requirements are in BOLD

Introduction

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

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

Int.B. Pulmonary medicine focuses on the etiology, diagnosis, prevention, and treatment of diseases affecting the lungs and related organs. Critical care medicine is concerned with the diagnosis, management, and prevention of complications in patients who are severely ill and who usually require intensive monitoring and/or organ system support. Pulmonary disease and critical care medicine fellowships must provide advanced education to allow the fellow to acquire competency in these subspecialties with sufficient expertise to act as an independent consultant. (Core)

Int.C. The educational program in pulmonary disease and critical care medicine must be 36 months in length. (Core)

I. Institutions

I.A. Sponsoring Institution

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

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

- I.A.1. A pulmonary disease and critical care medicine fellowship must function as an integral part of an ACGME-accredited residency in internal medicine. ^(Core)
- I.A.2. Located at the primary clinical site, there should be at least three ACGME-accredited internal medicine subspecialty programs from the following disciplines: cardiovascular disease, gastroenterology, infectious diseases, nephrology, or pulmonary disease. ^(Detail)
- I.A.3. The sponsoring institution should sponsor an ACGME-accredited residency in general surgery. ^(Detail)
- I.A.4. The sponsoring institution must:
 - I.A.4.a) establish the pulmonary disease and critical care medicine fellowship within a department of internal medicine or an administrative unit whose primary mission is the advancement of internal medicine subspecialty education and patient care; and, ^(Detail)
 - I.A.4.b) provide the program director with adequate support for the administrative activities of the fellowship. ^(Core)
 - I.A.4.b).(1) The program director must not be required to generate clinical or other income to provide this administrative support. ^(Core)
 - I.A.4.b).(2) This support should be 25-50% of the program director's salary, or protected time, depending on the size of the program. ^(Detail)
- I.A.5. The sponsoring institution and participating sites must share appropriate inpatient and outpatient faculty performance data with the program director. ^(Core)

I.B. Participating Sites

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

The PLA should:

- I.B.1.a) **identify the faculty who will assume both educational and supervisory responsibilities for fellows;** ^(Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document; ^(Detail)

I.B.1.c) specify the duration and content of the educational experience; and, ^(Detail)

I.B.1.d) state the policies and procedures that will govern fellow education during the assignment. ^(Detail)

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS). ^(Core)

II. Program Personnel and Resources

II.A. Program Director

II.A.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. ^(Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. ^(Core)

II.A.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. ^(Detail)

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; ^(Core)

II.A.3.a).(1) The program director must have at least five years of participation as an active faculty member in an ACGME-accredited internal medicine residency, or pulmonary disease or critical care medicine fellowship. ^(Detail)

II.A.3.b) current certification in the subspecialty by the American Board of Internal Medicine (ABIM), or subspecialty qualifications that are acceptable to the Review Committee; and, ^(Core)

II.A.3.b).(1) The Review Committee only accepts current ABIM

certification in pulmonary disease or critical care medicine.
(Core)

II.A.3.b).(2)

If the program director does not have appropriate credentials in both subspecialties, an appropriately-credentialed and full-time Key Clinical Faculty (KCF) member must be identified as responsible for the education program in the second specific area. (Core)

II.A.3.c)

current medical licensure and appropriate medical staff appointment. (Core)

II.A.4.

The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. (Core)

The program director must:

II.A.4.a)

oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; (Core)

II.A.4.b)

approve a local director at each participating site who is accountable for fellow education; (Core)

II.A.4.c)

approve the selection of program faculty as appropriate; (Core)

II.A.4.d)

evaluate program faculty; (Core)

II.A.4.e)

approve the continued participation of program faculty based on evaluation; (Core)

II.A.4.f)

monitor fellow supervision at all participating sites; (Core)

II.A.4.g)

prepare and submit all information required and requested by the ACGME; (Core)

II.A.4.g).(1)

This includes but is not limited to the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete. (Core)

II.A.4.h)

ensure compliance with grievance and due process procedures, as set forth in the Institutional Requirements and implemented by the sponsoring institution; (Detail)

II.A.4.i)

provide verification of fellowship education for all fellows, including those who leave the program prior to completion; (Detail)

- II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including moonlighting, ^(Core)**
- and, to that end, must:**
- II.A.4.j).(1) distribute these policies and procedures to the fellows and faculty; ^(Detail)**
- II.A.4.j).(2) monitor fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; ^(Core)**
- II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, ^(Detail)**
- II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. ^(Detail)**
- II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; ^(Detail)**
- II.A.4.l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of fellows, disciplinary action, and supervision of fellows; ^(Detail)**
- II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; ^(Detail)**
- II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including: ^(Core)**
- II.A.4.n).(1) all applications for ACGME accreditation of new programs; ^(Detail)**
- II.A.4.n).(2) changes in fellow complement; ^(Detail)**
- II.A.4.n).(3) major changes in program structure or length of training; ^(Detail)**
- II.A.4.n).(4) progress reports requested by the Review Committee; ^(Detail)**
- II.A.4.n).(5) requests for increases or any change to fellow duty**

- hours;** ^(Detail)
- II.A.4.n).(6)** **voluntary withdrawals of ACGME-accredited programs;** ^(Detail)
- II.A.4.n).(7)** **requests for appeal of an adverse action; and,** ^(Detail)
- II.A.4.n).(8)** **appeal presentations to a Board of Appeal or the ACGME.** ^(Detail)
- II.A.4.o)** **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** ^(Detail)
- II.A.4.o).(1)** **program citations, and/or,** ^(Detail)
- II.A.4.o).(2)** **request for changes in the program that would have significant impact, including financial, on the program or institution.** ^(Detail)
- II.A.4.p) be responsible for monitoring fellow stress, including mental or emotional conditions inhibiting performance or learning, and drug- or alcohol-related dysfunction. ^(Core)
- II.A.4.p).(1) The program director should provide access to timely confidential counseling and psychological support services to fellows. ^(Detail)
- II.A.4.p).(2) Situations that demand excessive service or that consistently produce undesirable stress on fellows must be evaluated and modified. ^(Detail)
- II.A.4.q) ensure that fellows' service responsibilities are limited to patients for whom the teaching service has diagnostic and therapeutic responsibility. ^(Core)
- II.A.4.r) dedicate an average of 20 hours per week of his or her professional effort to the fellowship, including time for administration of the program; ^(Detail)
- II.A.4.s) participate in academic societies and in educational programs designed to enhance his or her educational and administrative skills; ^(Detail)
- II.A.4.t) have a reporting relationship with the program director of the internal medicine residency program to ensure compliance with ACGME accreditation standards^(Core); and,
- II.A.4.u) be available at the primary clinical site. ^(Detail)

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows at that location. (Core)

The faculty must:

II.B.1.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 fellows; and (Core)

II.B.1.b) administer and maintain an educational environment conducive to educating fellows in each of the ACGME competency areas. (Core)

II.B.2. The physician faculty must have current certification in the subspecialty by the American Board of Internal Medicine, or possess qualifications judged acceptable to the Review Committee. (Core)

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. (Core)

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Detail)

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding; (Detail)

II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; (Detail)

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)

II.B.5.b).(4) participation in national committees or educational organizations. (Detail)

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

activities. ^(Core)

- II.B.6. The physician faculty must meet professional standards of ethical behavior. ^(Core)
- II.B.7. Key Clinical Faculty
- II.B.7.a) In addition to the program director, each program must have at least five Key Clinical Faculty (KCF). ^(Core)
- II.B.7.b) KCF are attending physicians who dedicate, on average, 10 hours per week throughout the year to the program. ^(Core)
- II.B.7.c) For programs with more than nine fellows, there must be at least one KCF for every 1.5 fellows. ^(Core)
- II.B.7.d) Key Clinical Faculty Qualifications
- II.B.7.d).(1) KCF must be active clinicians with knowledge of, experience with, and commitment to pulmonary disease or critical care medicine as a discipline. ^(Core)
- II.B.7.d).(2) KCF must have current ABIM certification in pulmonary disease or critical care medicine. ^(Core)
- II.B.7.d).(3) At least three KCF must be ABIM-certified in pulmonary disease and at least three KCF must be ABIM-certified in critical care medicine. ^(Core)
- II.B.7.e) Key Clinical Faculty Responsibilities
- II.B.7.e).(1) In addition to the responsibilities of all individual faculty members, the KCF and the program director are responsible for the planning, implementation, monitoring, and evaluation of the fellows' clinical and research education. ^(Core)
- II.B.7.e).(2) At least 50% of the KCF must demonstrate evidence of productivity in scholarship, specifically, peer-reviewed funding; publication of original research, review articles, editorials, or case reports in peer-reviewed journals; or chapters in textbooks. ^(Detail)
- II.B.7.e).(3) At least one of the KCF must:
- II.B.7.e).(3).(a) be knowledgeable in the evaluation and assessment of the ACGME competencies; and, ^(Detail)
- II.B.7.e).(3).(b) spend significant time in the evaluation of fellows,

including the direct observation of fellows with patients. ^(Detail)

II.B.7.e).(4) Appointment of one KCF to be an associate program director is suggested. ^(Detail)

II.B.8. Other Faculty

II.B.8.a) ABIM-certified clinical faculty members in nephrology, gastroenterology, cardiology, infectious disease, hematology, and oncology must participate in the program. ^(Core)

II.B.8.b) Faculty from several related disciplines, including general surgery, thoracic surgery, urology, orthopaedic surgery, obstetrics and gynecology, neurology, neurological surgery, emergency medicine, anesthesiology, cardiovascular surgery, and vascular surgery must be available to participate in the program. ^(Core)

II.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 of the program. ^(Core)

II.C.1. There must be services available from other health care professionals, including dietitians, language interpreters, nurses, occupational therapists, physical therapists, and social workers. ^(Detail)

II.C.2. Personnel must include nurses and technicians skilled in critical care instrumentation, respiratory function, and laboratory medicine. ^(Detail)

II.C.3. There must be appropriate and timely consultation from other specialties. ^(Detail)

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements. ^(Core)

II.D.1. Space and Equipment

There must be space and equipment for the program, including meeting rooms, examination rooms, computers, visual and other educational aids, and work/study space. ^(Core)

II.D.2. Facilities

II.D.2.a) Inpatient and outpatient systems must be in place to prevent fellows from performing routine clerical functions, such as

scheduling tests and appointments, and retrieving records and letters. ^(Detail)

- II.D.2.b) The sponsoring institution must provide the broad range of facilities and clinical support services required to provide comprehensive care of adult patients. ^(Core)
- II.D.2.c) Fellows must have access to a lounge facility during assigned duty hours. ^(Detail)
- II.D.2.d) When fellows are in the hospital, assigned night duty, or called in from home, they must be provided with a secure space for their belongings. ^(Detail)

II.D.3. Laboratory and Imaging Services

The following must be available at the primary clinical site:

- II.D.3.a) a supporting laboratory that provides complete and prompt laboratory evaluation; ^(Core)
- II.D.3.b) a pulmonary function testing laboratory; ^(Core)
- II.D.3.c) timely bedside imaging services for patients in the critical care units; ^(Core)
- II.D.3.d) computed tomography (CT) imaging, including CT angiography; and, ^(Core)
- II.D.3.e) a bronchoscopy suite, including appropriate space and staffing for pulmonary procedures. ^(Core)

II.D.4. Other Support Services

- II.D.4.a) The following must be available:
 - II.D.4.a).(1) an active open heart surgery program; ^(Core)
 - II.D.4.a).(2) a diagnostic laboratory for sleep disorders; ^(Core)
 - II.D.4.a).(3) pathology services, including exfoliative cytology; ^(Core)
 - II.D.4.a).(4) thoracic surgery service; ^(Core)
 - II.D.4.a).(5) an active emergency service; ^(Core)
 - II.D.4.a).(6) postoperative care and respiratory care services; and, ^(Core)
 - II.D.4.a).(7) nutritional support services. ^(Core)

- II.D.4.b) Critical care unit(s) must be located in a designated area within the hospital, and must be constructed and designed specifically for the care of critically-ill patients. ^(Core)
- II.D.4.b).(1) Whether operating in separate locations or in combined facilities, the program must provide the equivalent of a medical intensive care unit (MICU), a surgical intensive care unit (SICU), and a coronary intensive care unit (CICU). ^(Detail)
- II.D.4.c) The MICU or its equivalent must be at the primary clinical site, and should be the focus of a teaching service. ^(Core)
- II.D.4.d) There must be facilities to care for patients with acute myocardial infarction, severe trauma, shock, recent open heart surgery, recent major thoracic or abdominal surgery, and severe neurologic and neurosurgical conditions. ^(Core)
- II.D.4.e) Other services should be available, including anesthesiology, immunology, laboratory medicine, microbiology, occupational medicine, otolaryngology, pathology, physical medicine and rehabilitation, and radiology. ^(Core)
- II.D.5. Medical Records
- Access to an electronic health record should be provided. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation. ^(Core)
- II.D.6. Patient Population
- II.D.6.a) The patient population must have a variety of clinical problems and stages of diseases. ^(Core)
- II.D.6.b) There must be patients of each gender, with a broad age range, including geriatric patients. ^(Core)
- II.D.6.c) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. ^(Core)
- II.D.6.d) Because critical care medicine is multidisciplinary in nature, the program must provide opportunities to manage adult patients with a wide variety of serious illnesses and injuries requiring treatment in a critical care setting. ^(Detail)
- II.D.6.e) There must be an average daily census of at least five patients per fellow during assignments to critical care units. ^(Detail)

II.E. Medical Information Access

Fellows 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.
(Detail)

III. Fellow Appointments

III.A. Eligibility Criteria

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

III.A.1. Eligibility Requirements – Residency Programs

III.A.1.a) All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant’s level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program. (Core)

III.A.1.b) A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

III.A.1.c) A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission. (Core)

III.A.1.d) Review Committees will grant no other exceptions to these eligibility requirements for residency education. (Core)

III.A.2. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited

residency program, or in an RCPSC-accredited or CFPC- accredited residency program located in Canada. ^(Core)

Prior to appointment in the fellowship, fellows should have completed an ACGME- or RCPSC-accredited internal medicine program. ^(Core)

III.A.2.a) Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program. ^(Core)

III.A.2.b) Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions: ^(Core)**

III.A.2.b).(1) Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and, ^(Core)

III.A.2.b).(2) Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and, ^(Core)

III.A.2.b).(3) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3; and, ^(Core)

III.A.2.b).(4) For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, ^(Core)

III.A.2.b).(5) Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones

evaluation conducted at the conclusion of the residency program; and, ^(Core)

III.A.2.b).(5).(a)

If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. ^(Core)

**** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**

III.A.2.b).(6)

Fellows from non-ACGME- or RCPSC-accredited internal medicine program must have completed at least three years of internal medicine education prior to starting the fellowship. ^(Core)

III.A.2.b).(6).(a)

The program director must inform applicants from non-ACGME-accredited programs, prior to appointment, and in writing, of the ABIM policies and procedures that will affect their eligibility for ABIM certification. ^(Detail)

III.A.2.c)

The Review Committee for Internal Medicine does allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.2. ^(Core)

III.B. **Number of Fellows**

The program's educational resources must be adequate to support the number of fellows appointed to the program. ^(Core)

III.B.1.

The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. ^(Core)

III.B.2.

The number of available fellow positions in the program must be at least

one per year. ^(Detail)

III.C. Fellow Transfers

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

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

III.D. Appointment of Fellows and Other Learners

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 fellows' education. ^(Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMCC in accordance with sponsoring institution guidelines. ^(Detail)

IV. Educational Program

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

IV.A.1. Overall educational goals for the program, which the program must make available to fellows and faculty; ^(Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to fellows and faculty at least annually, in either written or electronic form; ^(Core)

IV.A.3. Regularly scheduled didactic sessions; ^(Core)

IV.A.3.a) The core curriculum must include a didactic program based upon the core knowledge content in the subspecialty area. ^(Core)

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

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

IV.A.3.a).(3) All core conferences must have at least one faculty

member present, and must be scheduled as to ensure peer-peer and peer-faculty interaction. ^(Detail)

IV.A.3.b) Patient-based teaching must include direct interaction between fellows and faculty members, bedside teaching, discussion of pathophysiology, and the use of current evidence in diagnostic and therapeutic decisions. ^(Core)

The teaching must be:

IV.A.3.b).(1) formally conducted on all inpatient, outpatient, and consultative services; and, ^(Detail)

IV.A.3.b).(2) conducted with a frequency and duration that ensures a meaningful and continuous teaching relationship between the assigned supervising faculty member(s) and fellows. ^(Detail)

IV.A.3.c) Fellows must receive instruction in practice management relevant to pulmonary disease and critical care medicine. ^(Detail)

IV.A.4. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows over the continuum of the program; and, ^(Core)

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: ^(Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows: ^(Outcome)

IV.A.5.a).(1).(a) must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care, and treatment of patients of each gender, from adolescence to old age, during health and all stages of illness; and, ^(Outcome)

IV.A.5.a).(1).(b) must demonstrate competence in the prevention, evaluation and management of both inpatients and outpatients with:

IV.A.5.a).(1).(b).(i) acute lung injury, including radiation, inhalation, and trauma; ^(Outcome)

IV.A.5.a).(1).(b).(ii)	acute metabolic disturbances, ^(Outcome)
IV.A.5.a).(1).(b).(ii).(a)	including overdosages and intoxication syndromes; ^(Detail)
IV.A.5.a).(1).(b).(iii)	anaphylaxis and acute allergic reactions in the critical care unit; ^(Outcome)
IV.A.5.a).(1).(b).(iv)	cardiovascular diseases in the critical care unit; ^(Outcome)
IV.A.5.a).(1).(b).(v)	circulatory failure; ^(Outcome)
IV.A.5.a).(1).(b).(vi)	detection and prevention of iatrogenic and nosocomial problems in critical care medicine; ^(Outcome)
IV.A.5.a).(1).(b).(vii)	diffuse interstitial lung disease; ^(Outcome)
IV.A.5.a).(1).(b).(viii)	disorders of the pleura and the mediastinum; ^(Outcome)
IV.A.5.a).(1).(b).(ix)	end of life issues and palliative care; ^(Outcome)
IV.A.5.a).(1).(b).(x)	hypertensive emergencies; ^(Outcome)
IV.A.5.a).(1).(b).(xi)	iatrogenic respiratory diseases, ^(Outcome)
IV.A.5.a).(1).(b).(xi).(a)	including drug-induced disease; ^(Detail)
IV.A.5.a).(1).(b).(xii)	immunosuppressed conditions in the critical care unit; ^(Outcome)
IV.A.5.a).(1).(b).(xiii)	metabolic, nutritional and endocrine effects of critical illness, and hematologic and coagulation disorders associated with critical illness; ^(Outcome)
IV.A.5.a).(1).(b).(xiv)	multi-organ system failure; ^(Outcome)
IV.A.5.a).(1).(b).(xv)	obstructive lung diseases, ^(Outcome)
IV.A.5.a).(1).(b).(xv).(a)	including asthma, bronchitis, emphysema, and bronchiectasis; ^(Detail)
IV.A.5.a).(1).(b).(xvi)	occupational and environmental lung diseases; ^(Outcome)
IV.A.5.a).(1).(b).(xvii)	perioperative critically-ill patients, ^(Outcome)

IV.A.5.a).(1).(b).(xvii).(a)	including hemodynamic and ventilatory support; ^(Detail)
IV.A.5.a).(1).(b).(xviii)	psychosocial and emotional effects of critical illness on patients and their families; ^(Outcome)
IV.A.5.a).(1).(b).(xix)	pulmonary embolism and pulmonary embolic disease; ^(Outcome)
IV.A.5.a).(1).(b).(xx)	pulmonary infections, including tuberculous, fungal, and infections in the immunocompromised host (e.g., HIV-related infections); ^(Outcome)
IV.A.5.a).(1).(b).(xxi)	pulmonary malignancy—primary and metastatic;
IV.A.5.a).(1).(b).(xxii)	pulmonary manifestations of systemic diseases, ^(Outcome)
IV.A.5.a).(1).(b).(xxii).(a)	including collagen vascular disease and diseases that are primary in other organs; ^(Detail)
IV.A.5.a).(1).(b).(xxiii)	pulmonary vascular disease, ^(Outcome)
IV.A.5.a).(1).(b).(xxiii).(a)	including primary and secondary pulmonary hypertension and the vasculitis and pulmonary hemorrhage syndromes; ^(Detail)
IV.A.5.a).(1).(b).(xxiv)	renal disorders in the critical care unit, including electrolyte and acid-base disturbance and acute renal failure; ^(Outcome)
IV.A.5.a).(1).(b).(xxv)	respiratory failure, ^(Outcome)
IV.A.5.a).(1).(b).(xxv).(a)	including the acute respiratory distress syndrome, acute and chronic respiratory failure in obstructive lung diseases, and neuromuscular respiratory drive disorders; ^(Detail)
IV.A.5.a).(1).(b).(xxvi)	sepsis and sepsis syndrome; ^(Outcome)
IV.A.5.a).(1).(b).(xxvii)	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; ^(Outcome)

IV.A.5.a).(1).(b).(xxviii)

shock syndromes; and, ^(Outcome)

IV.A.5.a).(1).(b).(xxix)

sleep-disordered breathing. ^(Outcome)

IV.A.5.a).(2)

Fellows must be able to competently perform all medical, diagnostic and surgical procedures considered essential for the area of practice. Fellows:
^(Outcome)

IV.A.5.a).(2).(a)

must demonstrate competence in interpreting data derived from various bedside devices commonly employed to monitor patients, and data from laboratory studies related to sputum, bronchopulmonary secretions, pleural fluid; and, ^(Outcome)

IV.A.5.a).(2).(b)

must demonstrate competence in procedural and technical skills, including: ^(Outcome)

IV.A.5.a).(2).(b).(i)

airway management; ^(Outcome)

IV.A.5.a).(2).(b).(ii)

the use of a variety of positive pressure ventilatory modes, including: ^(Outcome)

IV.A.5.a).(2).(b).(ii).(a)

initiation and maintenance of ventilatory support; ^(Detail)

IV.A.5.a).(2).(b).(ii).(b)

respiratory care techniques; and, ^(Detail)

IV.A.5.a).(2).(b).(ii).(c)

withdrawal of mechanical ventilatory support. ^(Detail)

IV.A.5.a).(2).(b).(iii)

the use of reservoir masks and continuous positive airway pressure masks for delivery of supplemental oxygen, humidifiers, nebulizers, and incentive spirometry; ^(Outcome)

IV.A.5.a).(2).(b).(iv)

flexible fiber-optic bronchoscopy procedures, ^(Outcome)

IV.A.5.a).(2).(b).(iv).(a)

including those where endobronchial and transbronchial biopsies, and transbronchial needle aspiration are performed (each fellow must

	perform a minimum of 100 such procedures); ^(Detail)
IV.A.5.a).(2).(b).(v)	pulmonary function tests to assess respiratory mechanics and gas exchange, ^(Outcome)
IV.A.5.a).(2).(b).(v).(a)	including spirometry, flow volume studies, lung volumes, diffusing capacity, arterial blood gas analysis, exercise studies, and interpretation of the results of bronchoprovocation testing using methacholine or histamine; ^(Detail)
IV.A.5.a).(2).(b).(vi)	diagnostic and therapeutic procedures, ^(Outcome)
IV.A.5.a).(2).(b).(vi).(a)	including paracentesis, lumbar puncture, thoracentesis, endotracheal intubation, and related procedures; ^(Detail)
IV.A.5.a).(2).(b).(vii)	use of chest tubes and drainage systems; ^(Outcome)
IV.A.5.a).(2).(b).(viii)	insertion of arterial, central venous, and pulmonary artery balloon flotation catheters; ^(Outcome)
IV.A.5.a).(2).(b).(ix)	operation of bedside hemodynamic monitoring systems; ^(Outcome)
IV.A.5.a).(2).(b).(x)	emergency cardioversion; ^(Outcome)
IV.A.5.a).(2).(b).(xi)	interpretation of intracranial pressure monitoring; ^(Outcome)
IV.A.5.a).(2).(b).(xii)	nutritional support; ^(Outcome)
IV.A.5.a).(2).(b).(xiii)	use of ultrasound techniques to perform thoracentesis and place intravascular and intracavitary tubes and catheters; ^(Outcome)
IV.A.5.a).(2).(b).(xiv)	use of transcutaneous pacemakers; and, ^(Outcome)
IV.A.5.a).(2).(b).(xv)	the use of paralytic agents and sedative and analgesic drugs in the critical care unit. ^(Outcome)

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: ^(Outcome)

- IV.A.5.b).(1) must demonstrate knowledge of the scientific method of problem solving, and evidence-based decision making. ^(Outcome)
- IV.A.5.b).(2) must demonstrate knowledge of indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, including the appropriate indication for and use of screening tests/procedures; ^(Outcome)
- IV.A.5.b).(3) must demonstrate knowledge in the indications, contraindications and complications of placement of percutaneous tracheostomies; and, ^(Outcome)
- IV.A.5.b).(4) must demonstrate knowledge of:
- IV.A.5.b).(4).(a) imaging techniques commonly employed in the evaluation of patients with pulmonary disease or critical illness, including the use of ultrasound; ^(Outcome)
- IV.A.5.b).(4).(b) monitoring and supervising special services, including: ^(Outcome)
- IV.A.5.b).(4).(b).(i) respiratory care units; ^(Detail)
- IV.A.5.b).(4).(b).(ii) pulmonary function laboratories, including quality control, quality assurance, and proficiency standards; and, ^(Detail)
- IV.A.5.b).(4).(b).(iii) respiratory care techniques and services. ^(Detail)
- IV.A.5.b).(4).(c) the basic sciences, with particular emphasis on: ^(Outcome)
- IV.A.5.b).(4).(c).(i) genetics and molecular biology as they relate to pulmonary diseases; ^(Detail)
- IV.A.5.b).(4).(c).(ii) developmental biology; ^(Detail)

- IV.A.5.b).(4).(c).(iii) pulmonary physiology and pathophysiology in systemic diseases; and, ^(Detail)
- IV.A.5.b).(4).(c).(iv) biochemistry and physiology, including cell and molecular biology and immunology, as they relate to pulmonary disease. ^(Detail)
- IV.A.5.b).(4).(d) indications, complications, and outcomes of lung transplantation; ^(Outcome)
- IV.A.5.b).(4).(e) pericardiocentesis; ^(Outcome)
- IV.A.5.b).(4).(f) percutaneous needle biopsies; ^(Outcome)
- IV.A.5.b).(4).(g) renal replacement therapy; ^(Outcome)
- IV.A.5.b).(4).(h) pharmacokinetics, pharmacodynamics, and drug metabolism and excretion in critical illness; ^(Outcome)
- IV.A.5.b).(4).(i) principles and techniques of administration and management of a MICU; ^(Outcome)
- IV.A.5.b).(4).(j) ethical, economic, and legal aspects of critical illness; ^(Outcome)
- IV.A.5.b).(4).(k) recognition and management of the critically-ill from disasters, ^(Outcome)
- IV.A.5.b).(4).(k).(i) including those caused by chemical and biological agents; and, ^(Detail)
- IV.A.5.b).(4).(l) the psychosocial and emotional effects of critical illness on patients and their families. ^(Outcome)

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.
^(Outcome)

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;** ^(Outcome)
- IV.A.5.c).(2) set learning and improvement goals;** ^(Outcome)

- IV.A.5.c).(3) **identify and perform appropriate learning activities;**
(Outcome)
- IV.A.5.c).(4) **systematically analyze practice, using quality improvement methods, and implement changes with the goal of practice improvement;** (Outcome)
- IV.A.5.c).(5) **incorporate formative evaluation feedback into daily practice;** (Outcome)
- IV.A.5.c).(6) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;** (Outcome)
- IV.A.5.c).(7) **use information technology to optimize learning;**
(Outcome)
- IV.A.5.c).(8) **participate in the education of patients, families, students, fellows and other health professionals; and,**
(Outcome)
- IV.A.5.c).(9) obtain procedure-specific informed consent by competently educating patients about rationale, technique, and complications of procedures. (Outcome)

IV.A.5.d)

Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

Fellows are expected to:

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

IV.A.5.e)

Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. ^(Outcome)

Fellows are expected to demonstrate:

IV.A.5.e).(1)

compassion, integrity, and respect for others; ^(Outcome)

IV.A.5.e).(2)

responsiveness to patient needs that supersedes self-interest; ^(Outcome)

IV.A.5.e).(3)

respect for patient privacy and autonomy; ^(Outcome)

IV.A.5.e).(4)

accountability to patients, society and the profession; ^(Outcome)

IV.A.5.e).(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; and, ^(Outcome)

IV.A.5.e).(6)

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. ^(Outcome)

IV.A.5.f)

Systems-based Practice

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. ^(Outcome)

Fellows are expected to:

IV.A.5.f).(1)

work effectively in various health care delivery settings and systems relevant to their clinical specialty; ^(Outcome)

IV.A.5.f).(2)

coordinate patient care within the health care system relevant to their clinical specialty; ^(Outcome)

IV.A.5.f).(3)

incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; ^(Outcome)

IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems; ^(Outcome)

IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and, ^(Outcome)

IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions. ^(Outcome)

IV.A.6. Curriculum Organization and Fellow Experiences

IV.A.6.a) Fellows must have at least 18 months of clinical experience. ^(Core)

This must include:

IV.A.6.a).(1) at least nine months of 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; ^(Core)

IV.A.6.a).(2) at least nine months in critical care medicine, of which at least six months must be devoted to the care of critically-ill medical patients (MICU/CICU or equivalent); ^(Core)

IV.A.6.a).(3) at least three months devoted to the care of critically-ill non-medical patients (SICU, Burn Unit, Transplant Unit, Neurointensive Care, or equivalent); and, ^(Core)

IV.A.6.a).(3).(a) This 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. ^(Detail)

IV.A.6.a).(4) not more than 15 months of required intensive care unit experiences in the three years of education. ^(Detail)

IV.A.6.b) 24 months of clinical experience is suggested. ^(Detail)

IV.A.6.c) Fellows must participate in training using simulation. ^(Detail)

IV.A.6.d) Fellow experiences must include:

IV.A.6.d).(1) continuing responsibility for both acutely- and chronically-ill pulmonary patients in order to learn both the natural history of pulmonary disease and the effectiveness of therapeutic programs; ^(Core)

IV.A.6.d).(2) managing adult patients with a wide variety of serious illnesses and injuries requiring treatment in a critical care

- setting; ^(Core)
- IV.A.6.d).(3) clinical experience in the evaluation and management of patients: ^(Core)
- IV.A.6.d).(3).(a) with genetic and developmental disorders of the respiratory system, ^(Core)
- IV.A.6.d).(3).(a).(i) including cystic fibrosis; ^(Detail)
- IV.A.6.d).(3).(b) undergoing pulmonary rehabilitation; ^(Core)
- IV.A.6.d).(3).(c) with trauma; ^(Core)
- IV.A.6.d).(3).(d) with neurosurgical emergencies; ^(Core)
- IV.A.6.d).(3).(e) with critical obstetric and gynecologic disorders; and, ^(Core)
- IV.A.6.d).(3).(f) after discharge from the critical care unit. ^(Core)
- IV.A.6.e) Fellows must have clinical experience in examination and interpretation of lung tissue for infectious agents, cytology, and histopathology. ^(Core)
- IV.A.6.f) Experience with Continuity Ambulatory Patients
- IV.A.6.f).(1) Fellows must have a continuity ambulatory clinic experience that exposes them to the breadth and depth of the subspecialty. ^(Core)
- IV.A.6.f).(2) The ambulatory care clinic experience must occur throughout the 36 months of the fellowship. ^(Detail)
- IV.A.6.f).(2).(a) For programs with at least 24 months of clinical rotations, fellows must complete a minimum of 24 months of one half-day weekly ambulatory care clinic during the 36-month fellowship. ^(Detail)
- IV.A.6.f).(2).(b) For programs with 18-23 months of required clinical rotations, fellows must complete a minimum of 30 months of one half-day weekly ambulatory care clinic during the 36-month fellowship. ^(Detail)
- IV.A.6.f).(3) This experience must include an appropriate distribution of patients of each gender and a diversity of ages. ^(Core)
- This should be accomplished through either:
- IV.A.6.f).(3).(a) a continuity clinic which provides fellows the

- opportunity to learn the course of disease; or, ^(Detail)
- IV.A.6.f).(3).(b) consecutive selected blocks of at least six months duration for the length of the accredited fellowship. ^(Detail)
- IV.A.6.f).(3).(b).(i) If the above clinic blocks are interrupted by other clinical rotations, they must be extended so that their total duration is at least six months. ^(Detail)
- IV.A.6.f).(4) Each fellow should be responsible, on average, for four to eight patients during each half day session. ^(Detail)
- IV.A.6.f).(5) Up to six months may be exempted from ambulatory experiences during MICU rotations, other time-intensive rotations, or vacation. ^(Detail)
- IV.A.6.f).(6) Fellows should be informed of the status of their continuity patients when such patients are hospitalized, as clinically appropriate. ^(Detail)
- IV.A.6.g) Procedures and Technical Skills
- IV.A.6.g).(1) Direct supervision of procedures performed by each fellow must occur until proficiency has been acquired and documented by the program director. ^(Core)
- IV.A.6.g).(2) Faculty members must teach and supervise the fellows in the performance and interpretation of procedures, which must be documented in each fellow's record, including indications, outcomes, diagnoses, and supervisor(s). ^(Core)
- IV.A.6.g).(3) It is suggested that fellows have clinical experience in the placement of percutaneous tracheostomies. ^(Detail)
- IV.A.6.g).(4) Fellows must have experience in the role of a pulmonary disease consultant in both the inpatient and outpatient settings and as a critical care medicine consultant in the inpatient setting. ^(Core)

IV.B. Fellows' Scholarly Activities

IV.B.1. The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. ^(Core)

IV.B.2. Fellows should participate in scholarly activity. ^(Core)

IV.B.2.a) The majority of fellows must demonstrate evidence of scholarship

conducted during the fellowship.^(Outcome)

This should be achieved through one or more of the following:

- IV.B.2.a).(1) publication of articles, book chapters, abstracts, or case reports in peer-reviewed journals;^(Detail)
- IV.B.2.a).(2) publication of peer-reviewed performance improvement or education research;^(Detail)
- IV.B.2.a).(3) peer-reviewed funding; or,^(Detail)
- IV.B.2.a).(4) peer-reviewed abstracts presented at regional, state, or national specialty meetings.^(Detail)

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities.^(Detail)

V. Evaluation

V.A. Fellow Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee.^(Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty.^(Core)

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows in patient care and other health care settings.^(Core)

V.A.1.a).(1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee.^(Core)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee.^(Core)

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all fellow evaluations semi-annually; ^(Core)

V.A.1.b).(1).(b) prepare and ensure the reporting of Milestones evaluations of each fellow semi-annually to ACGME; and, ^(Core)

V.A.1.b).(1).(c) advise the program director regarding fellow progress, including promotion, remediation, and dismissal. ^(Detail)

V.A.2. Formative Evaluation

V.A.2.a) The faculty must evaluate fellow performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. ^(Core)

V.A.2.a).(1) The faculty must discuss this evaluation with each fellow at the completion of each assignment. ^(Core)

V.A.2.a).(2) Assessment of procedural competence should include a formal evaluation process and not be based solely on a minimum number of procedures performed. ^(Detail)

V.A.2.b) The program must:

V.A.2.b).(1) provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty- specific Milestones; ^(Core)

V.A.2.b).(1).(a) Patient Care

The program must assess each fellow in data gathering, clinical reasoning, patient management, and procedures in both the inpatient and outpatient setting. ^(Core)

V.A.2.b).(1).(a).(i) This assessment must involve direct observation of fellow-patient encounters. ^(Detail)

V.A.2.b).(1).(a).(ii) Each program must define criteria for competence for all required and elective procedures. ^(Detail)

V.A.2.b).(1).(a).(iii)	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. ^(Detail)
V.A.2.b).(1).(b)	<p>Medical Knowledge</p> <p>The program must use an objective formative assessment method. The same formative assessment method must be administered at least twice during the program. ^(Detail)</p>
V.A.2.b).(1).(c)	<p>Practice-based Learning and Improvement</p> <p>The program must use performance data to assess each fellow in:</p>
V.A.2.b).(1).(c).(i)	application of evidence to patient care; ^(Detail)
V.A.2.b).(1).(c).(ii)	practice improvement; ^(Detail)
V.A.2.b).(1).(c).(iii)	teaching skills involving peers and patients; and, ^(Detail)
V.A.2.b).(1).(c).(iv)	scholarship. ^(Detail)
V.A.2.b).(1).(d)	<p>Interpersonal and Communication Skills</p> <p>The program must use both direct observation and multi-source evaluation, including patients, peers and non-physician team members, to assess each fellow's performance in:</p>
V.A.2.b).(1).(d).(i)	communication with patient and family; ^(Detail)
V.A.2.b).(1).(d).(ii)	teamwork; ^(Detail)
V.A.2.b).(1).(d).(iii)	communication with peers, including transitions in care; and, ^(Detail)
V.A.2.b).(1).(d).(iv)	record keeping. ^(Detail)
V.A.2.b).(1).(e)	<p>Professionalism</p> <p>The program must use multi-source evaluation, including patients, peers, and non-physician team members, to assess each fellow's:</p>
V.A.2.b).(1).(e).(i)	honesty and integrity; ^(Detail)

- V.A.2.b).(1).(e).(ii) ability to meet professional responsibilities;
(Detail)
- V.A.2.b).(1).(e).(iii) ability to maintain appropriate professional relationships with patients and colleagues; and, (Detail)
- V.A.2.b).(1).(e).(iv) commitment to self-improvement. (Detail)
- V.A.2.b).(1).(f) **Systems-based Practice**
- The program must use multi-source evaluation, including peers, and non-physician team members, to assess each fellow's:
- V.A.2.b).(1).(f).(i) ability to provide care coordination, including transition of care; (Detail)
- V.A.2.b).(1).(f).(ii) ability to work in interdisciplinary teams; (Detail)
- V.A.2.b).(1).(f).(iii) advocacy for quality of care; and, (Detail)
- V.A.2.b).(1).(f).(iv) ability to identify system problems and participate in improvement activities. (Detail)
- V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);** (Detail)
- V.A.2.b).(3) document progressive fellow performance improvement appropriate to educational level; and,** (Core)
- V.A.2.b).(4) provide each fellow with documented semiannual evaluation of performance with feedback.** (Core)
- V.A.2.b).(4).(a) Fellows' performance in continuity clinic must be reviewed with them verbally and in writing at least semiannually. (Detail)
- V.A.2.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.** (Detail)
- V.A.3. Summative Evaluation**
- V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the**

program. ^(Core)

V.A.3.b) The program director must provide a summative evaluation for each fellow upon completion of the program. ^(Core)

This evaluation must:

V.A.3.b).(1) become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy; ^(Detail)

V.A.3.b).(2) document the fellow's performance during the final period of education; and, ^(Detail)

V.A.3.b).(3) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision. ^(Detail)

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. ^(Core)

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. ^(Detail)

V.B.3. This evaluation must include at least annual written confidential evaluations by the fellows. ^(Detail)

V.B.3.a) Fellows must have the opportunity to provide confidential written evaluations of each supervising faculty member at the end of each rotation. ^(Detail)

V.B.3.b) These evaluations must be reviewed with each faculty member annually. ^(Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). ^(Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one fellow; ^(Core)

V.C.1.a).(2) must have a written description of its responsibilities;

and, ^(Core)

V.C.1.a).(3)

should participate actively in:

V.C.1.a).(3).(a)

planning, developing, implementing, and evaluating educational activities of the program; ^(Detail)

V.C.1.a).(3).(b)

reviewing and making recommendations for revision of competency-based curriculum goals and objectives; ^(Detail)

V.C.1.a).(3).(c)

addressing areas of non-compliance with ACGME standards; and, ^(Detail)

V.C.1.a).(3).(d)

reviewing the program annually using evaluations of faculty, fellows, and others, as specified below. ^(Detail)

V.C.2.

The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. ^(Core)

The program must monitor and track each of the following areas:

V.C.2.a)

fellow performance; ^(Core)

V.C.2.b)

faculty development; ^(Core)

V.C.2.c)

graduate performance, including performance of program graduates on the certification examination; ^(Core)

V.C.2.c).(1)

At least 80% of the program's graduating fellows from the most recently defined five year period who are eligible should take the ABIM certifying examination. ^(Outcome)

V.C.2.c).(2)

At least 80% of a program's graduates taking the ABIM certifying examination for the first time during the most recently defined five year period should pass. ^(Outcome)

V.C.2.d)

program quality; and ^(Core)

V.C.2.d).(1)

Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and ^(Detail)

V.C.2.d).(2)

The program must use the results of fellows' and faculty members' assessments of the program together with other program evaluation results to

improve the program. ^(Detail)

V.C.2.d).(3)

At least 80% of the entering fellows should have completed the program when averaged over a five-year period. ^(Outcome)

V.C.2.e)

progress on the previous year's action plan(s). ^(Core)

V.C.3.

The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. ^(Core)

V.C.3.a)

The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. ^(Detail)

V.C.4.

Representative program personnel, at a minimum to include the program director, representative faculty, and one fellow, must review program goals and objectives, and the effectiveness with which they are achieved. ^(Detail)

VI. Fellow Duty Hours in the Learning and Working Environment

VI.A.

Professionalism, Personal Responsibility, and Patient Safety

VI.A.1.

Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. ^(Core)

VI.A.2.

The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment. ^(Core)

VI.A.3.

The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. ^(Core)

VI.A.4.

The learning objectives of the program must:

VI.A.4.a)

be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and, ^(Core)

VI.A.4.b)

not be compromised by excessive reliance on fellows to fulfill non-physician service obligations. ^(Core)

VI.A.5.

The program director and institution must ensure a culture of professionalism that supports patient safety and personal

responsibility. ^(Core)

VI.A.6. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.6.a) assurance of the safety and welfare of patients entrusted to their care; ^(Outcome)

VI.A.6.b) provision of patient- and family-centered care; ^(Outcome)

VI.A.6.c) assurance of their fitness for duty; ^(Outcome)

VI.A.6.d) management of their time before, during, and after clinical assignments; ^(Outcome)

VI.A.6.e) recognition of impairment, including illness and fatigue, in themselves and in their peers; ^(Outcome)

VI.A.6.f) attention to lifelong learning; ^(Outcome)

VI.A.6.g) the monitoring of their patient care performance improvement indicators; and, ^(Outcome)

VI.A.6.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data. ^(Outcome)

VI.A.7. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. ^(Outcome)

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care. ^(Core)

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. ^(Core)

VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process. ^(Outcome)

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care. ^(Detail)

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; ^(Core)

VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, ^(Core)

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules. ^(Detail)

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties. ^(Core)

VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home. ^(Core)

VI.D. Supervision of Fellows

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care. ^(Core)

VI.D.1.a) This information should be available to fellows, faculty members, and patients. ^(Detail)

VI.D.1.b) Fellows and faculty members should inform patients of their respective roles in each patient's care. ^(Detail)

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients. ^(Core)

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care

with feedback as to the appropriateness of that care. ^(Detail)

VI.D.3. Levels of Supervision

To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision: ^(Core)

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient. ^(Core)

VI.D.3.b) Indirect Supervision:

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

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

VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)

VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. ^(Core)

VI.D.4.a) The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria. ^(Core)

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows. ^(Detail)

VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. ^(Detail)

VI.D.5. Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising

faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions. ^(Core)

VI.D.5.a) Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. ^(Outcome)

VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. ^(Core)

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility. ^(Detail)

VI.E. Clinical Responsibilities

The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services. ^(Core)

VI.F. Teamwork

Fellows must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. ^(Core)

VI.G. Fellow Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. ^(Core)

VI.G.1.a) Duty Hour Exceptions

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. ^(Detail)

The Review Committee for Internal Medicine will not consider requests for exceptions to the 80-hour limit to the fellows' work week. ^(Detail)

VI.G.1.a).(1) 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.
(Detail)

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO. (Detail)

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program. (Core)

VI.G.2.b) Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit. (Core)

VI.G.2.c) PGY-1 residents are not permitted to moonlight. (Core)

VI.G.3. Mandatory Time Free of Duty

Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

VI.G.4. Maximum Duty Period Length

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration. (Core)

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. (Core)

VI.G.4.b).(1) Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. (Detail)

VI.G.4.b).(2) It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. (Core)

VI.G.4.b).(3) Fellows must not be assigned additional clinical

responsibilities after 24 hours of continuous in-house duty. ^(Core)

VI.G.4.b).(4)

In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. ^(Detail)

VI.G.4.b).(4).(a)

Under those circumstances, the fellow must:

VI.G.4.b).(4).(a).(i)

appropriately hand over the care of all other patients to the team responsible for their continuing care; and, ^(Detail)

VI.G.4.b).(4).(a).(ii)

document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. ^(Detail)

VI.G.4.b).(4).(b)

The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty. ^(Detail)

VI.G.5.

Minimum Time Off between Scheduled Duty Periods

VI.G.5.a)

PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. ^(Core)

VI.G.5.b)

Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. ^(Core)

Internal medicine subspecialty fellows are considered to be in the final years of education.

VI.G.5.c)

Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. ^(Outcome)

Internal medicine subspecialty fellows are considered to be in the final years of education.

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

VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. (Detail)

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

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

VI.G.5.c).(1).(d) The program director must review each submission of additional service and track both individual fellows' and program-wide episodes of additional duty. (Detail)

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

Fellows must not be scheduled for more than six consecutive nights of night float. (Core)

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). ^(Core)

VI.G.7.a) Internal Medicine fellowships must not average in-house call over a four-week period. ^(Core)

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. ^(Core)

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. ^(Core)

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”. ^(Detail)

***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf