

Program Requirements for Residency Education in Internal Medicine

[Common Program Requirements = Bold]

I. Introduction

A. Definition and Scope of Specialty

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.

B. Duration and Scope of Education

1. An accredited residency program in internal medicine must provide 36 months of supervised graduate education.
2. A minimum of 1/3 of the training time must be spent in ambulatory sites and a minimum of 1/3 of the time in inpatient sites.
3. Over the 36 months of training, at least 1/2 day each week must be spent in a continuity ambulatory experience (continuity clinic) managing a panel of general internal medicine patients.
4. 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 Residency Review Committee (RRC) evaluates the internal medicine components of the special educational tracks in the accreditation process.

C. Educational Standards

Residency training is primarily an educational experience. These program requirements define the minimum standards and outcomes for residency education in internal medicine. They balance didactic instruction and education through direct patient care.

II. 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 institutions.

The sponsoring institution must:

1. demonstrate a commitment to education and research sufficient to support the residency program;
2. 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;
3. provide resident compensation and benefits, faculty, facilities, and resources for education, clinical care, and research required for accreditation;
4. provide at least 50% salary support for the program director;
5. provide 20 hours per week salary support for each associate program director (APD) required to meet these Program Requirements;
6. notify the RRC within 60 days of:
 - a) a change in departmental leadership;
 - b) a change in the program director; the qualifications and the curriculum vitae of the new program director must be submitted to the RRC;
 - c) changes in institutional governance, affiliation, or resources that affect the educational program.

B. Participating Institutions

1. **Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.**

2. **Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement 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.**
3. Participation by any institution that provides 6 months or more of the training in the program must be approved by the RRC.
4. Assignments at participating institutions must be of sufficient length to ensure a quality educational experience, and should provide sufficient opportunity for continuity of care. Although the number of participating institutions may vary with the various specialties' needs, all participating institutions must demonstrate the ability to promote the program goals and educational and peer activities. Exceptions must be justified and prior-approved by the RRC.

III. Program Personnel and Resources

A. Program Director

1. **There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the RRC through the Web Accreditation Data System of the ACGME.**
2. **The program director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership.**

3. Qualifications of the program director are as follows:

- a) The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities, including**
 - (1) at least 5 years of participation as an active faculty member in an ACGME-accredited internal medicine residency program; and
 - (2) at least 3 years of graduate medical education administrative experience prior to appointment.
- b) The program director must be certified in General Internal Medicine by the American Board of Internal Medicine, or possess qualifications judged to be acceptable by the RRC.**
- c) The program director must be appointed in good standing and based at the primary teaching site; i.e., his or her home office must be at the principal clinical training institution. The program director must be responsible to the sponsoring organization.**

4. Responsibilities of the program director are as follows:

- a) The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.**
- b) The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.**
- c) The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**
- d) The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such**

changes, for example, include:

- (1) the addition or deletion of a participating institution;**
- (2) a change in the format of the educational program;**
- (3) a change in the approved resident complement.**

On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.

- e) The program director is responsible for monitoring 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.
- f) The program director must 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.
- g) The program director must 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.
- h) The program director must have the authority to ensure effective teaching, and obtain teaching commitments from other departments involved in the education of internal medicine residents.
- i) The program director must select residents for appointment to the program in accordance with institutional and departmental policies and procedures, and evaluate the quality of care rendered by the residents.
- j) The program director must prepare written educational goals and objectives of the program with respect to the Competencies of residents at each level of training (as outlined in Section V D of this document) and for each major rotation or other program

assignment.

- k) The program director must ensure that the written educational goals and objectives are readily available for review and are distributed to residents and faculty members.
- l) The program director must ensure that the residency does not place excessive reliance on residents for service as opposed to education.
- m) The program director must have responsibility for and appropriate authority to accomplish the general administration of the program and the maintenance of records related to program accreditation.
- n) The program director must establish a process to teach and document the residents' achievement of milestones in the Competencies.
- o) The program director must monitor any internal medicine subspecialty training programs sponsored by the institution to ensure compliance with the ACGME accreditation standards.
- p) The program director must have supervisory authority over all educational tracks in the internal medicine residency program.
- q) The program director must outline in writing the lines of responsibility for and supervision of patient care on all inpatient and ambulatory settings for all members of the teaching teams.
- r) The program director must participate in academic societies and in educational programs designed to enhance his or her educational and administrative skills.
- s) The program director must 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.

B. Faculty

- 1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program.**
- 2. The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the**

education of residents, and must support the goals and objectives of the educational program of which they are a member.

3. Qualifications of the physician faculty are as follows:

- a) The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.**
- b) The physician faculty must be certified in the specialty by the American Board of Internal Medicine, or possess qualifications judged to be acceptable by the RRC.**
- c) The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**
- d) The physician faculty must be licensed to practice medicine in the state where the sponsoring institution is located or the major teaching activity occurs. (Certain federal programs are exempted.)**
- e) The physician faculty must meet professional standards of ethical behavior.**

4. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. Scholarship is defined as the following:

- a) the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;**
- b) the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;**
- c) the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.**

Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research such as research design and

statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities. Although not all faculty members must be investigators, collectively their activity must include all of the elements outlined above.

5. Qualifications of the nonphysician faculty are as follows:

- a) **Nonphysician faculty must be appropriately qualified in their field.**
- b) **Nonphysician faculty must possess appropriate institutional appointments.**

6. Qualifications of all clinical faculty members are as follows:

- a) All clinical faculty members must have a commitment to the goals and objectives of the teaching program, including mastery of the Competencies and clinical judgment.
- b) All clinical faculty members should nurture in residents the attributes of the scholar, scientist, teacher, and humanist.
- c) All clinical faculty members should be available to residents for advice and counseling.
- d) All clinical faculty members must implement the written curriculum that describes both patient-based and educational elements of the residency.
- e) All clinical faculty members should participate in prescribed faculty development programs designed to enhance the effectiveness of their teaching.
- f) 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

Additional professional, technical, and clerical personnel must be provided to support the program.

1. Associate Program Directors

Associate Program Directors (APDs) 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, 1 APD; 41 to 79, 2 APDs; 80 to 119, 3 APDs; 120 to 159, 4 APDs; more than 159, 5 APDs.

- 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 *be certified in the specialty by the American Board of Internal Medicine or possess qualifications judged by the RRC to be acceptable*;
 - (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, 6 KCF; 120 to 159, 8 KCF; more than 159, 10 KCF.

- a) Qualifications of the Key Clinical Faculty are as follows:
- (1) Key Clinical Faculty must 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) Key Clinical Faculty must ***be certified in the specialty by the American Board of Internal Medicine or possess qualifications judged by the RRC to be acceptable.***
- b) Responsibilities for the Key Clinical Faculty are as follows:
- (1) Key Clinical Faculty must dedicate an average of at least 15 hours per week throughout the year to the internal medicine residency program;
 - (2) Key Clinical Faculty must provide teaching and supervision of residents in the clinical setting;
 - (3) Key Clinical Faculty must assist in the preparation of the written curriculum;
 - (4) Key Clinical Faculty must assist in the development and evaluation of the Competencies in the residents; and
 - (5) Key Clinical Faculty must 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 qualified individual (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 of the Subspecialty Education Coordinators are as follows:

- (1) The Subspecialty Education Coordinator ***must be certified in the specialty by the American Board of Internal Medicine or possess qualifications judged by the RRC to be acceptable;*** and
- (2) Each Subspecialty Education Coordinator should have a sufficient term of office to achieve the educational goals and objectives of the residency.

b) Responsibilities for the Subspecialty Education Coordinators are as follows:

- (1) The Subspecialty Education Coordinator must 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) The Subspecialty Education Coordinator must 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 6 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 program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.**
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. Medical Reference Material
 - a) There must be a means of access to an on-site library or to

reference material (print or electronic) in each participating institution at all times.

- b) Residents must have ready access to a computerized literature search system and electronic medical databases at all times.

5. 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.)

6. Pathology Material

- 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.

7. 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.

IV. Resident Appointment

A. Eligibility Criteria

1. **The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.**
2. 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 RRC will approve the number of residents based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching.

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 RRC 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. **To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.**
2. Residents must not be accepted for advanced standing from programs not accredited by the ACGME. Exceptions will be permitted for physicians with at least 3 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 appointment of fellows, other specialty residents, or students must not dilute or detract from the educational opportunities of internal medicine residents.

V. Program Curriculum

A. Program Design

1. Format

The program design and sequencing of educational experiences will be approved by the RRC as part of the accreditation process.

2. Goals and Objectives

The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments. 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.

B. Specialty Curriculum

The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.

C. Residents Scholarly Activities

Each program must provide an opportunity for residents to participate in

research or other scholarly activities, and residents must participate actively in such scholarly activities.

D. ACGME Competencies

The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:

1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health;
2. *Medical knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;
3. *Practice-based learning and improvement* that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;
4. *Interpersonal and communication skills* that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;
5. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
6. *Systems-based practice*, as manifested by actions that 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.

E. 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 3 days of the week for a minimum total of 4.5 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, and
- (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 4 1/2 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 1/2-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 institutions.
- 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
 - (2) 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
 - (3) 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 desirable that each resident attends at least 60% of these conferences.

F. Clinical

1. Ambulatory Medicine

- a) At least 1/3 of the residency training must be in the ambulatory care setting. (N.B.: In assessing the contribution of various clinical experiences with ambulatory patients to the 33% minimum, the following guidelines may be used: ½ day per week assigned to an ambulatory setting throughout all 3 years of training is equivalent to 10%; a 1-month block rotation is equivalent to 3%; 1 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, 1 faculty member must be responsible for no more than 5 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 1 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 3 or greater than 5 per scheduled 1/2-day session.
- (5) The number of patients seen by a second-year resident, when averaged over the year, must not be fewer than 4 or greater than 6 per scheduled 1/2-day session.
- (6) The number of patients seen by a third-year resident, when averaged over the year, must not be fewer than 4 per

scheduled 1/2-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) It is desirable that residents 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 4 weeks of direct experience in blocks of not less than 2 weeks.
- (3) Total required emergency medicine experience must not exceed 3 months in 3 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 2 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 8 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 4 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 1 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) There must be a minimum of 6 months of inpatient internal medicine teaching service assignments in the first year,
- (16) There must be a minimum of 6 months of inpatient internal medicine teaching service assignments over the second and third years of training combined.
- (17) The required 12 months of inpatient internal medicine must include a minimum of 3 months of inpatient general internal medicine teaching service assignments over the 3 years of training.
- (18) 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 3 months in 3 years of training.
- (2) Total required critical care experience must not exceed 6 months in 3 years of training. (N.B.: When elective experience occurs in the critical care unit, it must not result

in more than a total of 8 months of critical care in 3 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 1 month in 3 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.

VI. Resident Duty Hours and the Work Environment

Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

A. Supervision of Residents

- 1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.**
- 2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.**

3. **Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.**

B. Duty Hours

1. **Duty hours are defined as all clinical and academic activities related to the residency 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.**
2. **Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
3. **Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.**
4. **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.**

C. On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

1. **In-house call must occur no more frequently than every third night.**
2. **Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 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 new patient is defined as any patient to whom the resident has not previously provided care.**

4. ***At-home call (or pager call)*** is defined as a call taken from outside the assigned institution.
 - a) The frequency of at-home call is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
 - b) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
 - c) The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

D. Moonlighting

1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.
3. Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.

E. Oversight

1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.

2. **Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.**

F. Duty Hour Exception

The RRC for Internal Medicine will not consider requests for exceptions to the limit to 80 hours per week, averaged monthly.

G. 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 and participating institutions 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 1.5 months of night float during any year of training, or more than 4 months of night float over the 3 years of residency training. Residents must not be assigned to more than 1 month of consecutive night float rotation.
 - e) For each rotation or major clinical assignment, the teaching ratio must not exceed a total of 8 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.

H. 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.
- I. 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. Evaluation

A. Resident

1. Formative Evaluation

The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.

- a) **Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.**

- b) **Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations**, that includes formal evaluations of knowledge, skills, and professional growth of residents and required counseling by the program director or designee. **Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.**
- c) Permanent records of both of the evaluation and counseling sessions (and any others that occur) for each resident must be maintained in the resident's file and must be accessible to the resident and other authorized personnel.
- (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;
 - (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.

d) Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, including nurses, to achieve progressive improvements in residents' competence and performance.

2. Final (Summative) Evaluation

The program director must provide a final evaluation for each resident who completes the program. The evaluation must include a review of the resident's performance during the final period of education and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.

- a) The program director must also prepare annually a written summative evaluation of the clinical competence of each resident. (N.B.: This summative evaluation is in addition to the completion of the ABIM tracking form.)
- b) The summative 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

1. **The performance of the faculty must be evaluated by the program annually. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include 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.
2. The results of the evaluations must be used for faculty-member counseling and for selecting faculty members for specific teaching assignments.

C. Program

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

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. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMCC of the sponsoring institution, and the residents' annual confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.**
 - a) The evaluation should include the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative

support of the program, the volume and variety of patients available to the program for educational purposes, the effectiveness of inpatient and ambulatory teaching, the performance of faculty members, and the quality of supervision of residents.

- b) The residents must have the opportunity to assess formally the effectiveness of ambulatory teaching on an ongoing basis.

2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.

- a) The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of inpatient and ambulatory teaching
- b) 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.
- c) 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.

VIII. Experimentation and Innovation

A. Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

B. Performance Improvement Process

- 1. The program should identify and participate in at least 2 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.

IX. Certification

Residents who plan to seek certification by the American Board of Internal Medicine should communicate with the registration section of the board regarding fulfillment of requirements for certification. Residents must be certified in internal medicine prior to seeking certification in a subspecialty.

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