# Proposed ACGME Program Requirements for Graduate Medical Education in Combined Internal Medicine-Pediatrics

**Revision Information**
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Updated to include revised Common Program Requirements, effective July 1, 2023

**Definitions**
For more information, see the ACGME Glossary of Terms.

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 with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).

## Contents

**ACGME Program Requirements for Graduate Medical Education in Internal Medicine-Pediatrics**

**Common Program Requirements (Residency) are in BOLD**

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

## Introduction

### Int.A. Definition of Graduate Medical Education

***Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship.***

***Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.***

***Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.***

***Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.***

### Int.B. Definition of Specialty


 

Residency education in internal medicine-pediatrics encompasses integrative education and training in both internal medicine and pediatrics. The combined ~~training~~ program allows for the development of a physician knowledgeable in the full spectrum of human development, from newborns to the aged. It includes the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of infants, children, adolescents of all genders~~, men, and women~~. The scientific model of problem solving and evidence-based decision-making with a commitment to lifelong learning and an attitude of caring derived from humanistic and professional values is ~~are~~ integral to the specialty. ~~The~~A combined internal medicine-pediatrics program prepares graduates to provide health care in a broad spectrum of practice that includes primary and subspecialty care ~~and~~, as well as ambulatory and hospital-based care, with additional subspecialty education and training in urban, rural, and global settings.

**Int.C. Length of Educational Program**

The educational program in internal medicine-pediatrics must be 48 months in length. (Core)

## I. Oversight

**I.A. Sponsoring Institution**

***The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.***

***When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.***

**Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the residents. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.**

**I.A.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)**

**I.B. Participating Sites**

***A participating site is an organization providing educational experiences or educational assignments/rotations for residents.***

**I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)**


 

I.B.1.a) Relation to ~~Categorical~~Internal Medicine and Pediatrics Programs ~~Residencies~~

I.B.1.a).(1) The four-year combined ~~training~~ educational program in internal medicine and pediatrics must be provided by ACGME-accredited ~~categorical~~ programs in these specialties that are sponsored by the same ACGME-accredited Sponsoring Institution, except when the pediatrics program is sponsored by a children's hospital, and that are in close geographic proximity. (Core)

Specialty-Specific Background and Intent: If the pediatrics program is sponsored by a children's hospital, either the designated institutional official (DIO) of the institution that sponsors the internal medicine program or the DIO of the institution that sponsors the pediatrics program may have responsibility for oversight of the combined program.

~~I.B.1.a).(1).(a) The one exception is when the pediatrics program is sponsored by a children's hospital, in which case either the designated institutional official (DIO) of the institution that sponsors the internal medicine residency program or the DIO of the institution that sponsors the pediatric residency program may have responsibility for oversight of the combined program. (Core)~~

I.B.1.a).(2) The internal medicine and pediatrics ~~categorical~~ programs must each only participate in ~~only~~ one internal medicine-pediatrics program. (Core)

I.B.1.a).(3) The residents in the internal medicine program, the pediatrics program, ~~categorical~~ and the combined program must interact at all levels of ~~training~~ education. (Core)

I.B.1.a).(4) The program directors of the internal medicine and pediatrics ~~categorical~~ programs and the program director~~(s)~~ of the combined program must demonstrate collaboration and coordination of curriculum and rotations. (Core)

Specialty-Specific Background and Intent: To achieve appropriate coordination of the combined program and shared accountability, including integration of education and training and supervision in each discipline, the program directors of the internal medicine and pediatrics programs and the program director of the combined program can hold regular meetings that involve consultation with faculty members from both departments, as well as internal medicine-pediatrics residents and/or residents from both departments.

~~I.B.1.a).(4).(a) To achieve appropriate coordination of the combined program and shared accountability, including integration of training and supervision in~~


 

~~each discipline, the program directors of the categorical programs and the program director(s) of the combined program should hold at least quarterly meetings that involve consultation with faculty from both departments, as well as internal medicine-pediatrics residents and/or residents from both departments.~~ ~~(Detail)~~

**I.B.2.** **There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment.** **(Core)**

**I.B.2.a)** **The PLA must:**

**I.B.2.a).(1)** **be renewed at least every 10 years; and,** **(Core)**

**I.B.2.a).(2)** **be approved by the designated institutional official (DIO).** **(Core)**

**I.B.3.** **The program must monitor the clinical learning and working environment at all participating sites.** **(Core)**

**I.B.3.a)** **At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director.** **(Core)**

**Background and Intent: While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must ensure the quality of the educational experience.**

**Suggested elements to be considered in PLAs will be found in the Guide to the Common Program Requirements. These include:**

- **Identifying the faculty members who will assume educational and supervisory responsibility for residents**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of residents**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern resident education during the assignment**

Specialty-Specific Background and Intent: If ~~an internal medicine-pediatrics~~ the combined program uses a site that has been approved for use by ~~one of its sponsoring core~~ the internal medicine or pediatrics programs, the ~~internal medicine-pediatrics~~ combined program does not

need a separate PLA for that site. Separate PLAs are only needed for sites that are unique to the ~~internal medicine-pediatrics~~ combined program.

**I.B.4.** **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS).** (Core)

**I.C. Workforce Recruitment and Retention**

**The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative graduate medical education staff members, and other relevant members of its academic community.** (Core)

**Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of individuals underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims.**

**I.D. Resources**

**I.D.1.** **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education.** (Core)

I.D.1.a) The Sponsoring Institution must provide the broad range of facilities and clinical support services required to provide comprehensive care of the full spectrum of adult and pediatric patients. (Core)

I.D.1.b) ~~Additional services should include those for cardiac catheterization, bronchoscopy, gastrointestinal endoscopy, non-invasive cardiology studies, pulmonary function studies, hemodialysis, and imaging studies, including radionuclide, ultrasound, fluoroscopy, angiography, computerized tomography, and magnetic resonance imaging.~~ (Detail)

I.D.1.c) Adequate clinical and teaching space must be available, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids, medical and electronic resources to achieve all the required educational outcomes, and office space.~~for teaching staff.~~ (Core)

I.D.1.d) In addition to an emergency facility providing care for adults, there must be an emergency facility that specializes in the care of pediatric patients and that receives pediatric patients who have


 

been transported via the Emergency Medical Services system. (Core)

I.D.1.e) ~~There should be services available from other health care professionals such as nurses, social workers, case managers, language interpreters, and dieticians.~~ (Detail)

I.D.1.f) ~~Consultations from other clinical services should be available in a timely manner in all care settings where the residents work. All consultations should be performed by or under the supervision of a qualified specialist.~~ (Detail)

I.D.1.g) Appropriate in-person or virtual consultations, including those done using telecommunication technology, must be available in settings in which residents work. (Core)

I.D.1.h) The program must~~should~~ provide residents with ~~access to~~ training using simulation to support resident education and patient safety. (Core~~Detail~~)

Specialty-Specific Background and Intent: The Review Committees do not expect each program to own a simulator or to have a simulation center. “Simulation” is used broadly to mean learning about patient care in settings that do not include actual patients. This could include objective structured clinical examinations (OSCEs), standardized patients, patient simulators, or electronic simulation of resuscitation, procedures, and other clinical scenarios.

I.D.1.i) The program must provide access to an electronic health record (EHR). ~~In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation.~~(Core)

Specialty-Specific Background and Intent: An EHR can include electronic notes, orders, and lab reporting. Such a system also facilitates data reporting regarding the care provided to a patient or a panel of patients. It may also include systems for enhancing the quality and safety of patient care. An EHR does not have to be present at all participating sites and does not have to include every element of patient care information. However, a system that simply reports laboratory or imaging results does not meet the Review Committee’s expectations for an EHR.

I.D.1.j) ~~The program must provide a volume, variety, and complexity in diagnoses and age, from infants to geriatric patients, sufficient for residents to achieve all of the required educational outcomes.~~ (Core)

I.D.1.k) The program must provide residents with an adequate patient population representative of both the broad spectrum of clinical disorders and medical conditions managed by internists and pediatricians, and of the community being served. (Core)

**I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:**


 

**I.D.2.a)** **access to food while on duty; (Core)**

**I.D.2.b)** **safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)**

**Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may be stored. Food should be available when residents are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued resident.**

**I.D.2.c)** **clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)**

**Background and Intent: Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the resident with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the resident and the resident's family, as outlined in VI.C.1.c).(1).**

**I.D.2.d)** **security and safety measures appropriate to the participating site; and, (Core)**

**I.D.2.e)** **accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)**

**I.D.3.** **Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)**

**I.E.** **Other Learners and Health Care Personnel**

**The presence of other learners and other health care personnel, including but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core)**

**Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their**

**learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that residents' education is not compromised by the presence of other providers and learners.**

## II. Personnel

### II.A. Program Director

**II.A.1. There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements.** (Core)

**II.A.1.a) The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment.** (Core)

**Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and have overall responsibility for the program. The program director's nomination is reviewed and approved by the GMEC.**

**II.A.1.b) The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability.** (Core)

**Background and Intent: The success of residency programs is generally enhanced by continuity in the program director position. The professional activities required of a program director are unique and complex and take time to master. All programs are encouraged to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.**

**II.A.2. The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration.** (Core)

II.A.2.a) At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program: (Core)

| Number of Approved Resident Positions | Minimum Support Required (FTE) |
|---|---|
| <7 | 0.2 |
| 7-10 | 0.4 |
| >10 | 0.5 |

II.A.2.b) Programs with more than 15 residents must appoint an associate program director(s). The associate program director(s) must be provided with support equal to a dedicated minimum time for administration of the program as follows: (Core)


 

| Number of Approved Resident Positions | Minimum Aggregate APD Support Required (FTE) |
|---|---|
| <15 | n/a |
| 16-20 | 0.1 |
| 21-25 | 0.2 |
| 26-30 | 0.3 |
| 31-35 | 0.4 |
| 36-40 | 0.5 |
| 41-45 | 0.6 |
| 46-50 | 0.7 |
| 51-55 | 0.8 |
| 56-60 | 0.9 |
| 61-65 | 1.0 |
| > 65 | 1.1 |

**Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of residency programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of residents, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.**

**The ultimate outcome of graduate medical education is excellence in resident education and patient care.**

**The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the residency program, as defined in II.A.4.-II.A.4.a).(12). Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.**

**Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.**

**In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a *minimum*, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirement II.B.1. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the**


 

**Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors to fulfill their program responsibilities effectively.**

Specialty-Specific Background and Intent: For instance, a program with an approved complement of 24 residents is required to have 50 percent FTE support for the program director and 20 percent FTE support for the associate program director(s). The Review Committees decided not to specify how the support should be distributed among associate program director(s) to allow programs, in partnership with their Sponsoring Institution, to allocate the support as they see fit.

**II.A.3. Qualifications of the program director:**

**II.A.3.a) must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; (Core)**

**Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.**

**The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.**

**In certain circumstances, the program and Sponsoring Institution may propose and the Review Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.**

**II.A.3.b) must include current certification in the specialty for which they are the program director by the American Board of** Internal Medicine (ABIM) **or the American Osteopathic Board of** Internal Medicine (AOBIM), and the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP)**, or specialty qualifications that are acceptable to the Review Committee; (Core)**

**II.A.3.c) must include ongoing clinical activity; and, (Core)**

**Background and Intent: A program director is a role model for faculty members and residents. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the Core Competencies for the faculty members and residents.**

II.A.3.d) must include experience working as part of an interdisciplinary, interprofessional team to create an educational environment that promotes high-quality care, patient safety, and resident well-being. (Core)


 

**II.A.4.** **Program Director Responsibilities**

**The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care.** (Core)

**II.A.4.a)** **The program director must:**

**II.A.4.a).(1)** **be a role model of professionalism;** (Core)

**Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.**

**II.A.4.a).(2)** **design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program;** (Core)

**Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the structural and social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and eliminating health disparities.**

**II.A.4.a).(3)** **administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains;** (Core)

**Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.**

**II.A.4.a).(4)** **have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval;** (Core)


 

**Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators may enable the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of residents in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.**

**II.A.4.a).(5)** **have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)**

**Background and Intent: The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.**

**There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.**

**II.A.4.a).(6)** **submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)**

**Background and Intent: This includes providing information in the form and format requested by the ACGME and obtaining requisite sign-off by the DIO.**

**II.A.4.a).(7)** **provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)**

**II.A.4.a).(8)** **ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident; (Core)**

**Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and residents.**

**II.A.4.a).(9)** **ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)**


 

**II.A.4.a).(9).(a)** **Residents must not be required to sign a non-competition guarantee or restrictive covenant.** **(Core)**

**II.A.4.a).(10)** **document verification of education for all residents within 30 days of completion of or departure from the program;** **(Core)**

**II.A.4.a).(11)** **provide verification of an individual resident's education upon the resident's request, within 30 days; and,** **(Core)**

**Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.**

**II.A.4.a).(12)** **provide applicants who are offered an interview with information related to their eligibility for the relevant specialty board examination(s).** **(Core)**

**II.B.** **Faculty**

***Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.***

***Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.***

**Background and Intent: "Faculty" refers to the entire teaching force responsible for educating residents. The term "faculty," including "core faculty," does not imply or require an academic appointment.**

**II.B.1.** **There must be a sufficient number of faculty members with competence to instruct and supervise all residents.** (Core)

II.B.1.a) ~~Pediatric Subspecialty Faculty~~

~~There must be faculty members with pediatric subspecialty board certification who function on an ongoing basis as integral parts of the clinical and instructional components of the program in both inpatient and outpatient settings.~~ (Core)

**II.B.2.** **Faculty members must:**

**II.B.2.a)** **be role models of professionalism;** (Core)

**II.B.2.b)** **demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care;** (Core)

**Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.**

**II.B.2.c)** **demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities;** (Core)

**II.B.2.d)** **administer and maintain an educational environment conducive to educating residents;** (Core)

Specialty-Specific Background and Intent: An educational environment is one in which faculty members model and elicit critical thinking processes with residents as they care for patients and embed discussions about stressors of patients and patients' families in patient care.

**II.B.2.e)** **regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and,** (Core)

**II.B.2.f)** **pursue faculty development designed to enhance their skills at least annually:** (Core)

**Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the residency program faculty in the aggregate.**

**II.B.2.f).(1)** **as educators and evaluators;** (Detail)


 

**II.B.2.f).(2)** **in quality improvement, eliminating health inequities, and patient safety; (Detail)**

**II.B.2.f).(3)** **in fostering their own and their residents' well-being; and, (Detail)**

**II.B.2.f).(4)** **in patient care based on their practice-based learning and improvement efforts. (Detail)**

**Background and Intent: Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's practice and review of the literature, one is able to make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for residents in practice-based learning.**

**II.B.3. Faculty Qualifications**

**II.B.3.a)** **Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)**

**II.B.3.b)** **Physician faculty members must:**

**II.B.3.b).(1)** **have current certification in the specialty by the American Board of** Internal Medicine (ABIM), the American Board of Pediatrics (ABP), **or the American Osteopathic Board of** Internal Medicine (AOBIM), or the American Osteopathic Board of Pediatrics (AOBP)**, or possess qualifications judged acceptable to the Review Committee. (Core)**

II.B.3.c) There must be physicians with certification in internal medicine by the ABIM or AOBIM to teach and supervise internal medicine residents while they are on internal medicine inpatient and outpatient rotations. (Core)

Specialty-Specific Background and Intent: The Review Committee for Internal Medicine believes the best role models for internal medicine residents are internal medicine physicians with certification in internal medicine from the ABIM or AOBIM. Providing such faculty members ensures specialty-specific educators with significant experience managing and providing comprehensive patient care to complex patients. However, the Review Committee recognizes there are circumstances and clinical settings in which a non-internist who has been approved by the program director would be an appropriate supervisor. Examples include:

- On inpatient medicine ward rotations, it is appropriate for an American Board of Family Medicine (ABFM)- or American Osteopathic Board of Family Physicians (AOBFP)-certified physician with extensive experience in caring for inpatient adults to teach and supervise internal medicine residents, provided such an individual is approved by the site director and the program director. Working as an adult hospitalist for at least three years would be one way to demonstrate such extensive experience.


 

- On inpatient medicine rotations in the critical care setting, it would be appropriate for a non-internist who has been approved by the program director and the medical intensive care unit director to teach and supervise internal medicine residents. For example, it would be appropriate for emergency medicine physician with certification in internal medicine-critical care medicine supervising internal medicine residents on critical care medicine rotations, or physicians with certification in critical care from other disciplines teaching and supervising residents in limited circumstances like evening or weekend cross-coverage.
- On outpatient medicine rotations/experiences, it is appropriate for a non-internist with documented expertise, such as a family medicine physician with extensive outpatient/ambulatory experience or procedural proficiency, to teach and supervise internal medicine residents, provided the non-internist is approved by the site director and the program director.

II.B.3.d) Physicians certified by the ABIM or the AOBIM in the relevant subspecialty must be available to teach and supervise internal medicine residents when they are on internal medicine subspecialty rotations. (Core)

II.B.3.e) Physicians certified by an ABMS member board or AOA certifying board in the relevant subspecialty should be available to teach and supervise internal medicine residents when they are on multidisciplinary subspecialty rotations. (Core)

Specialty-Specific Background and Intent: For example, it would be appropriate for a faculty member certified in geriatric medicine by the ABIM, AOBIM, ABFM, or AOBFP to teach and supervise internal medicine residents on geriatric medicine rotations.

II.B.3.f) Physicians certified by an ABMS member board or AOA certifying board in the relevant specialty should be available to teach and supervise internal medicine residents while they are having non-internal medicine experiences. (Core)

Specialty-Specific Background and Intent: For example, it would be appropriate for a faculty member certified in neurology by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry to teach and supervise internal medicine residents on neurology rotations.

II.B.3.g) There must be faculty members with expertise in the analysis and interpretation of practice data, data management science and clinical decision support systems, and management of emerging health issues. (Core)

Specialty-Specific Background and Intent: Advances in technology are likely to significantly impact and redefine patient care, and this requirement is intended to ensure that residents are provided with access to faculty members with knowledge, skills, or experience in the analysis and interpretation of practice data, and who are able to analyze and evaluate the validity of decisions from advanced data management and clinical decision support systems. Faculty members with expertise in this area can be physicians or non-physicians, and can be core or non-core faculty members. Institutions may already have such experts assisting


 

programs in meeting the Common Program Requirement to systematically analyze practice data to improve patient care [IV.B.1.d).(1).(d)]. The Review Committees encourage programs that cannot identify an existing internal candidate with expertise in this area to consider this option.

II.B.3.h) For all pediatric subspecialty rotations there must be pediatric subspecialty physician faculty members who have current certification in their subspecialty by the ABP or the AOBP, or who possess qualifications judged acceptable by the Review Committee. (Core)

Specialty-Specific Background and Intent: The Review Committee for Pediatrics maintains that ABP and AOBP specialty/subspecialty board certification is the standard for expertise.

The onus of documenting alternate qualifications is the responsibility of the program director. For a faculty member without certification from the ABP or AOBP, the Review Committee will consider the following criteria in determining whether alternate qualifications are acceptable:

- completion of a pediatrics residency program
- completion of a pediatric subspecialty fellowship program
- demonstrated ability in teaching
- leadership and/or participation on committees in national pediatric organizations
- scholarship within the field of pediatrics, specifically, evidence of ongoing scholarship documented by contributions to the peer-reviewed literature in pediatrics and pediatrics presentations at national meetings
- experience in providing clinical care in pediatrics

The Review Committee expects faculty members who recently graduated from an ACGME-accredited or AOA-approved pediatrics program to take and pass the next available ABP or AOBP pediatrics certifying examination. An explanation is to be provided for any faculty member unable to take the next administration of the certifying examination.

Years of practice are not equivalent to specialty board certification.

II.B.3.i) Other physician faculty members must have current certification in their specialty by the appropriate American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board, or possess other qualifications judged to be acceptable by the Review Committee. (Core)

**II.B.4. Core Faculty**

**Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)**

**Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and**

**assessing curriculum, mentoring residents, and assessing residents' progress toward achievement of competence in and the autonomous practice of the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of residents, and also participate in non-clinical activities related to resident education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting resident applicants, providing didactic instruction, mentoring residents, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.**

**II.B.4.a)** **Core faculty members must complete the annual ACGME Faculty Survey.** **(Core)**

II.B.4.b) In addition to the program director, there must be at least one core faculty member certified in internal medicine by the ABIM or AOBIM and/or certified in pediatrics by the ABP or AOBP for every eight residents in the program. (Core)

II.B.4.c) Among the program director and the required number of internal medicine-pediatrics core faculty members, at least 50 percent of the individuals must be currently certified in internal medicine by the ABIM or AOBIM and at least 50 percent of the individuals must be currently certified in pediatrics by the ABP or AOBP. (Core)

II.B.4.d) At a minimum, the required core faculty members, in aggregate and excluding program leadership, must be provided with support equal to an average dedicated minimum of .1 FTE for educational and administrative responsibilities that do not involve direct patient care. (Core)

Specialty-Specific Background and Intent: The Review Committees specified the minimum required number of ABIM- or AOBIM-certified and ABP- or AOBP-certified core faculty members but did not specify how the aggregate FTE support should be distributed to allow programs, in partnership with their Sponsoring Institution, to allocate the support as they see fit. For instance, a program with an approved complement of 32 residents is required to have a minimum of four core faculty members, two ABIM- or AOBIM-certified and two ABP- or AOBP-certified core faculty members, and a minimum aggregate FTE of 40 percent. The program could choose to operationalize this as two ABIM- or AOBIM-certified and two ABP- or AOBP-certified faculty members each with 10 percent FTE support, but it could also have four ABIM- or AOBIM-certified and four ABP- or AOBP-certified faculty eight members each with five percent FTE support.

## II.C. Program Coordinator

**II.C.1.** **There must be a program coordinator.** **(Core)**


 

**II.C.2.** **The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration.** (Core)

II.C.2.a) At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. Additional administrative support must be provided based on the program size as follows: (Core)

| Number of Approved Resident Positions | Minimum FTE Required for Coordinator Support | Additional Aggregate FTE Required for Administration of the Program |
|---|---|---|
| <7 | 0.5 | n/a |
| 7-10 | 0.5 | 0.2 |
| 11-15 | 0.5 | 0.3 |
| 16-20 | 0.5 | 0.4 |
| 21-25 | 0.5 | 0.5 |
| 26-30 | 0.5 | 0.6 |
| 31-35 | 0.5 | 0.7 |
| 36-40 | 0.5 | 0.8 |
| 41-45 | 0.5 | 0.9 |
| 46-50 | 0.5 | 1.0 |
| 51-55 | 0.5 | 1.1 |
| 56-60 | 0.5 | 1.2 |
| 61-65 | 0.5 | 1.3 |
| > 65 | 0.5 | 1.4 |

**Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.**

**Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as otherwise titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison and facilitator between the learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.**

**The program coordinator is a key member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management appropriate to the complexity of the program. Program coordinators are expected to develop in-depth knowledge of the ACGME and Program Requirements, including policies and procedures. Program coordinators assist the program director in meeting accreditation requirements, educational programming, and support of residents.**

**Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer**

**residents may not require a full-time coordinator; one coordinator may support more than one program.**

**The minimum required dedicated time and support specified in II.C.2.a) is inclusive of activities directly related to administration of the accredited program. It is understood that coordinators often have additional responsibilities, beyond those directly related to program administration, including, but not limited to, departmental administrative responsibilities, medical school clerkships, planning lectures that are not solely intended for the accredited program, and mandatory reporting for entities other than the ACGME. Assignment of these other responsibilities will necessitate consideration of allocation of additional support so as not to preclude the coordinator from devoting the time specified above solely to administrative activities that support the accredited program.**

**In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program coordinator, is also addressed in Institutional Requirement II.B.4. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program coordinators to fulfill their program responsibilities effectively.**

Specialty-Specific Background and Intent: For instance, a program with an approved complement of 24 residents is required to have 100 percent FTE for coordinator support. The Review Committee decided not to specify how the support should be distributed to allow programs, in partnership with their Sponsoring Institution, to allocate the support as they see fit.

### II.D. Other Program Personnel

**The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program.** **(Core)**

II.D.1. ~~The program must provide support for other support personnel required for operation of the program.~~ ~~(Core)~~

**Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.**

## III. Resident Appointments

### III.A. Eligibility Requirements


 

**III.A.1.** **An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program:** (Core)

**III.A.1.a)** **graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or,** (Core)

**III.A.1.b)** **graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications:** (Core)

**III.A.1.b).(1)** **holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or,** (Core)

**III.A.1.b).(2)** **holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located.** (Core)

**III.A.2.** **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, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation.** (Core)

**III.A.2.a)** **Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation.** (Core)

**Background and Intent: Programs with ACGME-I Foundational Accreditation or from institutions with ACGME-I accreditation do not qualify unless the program has also achieved ACGME-I Advanced Specialty Accreditation. To ensure entrants into ACGME-accredited programs from ACGME-I programs have attained the prerequisite milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.**

**III.B.** **Resident Complement**

**The program director must not appoint more residents than approved by the Review Committee.** (Core)

**Background and Intent: Programs are required to request approval of all complement changes, whether temporary or permanent, by the Review Committee through ADS. Permanent increases require prior approval from the Review Committee and temporary**


 

**increases may also require approval. Specialty-specific instructions for requesting a complement increase are found in the "Documents and Resources" page of the applicable specialty section of the ACGME website.**

**III.C. Resident Transfers**

**The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation.** (Core)

III.C.1. Residents must not enter the combined ~~residency~~ program beyond the beginning of the PGY-2 level. (Core)

**IV. Educational Program**

***The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.***

***The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.***

***It is recognized that programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.***

**IV.A. Educational Components**

**The curriculum must contain the following educational components:**

**IV.A.1. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members;** (Core)

**IV.A.2. competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members;** (Core)

**Background and Intent: The trajectory to autonomous practice is documented by Milestones evaluations. Milestones are considered formative and should be used to identify learning needs. Milestones data may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.**


 

**IV.A.3.** **delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)**

**Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.**

**IV.A.4.** **a broad range of structured didactic activities; and, (Core)**

**IV.A.4.a)** **Residents must be provided with protected time to participate in core didactic activities. (Core)**

**Background and Intent: It is intended that residents will participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.**

**IV.A.5.** **formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)**

**IV.B.** **ACGME Competencies**

**Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.**

**IV.B.1.** **The program must integrate the following ACGME Competencies into the curriculum:**

**IV.B.1.a)** **Professionalism**

**Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)**

**IV.B.1.a).(1)** **Residents must demonstrate competence in:**

**IV.B.1.a).(1).(a)** **compassion, integrity, and respect for others; (Core)**

**IV.B.1.a).(1).(b)** **responsiveness to patient needs that supersedes self-interest; (Core)**


 

**IV.B.1.a).(1).(c)** **cultural humility; (Core)**

**IV.B.1.a).(1).(d)** **respect for patient privacy and autonomy; (Core)**

**IV.B.1.a).(1).(e)** **accountability to patients, society, and the profession; (Core)**

**IV.B.1.a).(1).(f)** **respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)**

**IV.B.1.a).(1).(g)** **ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)**

**IV.B.1.a).(1).(h)** **appropriately disclosing and addressing conflict or duality of interest. (Core)**

**Background and Intent: This includes the recognition that under certain circumstances, the interests of the patient may be best served by transitioning care to another practitioner. Examples include fatigue, conflict or duality of interest, not connecting well with a patient, or when another physician would be better for the situation based on skill set or knowledge base.**

**IV.B.1.b)** **Patient Care and Procedural Skills**

**Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.**

**IV.B.1.b).(1)** **Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)**

IV.B.1.b).(1).(a) Residents must demonstrate the ability to provide comprehensive medical care to infants, children, adolescents, and adults, including: (Core)

IV.B.1.b).(1).(a).(i) ~~manage~~managing the care of patients in a variety of roles within a health system with progressive responsibility, ~~to include~~ to include serving as the direct provider, as a member or ~~the~~ leader ~~or member~~ of an interprofessional ~~multi-disciplinary~~team of providers, as a consultant to other physicians, and as a teacher to the patient,

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|---|---|
| | the patient's family, and other health care workersphysicians; (Core) |
| IV.B.1.b).(1).(a).(ii) | manage managing the care of patients in the prevention, counseling, detection, and diagnosis, and treatment of adult and pediatricgender-specific diseases; (Core) |
| IV.B.1.b).(1).(a).(iii) | manage managing the care of patients in a variety of health care settings, to include the inpatient ward, the critical care units, the emergency setting, and various the ambulatory settings; (Core) |

Specialty-Specific Background and Intent: Emerging models of care and needs of populations served by programs will result in residents having educational experiences in novel or non-traditional settings, such as rotations on mobile buses that travel to areas of increased need, and "pop-up" health clinics within community centers.

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| IV.B.1.b).(1).(a).(iv) | manage managing patients across the spectrum of clinical disorders seen in the practice of general internal medicine and pediatrics in both inpatient and ambulatory settings; (Core) |
| IV.B.1.b).(1).(a).(v) | managemanaging a sufficient number of undifferentiated acutely and severely ill patients; (Core) |
| IV.B.1.b).(1).(a).(vi) | gathering essential and accurate information about athe patient through history and physical examination; (Core) |

Specialty-Specific Background and Intent: History comprises medical record review and directed interview with the patient/patient's family, including the use of interpretive services when necessary. Physical examination is inclusive of a developmentally appropriate approach and may be direct or technology-assisted.

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| IV.B.1.b).(1).(a).(vii) | conducting health supervision, minor sick, and acute severe illness encounters, in addition to managing complex or chronic conditions; (Core) |

Specialty-Specific Background and Intent: These visits are both face-to-face and technology-assisted (i.e., telehealth) encounters. This would include exposure to the principles of managing patients in a medical home for both well children and adults and those with complex medical problems.


 

IV.B.1.b).(1).(a).(viii) assessing growth and development of pediatric patients from birth through the transition to adult practitioners; (Core)

Specialty-Specific Background and Intent: As specialists caring for both children and adults, residents are expected to foster the coordination of safe, effective, and intentional transition of adolescents and young adults to adult care environments.

IV.B.1.b).(1).(a).(ix) recognizing normal variations in pediatric growth, development, and wellness, and anticipating, preventing, and detecting disruptions in health and well-being; (Core)

IV.B.1.b).(1).(a).(x) diagnosing and treating common conditions while recognizing, critically evaluating, and managing complexities; (Core)

IV.B.1.b).(1).(a).(xi) incorporating consideration of the impacts of social determinants of health and advocating for social justice; (Core)

Specialty-Specific Background and Intent: Social justice utilizes the principles of human rights, participation, access, and equity. Patients may be impacted by conditions in their environment, including both challenges, such as climate change, homelessness, catastrophic events, differential access to resources, trauma, violence, neglect, structural racism, and food insecurity; and strengths, such as access to quality childcare, balanced nutrition, diversity, and family support systems. Pediatric patients may be impacted by these conditions as well, such as through bullying, dating violence, child sexual abuse, school shootings, or family with adults with low levels of education.

IV.B.1.b).(1).(a).(xii) prioritizing and organizing ~~organize and prioritize responsibilities to provide~~patient care that is safe, effective, and efficient, taking into account severity of illness and patient volume; (Core)

IV.B.1.b).(1).(a).(xiii) identifying and managing common behavioral/mental health conditions in pediatric and adult patients; (Core)

IV.B.1.b).(1).(a).(xiv) providing medical care that addresses concerns of patients and patients' families; (Core)

IV.B.1.b).(1).(a).(xv) providing medical care that addresses concerns of groups of patients; (Detail)

IV.B.1.b).(1).(a).(xvi) participating in real or simulated end-of-life care coordination and grief and bereavement management; (Detail)


 

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| IV.B.1.b).(1).(a).(xvii) | using clinical reasoning based on interpretation of diagnostic information and problem solving, and adjusting management strategies to changing conditions and ambiguous situations; (Core) |
| ~~IV.B.1.b).(1).(a).(xviii)~~ | ~~provide transfer of care that ensures seamless transitions; (Core)~~ |
| ~~IV.B.1.b).(1).(a).(xix)~~ | ~~interview patients and families about the particulars of the medical condition for which they seek care, with specific attention to behavioral, psychosocial, environmental, and family unit correlates of disease; (Core)~~ |
| ~~IV.B.1.b).(1).(a).(xx)~~ | ~~perform complete and accurate physical examinations; (Core)~~ |
| ~~IV.B.1.b).(1).(a).(xxi)~~ | ~~make informed diagnostic and therapeutic decisions that result in optimal clinical judgment; (Core)~~ |
| IV.B.1.b).(1).(a).(xxii) | referring patients who require consultation, to include those with surgical problems; (Core) |
| IV.B.1.b).(1).(a).(xxiii) | resuscitating, stabilizing, and triaging patients to align care with severity of illness; (Core) |
| ~~IV.B.1.b).(1).(a).(xxiv)~~ | ~~develop and carry out management plans; (Core)~~ |
| ~~IV.B.1.b).(1).(a).(xxv)~~ | ~~provide effective health maintenance and anticipatory guidance; (Core)~~ |
| ~~IV.B.1.b).(1).(a).(xxvi)~~ | ~~provide appropriate role modeling; and, (Core)~~ |
| ~~IV.B.1.b).(1).(a).(xxvii)~~ | ~~provide appropriate supervision. (Core)~~ |
| IV.B.1.b).(1).(a).(xxviii) | providing care to patients with whom the residents have limited or no physical contact through the use of telemedicine; (Core) |
| IV.B.1.b).(1).(a).(xxix) | providing care in the subspecialties of internal medicine; (Core) |
| IV.B.1.b).(1).(a).(xxx) | using population-based data; and, (Core) |

Specialty-Specific Background and Intent: Understanding population health within the context of prevention is an important competency for the physician practicing medicine in the future. Residents need experience using, understanding, and analyzing population health data so


 

that they can develop health care plans to improve health outcomes for their patients. For instance, residents may be provided with experience in analyzing and interpreting data from health registries, learning to understand the local impact of infectious and non-infectious epidemics (e.g., obesity, opioid) and pandemics, and the important role social determinants of health have in developing and applying health care and preventive care decisions.

IV.B.1.b).(1).(a).(xxxi) using critical thinking and evidence-based tools. (Core)

**IV.B.1.b).(2)** **Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**

~~IV.B.1.b).(2).(a)~~ ~~Residents must demonstrate the ability to manage patients using the laboratory and imaging techniques appropriately; (Core)~~

IV.B.1.b).(2).(b) Residents must treat their patients' conditions with practices that are patient-centered, safe, scientifically based, effective, efficient, timely, and cost effective. (Core)

IV.B.1.b).(2).(c) ~~Residents must be able to competently perform procedures used by an internist and pediatrician in general practice, including being able to describe the steps in the procedure, indications, contraindications, complications, pain management, post-procedure care, and interpretation of applicable results; (Core)~~

IV.B.1.b).(2).(d) Residents must demonstrate ~~procedural~~ competence ~~by performing~~ in the following procedures ~~on~~ for pediatric patients~~; and~~:(Core)

IV.B.1.b).(2).(d).(i) bag-mask ventilation; (Core)

~~IV.B.1.b).(2).(d).(ii)~~ ~~bladder catheterization; (Core)~~

~~IV.B.1.b).(2).(d).(iii)~~ ~~immunizations; (Core)~~

~~IV.B.1.b).(2).(d).(iv)~~ ~~incision and drainage of abscess; (Core)~~

IV.B.1.b).(2).(d).(v) lumbar puncture; (Core)

IV.B.1.b).(2).(d).(vi) neonatal ~~endotracheal intubation~~ delivery room stabilization; (Core)

IV.B.1.b).(2).(d).(vii) peripheral intravenous catheter placement; and, (Core)

~~IV.B.1.b).(2).(d).(viii)~~ ~~reduction of simple dislocation; (Core)~~


 

IV.B.1.b).(2).(d).(ix) simple laceration repair. (Core)

~~IV.B.1.b).(2).(d).(x) simple removal of foreign body; (Core)~~

~~IV.B.1.b).(2).(d).(xi) temporary splinting of fracture; (Core)~~

~~IV.B.1.b).(2).(d).(xii) umbilical catheter placement; and, (Core)~~

~~IV.B.1.b).(2).(d).(xiii) venipuncture. (Core)~~

IV.B.1.b).(2).(e) The program must provide instruction and opportunities for residents to perform procedures as applicable to each resident's future career plans. (Core)

Specialty-Specific Background and Intent: The procedural skills a resident will need to develop will be determined by the program director or designee in collaboration with the individual resident, considering program aims, the resident's future career plans, and the needs of the community being served. Examples of pediatric procedures to consider include: incision and drainage of an abscess; simple removal of a foreign body; venipuncture; umbilical catheter placement; immunization administration; neonatal male circumcision; temporary splinting of a fracture; reduction of simple joint dislocation; replacement of gastrostomy tube; replacement of tracheostomy tube; and point-of-care laboratory and imaging. The use of simulation to supplement clinical experience is encouraged.

The Review Committee for Internal Medicine intentionally did not identify specific procedures that residents must perform because it believes that scientific advances will be constant and ongoing, and whatever is codified in the Program Requirements quickly becomes outdated. Additionally, the decision to not specifically identify procedures aligns with the Committee's overall position that residents need to perform and develop expertise with those procedures appropriate to their future practice needs, as is noted in the requirement.

IV.B.1.b).(2).(f) Residents must complete training, ~~and~~ maintain certification, and achieve competence in ~~Pediatric~~Aadvanced ~~L~~life ~~S~~support skills in pediatrics and advanced life support skills in neonates~~, including simulated placement of an intraosseous line, and neonatal resuscitation~~. (Core)

**IV.B.1.c) Medical Knowledge**

**Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)**

IV.B.1.c).(1) Residents must demonstrate knowledge of those areas appropriate for an internal medicine and pediatrics specialist, specifically: (Core)


 

IV.B.1.c).(1).(a) the broad spectrum of clinical disorders seen in the practices of general internal medicine and pediatrics; and, (Core)

IV.B.1.c).(1).(b) the core content of general internal medicine and pediatrics, including the subspecialties and relevant specialties outside of internal medicine and pediatrics. (Core)

IV.B.1.c).(2) Residents must demonstrate sufficient knowledge in the:

IV.B.1.c).(2).(a) ~~to~~ evaluate~~e~~ion of patients with an undiagnosed and undifferentiated presentation; (Core)

IV.B.1.c).(2).(b) pharmacotherapeutic and non-pharmacotherapeutic ~~to~~ treatment of the broad spectrum of medical conditions and clinical disorders ~~common to children and adults~~ managed by internists and pediatricians; (Core)

IV.B.1.c).(2).(c) ~~to~~ provi~~de~~sion of preventive care; (Core)

IV.B.1.c).(2).(d) ~~to~~ interpretation of clinical tests and images commonly used by ~~general~~ internists and pediatricians; and, (Core)

IV.B.1.c).(2).(e) ~~to recognize and provide~~recognition and initial management of ~~emergency~~ urgent medical problems. (Core)

Specialty-Specific Background and Intent: Advances in technology will likely continue to make substantive changes in patient diagnosis and management. This requirement ensures that residents will be able to gain experience and become familiar with emerging technologies, such as intensive care units managed remotely or the use of personalized or precision medicine.

~~IV.B.1.c).(2).(f) of pharmacotherapy; and, (Core)~~

~~IV.B.1.c).(2).(g) to appropriately use and perform diagnostic and therapeutic procedures. (Core)~~

IV.B.1.c).(3) Residents must demonstrate ~~sufficient~~ knowledge of the basic and clinically supportive sciences appropriate to internal medicine and pediatrics. (Core)

IV.B.1.c).(4) Residents must demonstrate knowledge of central principles that drive exceptional health outcomes; high-value, patient-centered care; continuous quality improvement; and equitable service delivery. (Core)


 

IV.B.1.c).(5) Residents must demonstrate knowledge of the full spectrum of inpatient and outpatient care of well and sick infants, children, and adolescents through the transition to adult care, in addition to diagnosis and management of common presentations, to include but not limited to knowledge of the: (Core)

IV.B.1.c).(5).(a) indications and contraindications for, and complications of procedures; (Core)

IV.B.1.c).(5).(b) diagnosis and initial management of behavioral/mental health issues, including attention-deficit/hyperactivity disorder, anxiety, depression, and suicidality; (Core)

Specialty-Specific Background and Intent: Behavioral and mental health is central to pediatric practice and requires the pediatrician to incorporate a focus on behavioral wellness and prevention of behavioral and mental health problems from infancy to young adulthood. Care of patients with behavioral and mental health problems also includes engaging with the patient's family, which may include family systems thinking, parenting programs and secondary prevention, and teaching and affirming social-emotional well-being and resilience.

Mental health education and training could include experiences with psychologists, general pediatricians, adolescent medicine physicians, developmental behavioral pediatricians, child and adolescent psychiatrists, and social workers.

IV.B.1.c).(5).(c) application of information technologies and telehealth; (Core)

IV.B.1.c).(5).(d) selection and interpretation of screening tools and tests; (Core)

IV.B.1.c).(5).(e) components of requests for and provision of patient consultation; (Core)

IV.B.1.c).(5).(f) components of effective hand-offs; (Core)

IV.B.1.c).(5).(g) cost of lab tests, pharmaceuticals, and imaging; (Detail)

IV.B.1.c).(5).(h) evidence-based guidelines that inform care; (Core)

IV.B.1.c).(5).(i) preventive health services for children and the components of normal childhood development; (Core)

IV.B.1.c).(5).(j) components of the transition of care to adult practitioners; (Core)

IV.B.1.c).(5).(k) components of quality improvement and patient safety; (Core)


 

IV.B.1.c).(5).(l) medication side effects and identification of adverse events; and, (Core)

IV.B.1.c).(5).(m) explicit and implicit biases, and health care inequities related to gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation. (Core)

~~IV.B.1.c).(6) Residents must demonstrate an understanding of the indications and contraindications for, and complications of the following pediatric procedures: (Core)~~

~~IV.B.1.c).(6).(a) arterial line placement; (Core)~~

~~IV.B.1.c).(6).(b) arterial puncture; (Core)~~

~~IV.B.1.c).(6).(c) chest tube placement; (Core)~~

~~IV.B.1.c).(6).(d) circumcision; (Core)~~

~~IV.B.1.c).(6).(e) endotracheal intubation of non-neonates; and, (Core)~~

~~IV.B.1.c).(6).(f) thoracentesis. (Core)~~

~~IV.B.1.c).(7) Residents should receive real and/or simulated training when these procedures are important for a resident's post-residency career. (Detail)~~

**IV.B.1.d) Practice-based Learning and Improvement**

**Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)**

**IV.B.1.d).(1) Residents must demonstrate competence in:**

**IV.B.1.d).(1).(a) identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)**

**IV.B.1.d).(1).(b) setting learning and improvement goals; (Core)**

**IV.B.1.d).(1).(c) identifying and performing appropriate learning activities; (Core)**

**IV.B.1.d).(1).(d) systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement; (Core)**


 

**IV.B.1.d).(1).(e)** **incorporating feedback and formative evaluation into daily practice; and, (Core)**

**IV.B.1.d).(1).(f)** **locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)**

~~IV.B.1.d).(1).(g)~~ ~~being an effective teacher; and, (Core)~~

IV.B.1.d).(1).(h) ~~taking primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and experience-specific goals and objectives and attendance at conferences. (Core)~~

**IV.B.1.e)** **Interpersonal and Communication Skills**

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

**IV.B.1.e).(1)** **Residents must demonstrate competence in:**

**IV.B.1.e).(1).(a)** **communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient; (Core)**

**IV.B.1.e).(1).(b)** **communicating effectively with physicians, other health professionals, and health-related agencies; (Core)**

**IV.B.1.e).(1).(c)** **working effectively as a member or leader of a health care team or other professional group; (Core)**

**IV.B.1.e).(1).(d)** **educating patients, patients' families, students, other residents, and other health professionals; (Core)**

**IV.B.1.e).(1).(e)** **acting in a consultative role to other physicians and health professionals; and, (Core)**

**IV.B.1.e).(1).(f)** **maintaining comprehensive, timely, and legible health care records, if applicable. (Core)**


 

IV.B.1.e).(1).(g) ~~demonstrating the insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions.~~ ~~(Core)~~

**IV.B.1.e).(2)** **Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.** **(Core)**

IV.B.1.e).(3) This must include:

IV.B.1.e).(3).(a) age-appropriate communication strategies, including risk assessment and anticipatory guidance; (Core)

Specialty-Specific Background and Intent: Anticipatory guidance about risks may extend to public health threats for children, such as appropriate use of social media, firearm violence prevention, suicide prevention, food insecurity, healthy lifestyle, and alcohol and drug use.

IV.B.1.e).(3).(b) effective communication strategies with pediatric patients and patients' families who hesitate to accept recommended treatment, including vaccines; and, (Core)

IV.B.1.e).(3).(c) effective communication strategies with pediatric patients and patients' families consistent with trauma-informed care (TIC). (Detail)

Specialty-Specific Background and Intent: TIC is considered by the Review Committees to be medical care in which all parties involved assess, recognize, and respond to the effects of traumatic stress on children, caregivers, and health care practitioners. In the clinical setting, TIC includes the prevention, identification, and assessment of trauma; response to trauma; and recovery from trauma as a focus of all services.

**IV.B.1.f)** **Systems-based Practice**

**Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.** **(Core)**

**Background and Intent: Medical practice occurs in the context of an increasingly complex clinical care environment where optimal patient care requires attention to compliance with external and internal administrative and regulatory requirements.**

**IV.B.1.f).(1)** **Residents must demonstrate competence in:**

**IV.B.1.f).(1).(a)** **working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)**

**IV.B.1.f).(1).(b)** **coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)**

**Background and Intent: Every patient deserves to be treated as a whole person. Therefore it is recognized that any one component of the health care system does not meet the totality of the patient's needs. An appropriate transition plan requires coordination and forethought by an interdisciplinary team. The patient benefits from proper care and the system benefits from proper use of resources.**

**IV.B.1.f).(1).(c)** **advocating for quality patient care and optimal patient care systems; (Core)**

**IV.B.1.f).(1).(d)** **participating in identifying system errors and implementing potential systems solutions; (Core)**

**IV.B.1.f).(1).(e)** **incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; (Core)**

**IV.B.1.f).(1).(f)** **understanding health care finances and its impact on individual patients' health decisions; and, (Core)**

**IV.B.1.f).(1).(g)** **using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)**

~~IV.B.1.f).(1).(h)~~ ~~working in teams and effectively transmitting necessary clinical information to ensure safe and proper care of patients including the transition of care between settings; and, (Core)~~

~~IV.B.1.f).(1).(i)~~ ~~advocating for the promotion of health and the prevention of disease and injury in populations. (Core)~~

**IV.B.1.f).(2)** **Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)**

IV.B.1.f).(3) Residents must learn to collaborate with community organizations, including schools and/or leaders in health care systems, to improve health care and well-being of pediatric patients. (Detail)


 

## IV.C. Curriculum Organization and Resident Experiences

**IV.C.1. The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)**

IV.C.1.a) Rotations must be of sufficient length to provide longitudinal relationships with faculty members to allow for meaningful assessment and feedback. (Core)

IV.C.1.b) Rotations must be structured to ~~Programs should develop models and schedules for ambulatory training that~~minimize conflicting inpatient and outpatient responsibilities. ~~(Detail)~~Core)

**Background and Intent: In some specialties, frequent rotational transitions, inadequate continuity of faculty member supervision, and dispersed patient locations within the hospital have adversely affected optimal resident education and effective team-based care. The need for patient care continuity varies from specialty to specialty and by clinical situation, and may be addressed by the individual Review Committee.**

Specialty-Specific Background and Intent: The Review Committees encourage programs to think of ways to balance the inherent conflicts between inpatient and outpatient responsibilities, including using an effective hand-off process. For example, programs may want to consider schedules that allow members of the interprofessional health care team to provide coverage for the inpatient service when residents are in continuity clinics. Alternatively, programs may consider creating schedules that either provide more continuity clinic experiences or an exclusive continuity clinic experience when residents are not on inpatient rotations to allow them to have less or no clinic during inpatient rotations.

**IV.C.2. The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)**

IV.C.3. The ~~core curriculum~~educational program must include ~~a~~ didactic instruction~~program~~ based on the core knowledge content of internal medicine and pediatrics to ensure each resident acquires the knowledge, skills, and attitudes needed for the practice of internal medicine and pediatrics. (Core)

IV.C.3.a) ~~The program must afford each resident an opportunity to review all of the core curriculum topics. (Core)~~

~~IV.C.3.a).(1) The didactic program should include lectures, web-based content, pod casts, etc. (Detail)~~

IV.C.3.b) ~~Residents should have the opportunity to participate in morning report, grand rounds, journal club, and morbidity and mortality (or quality improvement) conferences that also involve faculty. (Detail)~~


 

IV.C.3.c) The program should document monthly meetings for educational activities ~~with internal medicine-pediatrics residents~~, such as jointly sponsored journal clubs, clinic conferences, occasional combined grand rounds, conferences on medical ethics program administration, and research. (Detail)

IV.C.3.d) The program should provide opportunities for residents to have peer-peer and peer-faculty member interaction. (Detail)

IV.C.4. Residents must be provided a patient- or case-based approach to clinical teaching ~~Patient-based teaching must include direct~~that includes interactions between an individual resident and the ~~attending physician~~ teaching faculty member,~~at the patient's~~ bedside teaching, ~~in consultative services or in clinic settings with~~ discussion of pathophysiology, and the ~~use~~ application of current evidence in ~~up-to-date~~ diagnostic and therapeutic decision making~~evidence~~. (Core)

IV.C.5. Curriculum

IV.C.5.a) The majority of educational experiences that constitute the combined ~~nternal medicine-pediatrics~~curriculum must be derived from the educational ~~experiences~~ and training experiences ~~that have been accredited as part~~ of the ~~categorical~~ accredited internal medicine program, as prescribed ~~by the Review Committee for~~ in the ACGME Program Requirements for Graduate Medical Education in Internal Medicine, and ~~as part~~of the ~~categorical~~ accredited pediatrics program, as prescribed ~~by~~ in the ~~Review Committee~~ACGME Program Requirements for Graduate Medical Education in Pediatrics. (Core)

IV.C.5.b) The curriculum must provide a cohesive planned educational experience and not simply be a series of rotations between the two specialties. (Core)

IV.C.5.c) For each required rotation (four-week or one-month block or longitudinal experience), a faculty member must be responsible for curriculum development, and for ensuring orientation, supervision, teaching, and timely feedback and evaluation of the residents. (Core)

IV.C.5.d) ~~Residents must have graded responsibility for patient care and teaching. (Core)~~

IV.C.5.e) There must be 24 months of education and training in each specialty. (Core)

IV.C.5.e).(1) Twenty-two of these months ~~of training~~ must be in clinical rotations and other educational experiences. (Core)


 

IV.C.5.f) Night assignments should have formal goals and objectives, and a specific evaluation component. (Core)

IV.C.5.g) Off-site elective experiences should not exceed two months in either specialty (no more than two months in internal medicine, and no more than two months in pediatrics) during the four years of ~~training~~the educational program. (Detail)

IV.C.5.h) Continuous assignments to one specialty or the other should be for periods of at least one rotation and not more than six rotations. (Detail)

IV.C.5.i) ~~In order t~~To provide a breadth of exposure, unnecessary duplication of educational experiences should be avoided. (Detail)

IV.C.6. Continuity Clinic~~s~~

IV.C.6.a) The longitudinal continuity experience must allow residents to develop a continuous, long-term therapeutic relationship with a panel of general medicine and pediatric patients. (Core)

IV.C.6.b) The continuity clinic experience must ensure a minimum of 36 half-day sessions per year of a longitudinal outpatient experience. (Core)

IV.C.6.b).(1) ~~The sessions must be scheduled over a minimum of 26 weeks per year. (Core)~~

IV.C.6.b).(2) The interval between these sessions should not exceed 8 weeks. (Core)

IV.C.6.b).(3) Continuity clinic experience should be obtained either by a combined internal medicine-pediatrics continuity clinic or by alternating internal medicine and pediatrics continuity clinics. (Detail)

IV.C.6.b).(4) ~~Each resident's~~The longitudinal continuity experience:

IV.C.6.b).(4).(a) should ensure ~~include the~~ resident~~s~~ ~~serving~~ serve as the primary physician in a medical home model for a panel of patients, with responsibility for chronic disease management, management of acute health problems, and preventive health care for their patients; (Core ~~Detail~~)

IV.C.6.b).(4).(b) ~~should include evaluation of performance data for each resident's continuity panel of patients relating to both chronic disease management and preventive health care; (Detail)~~


 

~~IV.C.6.b).(4).(c)~~ ~~should include faculty guidance for developing a data-based action plan that is evaluated at least twice a year;~~ ~~(Detail)~~

IV.C.6.b).(4).(d) should ensure residents ~~include resident participation~~ participate in the coordination of care of patients across health care settings and between outpatient visits; (Core~~Detail~~)

~~IV.C.6.b).(4).(d).(i)~~ ~~Residents should be available to participate in the management of their continuity panel of patients between outpatient visits.~~ ~~(Detail)~~

~~IV.C.6.b).(4).(d).(ii)~~ ~~There should be systems of care to provide coverage of urgent problems when a resident is not readily available.~~ ~~(Detail)~~

IV.C.6.b).(4).(e) must include supervision and teaching by faculty members with whom they have ~~who~~ developed a longitudinal relationship~~with residents throughout the duration of their continuity experience~~; and, (Core)

IV.C.6.b).(4).(f) should maintain a ratio of residents or other learners to faculty preceptors not to exceed 4:1. (Detail)

~~IV.C.6.b).(4).(g)~~ ~~must have sufficient supervision and teaching.~~ ~~(Core)~~

IV.C.6.b).(4).(g).(i) Faculty members should not have other patient care responsibilities ~~duties~~while supervising more than two residents or other learners. (Detail)

~~IV.C.6.b).(4).(g).(ii)~~ ~~Other faculty responsibilities should not detract from the supervision and teaching of residents.~~ ~~(Detail)~~

IV.C.6.b).(4).(g).(iii) Faculty members serving as preceptors should have expertise in primary care and the principles of the medical home. (Detail)

IV.C.6.b).(5) ~~There must be an adequate volume of patients to ensure exposure to the spectrum of normal development at all age levels, as well as the longitudinal management of children and adults with special health care needs and chronic conditions.~~ ~~(Core)~~

IV.C.6.b).(6) There must be an even distribution of pediatric and adult patients, whether the experience occurs in combined or alternating separate clinic settings. (Core)


 

~~IV.C.6.b).(6).(a) Residents should see a minimum of 54 adult and a minimum of 54 pediatric patient visits in the PGY-1. (Detail)~~

~~IV.C.6.b).(6).(b) Residents should see a minimum of 72 adult and a minimum of 72 pediatric patient visits in the PGY-2. (Detail)~~

~~IV.C.6.b).(6).(c) Residents should see a minimum of 90 adult and a minimum of 90 pediatric patient visits in the PGY-3. (Detail)~~

~~IV.C.6.b).(6).(d) Residents should see a minimum of 90 adult and a minimum of 90 pediatric patient visits in the PGY-4. (Detail)~~

IV.C.6.b).(7) Programs must not be structured to provide sequential continuity experiences (e.g., 24 months of internal medicine followed by 24 months of pediatrics). (Core)

IV.C.6.b).(8) Residents should follow their continuity patients ~~during~~over the course of a hospitalization. (Detail)

IV.C.6.b).(9) PGY-4 residents should continue this experience at the same clinical site or, if appropriate for an individual resident's career goals, sessions in the final year may take place in a longitudinal subspecialty clinic or alternate primary care site. (Detail)

IV.C.7. ~~C~~ritical Care Medicine ~~Intensive Care~~

IV.C.7.a) The total required critical care experience must not exceed eight months, and must include at least ~~three~~ two months in pediatrics and at least two months in internal medicine. (Core)

IV.C.8. Internal Medicine Component

The ~~training in~~ internal medicine curriculum for the combined program must include:

IV.C.8.a) 20 months of ~~direct patient care or supervision of more junior residents in direct patient care~~ foundational clinical experiences in internal medicine, including: (Core)

IV.C.8.b) ~~experience in the Emergency Department; (Core)~~

~~IV.C.8.b).(1) This should include at least a one-month experience in the Emergency Department during the first or second year. (Detail)~~

IV.C.8.c) ~~clinical experiences with hospitalized patients; (Core)~~

~~IV.C.8.c).(1)~~ ~~At least one-third of the residency training must occur in the ambulatory setting and at least one-third must occur in the inpatient setting.~~ ~~(Core)~~

IV.C.8.c).(2) ~~The inpatient experience should be~~ at least eight months ~~of clinical experiences in duration~~ in the inpatient setting, to include critical care; ~~(Detail)~~(Core)

IV.C.8.c).(3) at least eight months of clinical experiences in the outpatient setting; (Core)

IV.C.8.c).(4) Clinical experiences in each of the internal medicine subspecialties; (Core)

IV.C.8.c).(5) Clinical experience in geriatric medicine, hospice and palliative medicine, addiction medicine, emergency medicine, and neurology; and, (Core)

IV.C.8.c).(6) individualized educational experiences to participate in opportunities relevant to each resident's future practice goals or to further development of skills/competence in the foundational areas. (Core)

Specialty-Specific Background and Intent: This requirement acknowledges that in addition to providing residents with broad foundational educational experiences in internal medicine, programs must ensure residents educational experiences that take into account their future career plans. The program director will consider demonstrated competence in the foundational areas, program resources, program aims, and a resident's future practice plans when developing individualized learning experiences. These opportunities may include more ambulatory/outpatient experiences for residents interested in practicing in an outpatient setting after residency, more inpatient experiences for those interested in hospitalist medicine careers, or more experiences in a subspecialty for those interested in subspecializing. Individualized educational experiences may be integrated throughout the entirety of the educational program and do not need to be consecutive. The amount of time devoted to such experiences is not specified because individuals learn at different paces, and some may need to devote most of their residency experience to achieving competence in the foundational areas.

IV.C.9. While on inpatient medicine rotations:

IV.C.9.a) ~~a first-year~~ PGY-1 residents must not be assigned more than five new patients per admitting day; (Core)

IV.C.9.a).(1) An additional two patients may be assigned if they are in-house transfers from medical services. (Core)

IV.C.9.b) ~~a first-year~~PGY-1 residents must not be assigned more than eight new patients in a 48-hour period; (Core)


 

IV.C.9.c) ~~a first-year~~PGY-1 residents must not be responsible for the ongoing care of more than 10 patients; (Core)

IV.C.9.d) and when supervising more than one ~~first-year~~ PGY-1 resident, the PGY-2, -3, or -4 supervising resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day, or more than 16 new patients in a 48-hour period; (Core)

IV.C.9.e) and when supervising one PGY-1 ~~first-year~~resident, the PGY-2, -3, or -4 supervising resident must not be responsible for the ongoing care of more than 14 patients; (Core)

IV.C.9.f) and when supervising more than one ~~first-year~~ PGY-1 resident, the PGY-2, -3, or -4 supervising resident must not be responsible for the ongoing care of more than 20 patients; (Core)

Specialty-Specific Background and Intent: The Review Committee for Internal Medicine cannot prescriptively and explicitly assign patient census limits for every possible educational scenario or circumstance given the variability in these settings and the complexity and acuity of the patients. Instead, the Review Committee asks program and institutional leadership teams to proactively and regularly monitor the census, complexity, and acuity of patients assigned to resident-comprised health care teams, and the structure and composition of the team, particularly the knowledge, skills, and abilities of the team members, to determine the appropriate patient team size for the situation. Although the Review Committee limits the number of new patients PGY-2, -3, and -4 residents can be assigned per admitting day, programs can exercise flexibility and deviate from these limits for PGY-3 or -4 residents who have significant experience in the inpatient setting and are interested in hospitalist medicine careers in the future. The leadership team will need to carefully review institutional patient safety outcome data when determining patient census team limits in such scenarios. The census limits noted above apply to all inpatient experiences during the 48 months of supervised GME regardless of whether an inpatient rotation is part of the foundational inpatient educational experiences or part of the individualized experiences.

IV.C.9.g) residents must write all orders for patients under their care, with appropriate supervision by the attending physician, except in those emergent circumstances when another attending physician or ~~subspecialty resident~~ consultant writes an order for a resident's patient, in which case the attending physician or consultant ~~subspecialty resident~~ must communicate ~~his or her~~ the action to the resident in a timely manner; (Core)

IV.C.9.h) ~~second- or third-year categorical internal medicine residents, or, second-, third- or fourth-year internal medicine-pediatrics residents or other appropriate supervisory physicians (e.g., fellows, or attending physicians) 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;~~ (Core)

IV.C.9.i) the resident team and each attending physician must have ~~each physician of record has~~ the responsibility to make management rounds on ~~his or her~~ their patients and ~~to~~ communicate effectively with ~~the residents participating in the care of these patients~~ each other at a frequency appropriate to the changing care needs of the patients; (Core)

IV.C.9.j) residents' ~~service~~ responsibilities must be limited to patients for whom the teaching team ~~service~~has diagnostic and therapeutic responsibility~~(N. B. : Teaching Service is defined as those patients for whom medicine-pediatrics residents routinely provide care)~~; (Core)

IV.C.9.k) programs must monitor and limit the number of resident-attending physician relationships to ensure that communication and education are not compromised; (Core)

IV.C.9.l) ~~residents must not be required to relate to an excessive number of attending physicians; and,~~ (Core)

IV.C.9.m) non-physician faculty members must not supervise internal medicine residents; (Core)

IV.C.9.n) residents from other specialties must not supervise internal medicine-pediatrics residents on any internal medicine or pediatrics inpatient rotation; and, (Core)

IV.C.9.o) residents must have a maximum of two months of night float over the duration of the program, with no more than one month of night float during any one year of the program. (Core)

IV.C.9.p) ~~care of adults with various illnesses in critical care units (e.g., intensive care units, cardiac care units, respiratory care units);~~ (Core)

~~IV.C.9.p).(1) Patient care experiences in the critical care units should occur during the first or second year and again in subsequent years.~~ (Detail)

IV.C.9.q) ~~subspecialty experience, including exposure to neurology, that is inpatient, outpatient, or a combination of the two settings;~~ (Core)

~~IV.C.9.q).(1) Residents should have at least four months of subspecialty experiences.~~ (Detail)

~~IV.C.9.q).(2) This experience should include serving as a consultant.~~ (Detail)

IV.C.9.r) ~~clinical experience in geriatrics;~~ (Core)

~~IV.C.9.r).(1) Residents should have at least one geriatrics rotation.~~ (Detail)


 

IV.C.9.s) ~~required transplant rotations in dedicated units not to exceed one month in four years.~~ ~~(Detail)~~

IV.C.10. Pediatrics Component

IV.C.10.a) ~~A pediatric educational unit must be a block (four weeks or one month) or longitudinal experience.~~ ~~(Core)~~

~~IV.C.10.a).(1) A longitudinal outpatient educational unit should be a minimum of 32 half-day sessions. A longitudinal inpatient educational unit should be a minimum of 200 hours.~~ ~~(Detail)~~

IV.C.10.b) The pediatrics curriculum be organized as block and/or longitudinal experiences and must include: (Core)

IV.C.10.b).(1) a minimum of 32 weeks of primarily ambulatory care experiences, including elements of community pediatrics and child advocacy, to include a minimum of:

IV.C.10.b).(1).(a) 8 weeks of general ambulatory pediatric clinic; (Core)

Specialty-Specific Background and Intent: The Review Committee for Pediatrics recognizes the value of ambulatory experience to align with pediatric practice trends for the care of well children, the acutely ill, and those with chronic diseases. The eight weeks of general ambulatory pediatric clinic is in addition to the longitudinal clinic. Programs need to find the experiences that best fulfill this requirement in their own institutions. Patients seen in urgent care sites may be counted toward the general ambulatory pediatric clinic experience. However, it is up to the program director to ensure that a broad experience is provided that will reflect the experience graduates will encounter in practice after residency.

IV.C.10.b).(1).(b) 4 weeks of subspecialty outpatient experience, composed of no fewer than two subspecialties, in the first 24 months of the program; (Core)

IV.C.10.b).(1).(c) 4 weeks adolescent medicine; (Core)

IV.C.10.b).(1).(d) 4 weeks of mental health; (Core)

IV.C.10.b).(1).(e) 4 weeks developmental-behavioral pediatrics; and, (Core)

Specialty-Specific Background and Intent: Early exposure to a variety of subspecialties can serve as a foundation for both general and subspecialty pediatricians and includes exposure to common conditions referred for subspeciality evaluation. Adolescent medicine, mental health, and developmental-behavioral rotations may include inpatient components but should not be exclusively inpatient in focus, so these experiences are included in the ambulatory section of the Program Requirements.

IV.C.10.b).(1).(f) 8 weeks of pediatric emergency medicine. (Core)


 

IV.C.10.b).(2) a minimum of 32 weeks of inpatient care experiences, to include: (Core)

IV.C.10.b).(2).(a) 20 weeks of inpatient medicine, with a minimum of 16 weeks of general pediatrics or pediatric hospital medicine service; (Core)

IV.C.10.b).(2).(a).(i) The remaining time must be on the general pediatrics or pediatric hospital medicine service or other subspecialty services, and no more than 4 weeks spent on a single subspecialty service, exclusive of pediatric hospital medicine. (Core)

IV.C.10.b).(2).(b) 8 weeks intensive care, to include a minimum of 4 weeks of pediatric intensive care unit and 4 weeks of neonatal intensive care unit; and, (Core)

IV.C.10.b).(2).(c) 4 weeks of newborn nursery. (Core)

IV.C.10.b).(3) a minimum of 20 weeks of an individualized curriculum. (Core)

IV.C.10.b).(3).(a) The individualized curriculum must be determined by the learning needs and career plans of each resident and developed with guidance of the program director or designee. (Core)

IV.C.10.b).(3).(b) Experiences must be distributed across all years of the educational program. (Core)

IV.C.10.b).(3).(c) There must be a minimum of 12 weeks of at least 3 additional pediatric subspecialty experiences beyond those used to meet the inpatient and outpatient requirements. (Core)

IV.C.10.b).(3).(c).(i) Each subspecialty experience must be a minimum of 1 week and a maximum of 4 weeks in duration. (Core)

Specialty-Specific Background and Intent: Subspecialty experiences used to meet this requirement may not also be counted toward the required time for inpatient and outpatient experiences. For example, the required four weeks of adolescent medicine may not count toward the required five additional subspecialty experiences. However, the individualized curriculum may include additional time in adolescent medicine as an elective experience. There is no double counting of subspecialty experience.

IV.C.10.b).(3).(d) There must be a minimum of 8 weeks of elective clinical, scholarly, and/or other experiences. (Core)


 

IV.C.10.c) Residents must have experience in a supervisory role, under faculty guidance. (Core)

IV.C.10.c).(1) This experience should occur for a minimum of 16 weeks during the final three years in the program. (Core)

IV.C.10.c).(2) 8 weeks of this experience should be on the inpatient general pediatrics or pediatric hospital medicine service. (Detail)

~~IV.C.10.c).(3) a minimum of nine educational units of inpatient care experiences, including: (Core)~~

~~IV.C.10.c).(3).(a) pediatric critical care; (Core)~~

~~IV.C.10.c).(3).(a).(i) There should be one educational unit. (Detail)~~

~~IV.C.10.c).(3).(b) neonatal intensive care; (Core)~~

~~IV.C.10.c).(3).(b).(i) There should be two educational units. (Detail)~~

~~IV.C.10.c).(3).(c) inpatient pediatrics; and, (Core)~~

~~IV.C.10.c).(3).(c).(i) There should be five educational units. (Detail)~~

~~IV.C.10.c).(3).(d) term newborn care. (Core)~~

~~IV.C.10.c).(3).(d).(i) There should be one educational unit. (Detail)~~

~~IV.C.10.c).(4) a minimum of six educational units of additional subspecialty experiences, including: (Core)~~

~~IV.C.10.c).(4).(a) developmental-behavioral pediatrics; (Core)~~

~~IV.C.10.c).(4).(a).(i) There should be one educational unit. (Detail)~~

~~IV.C.10.c).(4).(b) adolescent medicine; and, (Core)~~

~~IV.C.10.c).(4).(b).(i) There should be one educational unit. (Detail)~~

~~IV.C.10.c).(4).(c) four educational units of four of the following subspecialties: (Core)~~

~~IV.C.10.c).(4).(c).(i) child abuse; (Core)~~

~~IV.C.10.c).(4).(c).(ii) medical genetics; (Core)~~

~~IV.C.10.c).(4).(c).(iii) pediatric allergy and immunology; (Core)~~

~~IV.C.10.c).(4).(c).(iv) pediatric cardiology; (Core)~~


 

~~IV.C.10.c).(4).(c).(v) pediatric dermatology; (Core)~~

~~IV.C.10.c).(4).(c).(vi) pediatric endocrinology; (Core)~~

~~IV.C.10.c).(4).(c).(vii) pediatric gastroenterology; (Core)~~

~~IV.C.10.c).(4).(c).(viii) pediatric hematology-oncology; (Core)~~

~~IV.C.10.c).(4).(c).(ix) pediatric infectious diseases; (Core)~~

~~IV.C.10.c).(4).(c).(x) pediatric nephrology; (Core)~~

~~IV.C.10.c).(4).(c).(xi) pediatric neurology; (Core)~~

~~IV.C.10.c).(4).(c).(xii) pediatric pulmonology; or, (Core)~~

~~IV.C.10.c).(4).(c).(xiii) pediatric rheumatology. (Core)~~

~~IV.C.10.c).(5) a minimum of four educational units of ambulatory experiences, including: (Core)~~

~~IV.C.10.c).(5).(a) two educational units of emergency medicine (one educational unit of emergency medicine is equivalent to 160 hours); and, (Detail)~~

~~IV.C.10.c).(5).(a).(i) Residents should have first-contact evaluation of pediatric patients in the Emergency Department. (Detail)~~

~~IV.C.10.c).(5).(b) two educational units of ambulatory experiences, to include elements of community pediatrics and child advocacy. (Detail)~~

~~IV.C.10.c).(6) two educational units as an individualized curriculum. (Core)~~

~~IV.C.10.c).(6).(a) The individualized curriculum should be determined by the learning needs and career plans of the resident and should be developed through the guidance of a faculty mentor. (Detail)~~

## IV.D. Scholarship

***Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.***


 

***The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.***

**IV.D.1. Program Responsibilities**

**IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)**

**IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)**

**IV.D.1.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)**

**IV.D.2. Faculty Scholarly Activity**

**IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)**

- **Research in basic science, education, translational science, patient care, or population health**
- **Peer-reviewed grants**
- **Quality improvement and/or patient safety initiatives**
- **Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports**
- **Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials**
- **Contribution to professional committees, educational organizations, or editorial boards**
- **Innovations in education**

**IV.D.2.b) The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:**

**Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the residents' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core**


 

**and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.**

**IV.D.2.b).(1)** **faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)**

**IV.D.2.b).(2)** **peer-reviewed publication. (Outcome)**

Specialty-Specific Background and Intent: As the majority of faculty members in the combined program are ~~derived~~from the ~~categorical~~ associated specialty programs, and ~~the internal medicine-pediatrics~~combined programs are only required to list in ADS ~~faculty who are part of~~ the program leadership and the minimum number of core faculty members, ~~who are unique to the combined program,~~ faculty scholarly activity will only be reviewed within the context of the specialty ~~categorical~~program reviews and subject to the requirements of the ~~categorical~~ associated specialty program (internal medicine or pediatrics). Note that the requirement for peer-reviewed publications is included as it pertains to expectations of pediatrics faculty members; peer-reviewed publications are not an expectation of internal medicine faculty members.

**IV.D.3. Resident Scholarly Activity**

**IV.D.3.a)** **Residents must participate in scholarship. (Core)**

IV.D.3.a).(1) A program's graduates must demonstrate dissemination of scholarship within or external to the program by any of the following methods: (Core)

IV.D.3.a).(1).(a) presenting at grand rounds or poster sessions; leading conference presentations (journal club, morbidity and mortality, case conferences); presenting at workshops; giving quality improvement presentations; making podium presentations; conducting grant leadership; contributing to non-peer-reviewed print/electronic resources; contributing to articles or publications; authoring book chapters; contributing to textbooks; presenting at webinars; serving on professional committees; or serving as a journal reviewer, journal editorial board member, or editor. (Core)

## V. Evaluation

### V.A. Resident Evaluation


 

## V.A.1. Feedback and Evaluation

**Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.**

**Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring resident learning* and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:**

- **residents identify their strengths and weaknesses and target areas that need work**
- **program directors and faculty members recognize where residents are struggling and address problems immediately**

**Summative evaluation is *evaluating a resident's learning* by comparing the residents against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.**

**End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.**

**Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.**

**V.A.1.a)** **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**

~~V.A.1.a).(1)~~ ~~Residents must be evaluated utilizing a structured approach by faculty members or other appropriate supervisors using multiple assessment methods, in different settings, for: (Core)~~

~~V.A.1.a).(1).(a)~~ ~~performing histories and physical examinations; (Detail)~~

~~V.A.1.a).(1).(b)~~ ~~providing effective counseling of patients and families on the broad range of issues; and, (Detail)~~

~~V.A.1.a).(1).(c)~~ ~~demonstrating the ability to make diagnostic and therapeutic decisions based on best evidence and to develop and carry out management plans. (Detail)~~


 

**Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Residents require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.**

**V.A.1.b)** **Evaluation must be documented at the completion of the assignment.** (Core)

**V.A.1.b).(1)** **For block rotations of greater than three months in duration, evaluation must be documented at least every three months.** (Core)

**V.A.1.b).(2)** **Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion.** (Core)

**V.A.1.c)** **The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must:** (Core)

**V.A.1.c).(1)** **use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and,** (Core)

~~V.A.1.c).(1).(a)~~ ~~Assessment of residents' communication skills and professionalism should include evaluations by patients and/or patients' families.~~ (Detail)

**V.A.1.c).(2)** **provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice.** (Core)

~~V.A.1.c).(3)~~ ~~This assessment should involve direct observation of resident-patient encounters.~~ (Detail)

~~V.A.1.c).(4)~~ ~~The program should use an objective validated formative assessment method (e.g., in-training examination, chart stimulated recall).~~ (Detail)

~~V.A.1.c).(4).(a)~~ ~~The same formative assessment method should be administered annually for each specialty.~~ (Detail)

**V.A.1.d)** **The program director or their designee, with input from the Clinical Competency Committee, must:**

**V.A.1.d).(1)** **meet with and review with each resident their documented semi-annual evaluation of performance,**


 

**including progress along the specialty-specific Milestones; (Core)**

**V.A.1.d).(2)** **assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)**

~~V.A.1.d).(2).(a)~~ ~~create and document an individualized learning plan at least annually. (Core)~~

~~V.A.1.d).(2).(a).(i)~~ ~~The program should provide a system to assist residents in this process, including: (Detail)~~

~~V.A.1.d).(2).(a).(i).(a)~~ ~~faculty mentorship to help residents create learning goals; and, (Detail)~~

~~V.A.1.d).(2).(a).(i).(b)~~ ~~systems for tracking and monitoring progress toward completing the individualized learning plan. (Detail)~~

**V.A.1.d).(3)** **develop plans for residents failing to progress, following institutional policies and procedures. (Core)**

**Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.**

**Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.**

**V.A.1.e)** **At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)**

**V.A.1.f)** **The evaluations of a resident's performance must be accessible for review by the resident. (Core)**

V.A.1.g) ~~The record of evaluation should include a logbook or an equivalent method to document that each resident has achieved~~

~~sufficient experience performing invasive procedures to achieve competence.~~ (Detail)

V.A.1.h) The evaluation process must be structured to mitigate implicit bias in the evaluation of residents. (Detail)

V.A.1.i) The program must administer an in-training examination annually. (Core)

Specialty-Specific Background and Intent: Programs have the option of using an in-training examination offered by a certifying board or another examination, including one developed by the program itself.

**V.A.2. Final Evaluation**

**V.A.2.a) The program director must provide a final evaluation for each resident upon completion of the program. (Core)**

**V.A.2.a).(1) The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)**

**V.A.2.a).(2) The final evaluation must:**

**V.A.2.a).(2).(a) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)**

**V.A.2.a).(2).(b) verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core)**

**V.A.2.a).(2).(c) be shared with the resident upon completion of the program. (Core)**

**V.A.3. A Clinical Competency Committee must be appointed by the program director. (Core)**

**V.A.3.a) At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)**

**V.A.3.a).(1) Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)**


 

**Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. Inclusivity is an important consideration in the appointment of Clinical Competency Committee members, allowing for diverse participation to ensure fair evaluation. The program director has final responsibility for resident evaluation and promotion decisions.**

**The program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.**

**V.A.3.b)** **The Clinical Competency Committee must:**

**V.A.3.b).(1)** **review all resident evaluations at least semi-annually; (Core)**

**V.A.3.b).(2)** **determine each resident's progress on achievement of the specialty-specific Milestones; and, (Core)**

**V.A.3.b).(3)** **meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)**

**V.B.** **Faculty Evaluation**

**V.B.1.** **The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)**

**Background and Intent: The program director is responsible for the educational program and all educators. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the diverse operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical**


 

**productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.**

**V.B.1.a)** **This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities.** (Core)

**V.B.1.b)** **This evaluation must include written, anonymous, and confidential evaluations by the residents.** (Core)

**V.B.2.** **Faculty members must receive feedback on their evaluations at least annually.** (Core)

**V.B.3.** **Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.** (Core)

**Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the residents' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.**

**V.C.** **Program Evaluation and Improvement**

**V.C.1.** **The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.** (Core)

**V.C.1.a)** **The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident.** (Core)

**V.C.1.b)** **Program Evaluation Committee responsibilities must include:**

**V.C.1.b).(1)** **review of the program's self-determined goals and progress toward meeting them;** (Core)

**V.C.1.b).(2)** **guiding ongoing program improvement, including development of new goals, based upon outcomes; and,** (Core)

**V.C.1.b).(3)** **review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.** (Core)


 

**Background and Intent: To achieve its mission and educate and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of residents and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims. The Program Evaluation Committee advises the program director through program oversight.**

**V.C.1.c)** **The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program.** (Core)

**Background and Intent: Other data to be considered for assessment include:**

- **Curriculum**
- **ACGME letters of notification, including citations, Areas for Improvement, and comments**
- **Quality and safety of patient care**
- **Aggregate resident and faculty well-being; recruitment and retention; workforce diversity, including graduate medical education staff and other relevant academic community members; engagement in quality improvement and patient safety; and scholarly activity**
- **ACGME Resident and Faculty Survey results**
- **Aggregate resident Milestones evaluations, and achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance.**
- **Aggregate faculty evaluation and professional development**

**V.C.1.d)** **The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats.** (Core)

**V.C.1.e)** **The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO.** (Core)

**V.C.2.** **The program must complete a Self-Study and submit it to the DIO.** (Core)

**Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the accreditation Self-Study process. The accreditation Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the accreditation Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the accreditation Self-Study are provided in the *ACGME***


 

***Manual of Policies and Procedures*. Additionally, a description of the accreditation Self-Study process is available on the ACGME website.**

**V.C.3.** ***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.***

***The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.***

**V.C.3.a)** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** **(Outcome)**

**V.C.3.b)** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** **(Outcome)**

**V.C.3.c)** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** **(Outcome)**

**V.C.3.d)** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** **(Outcome)**

**V.C.3.e)** **For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.** **(Outcome)**

**Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.**


 

**There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.**

**V.C.3.f)** **Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.** (Core)

**Background and Intent: It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.**

**The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.**

**In the future, the ACGME may establish parameters related to ultimate board certification rates.**

## VI. The Learning and Working Environment

***Residency education must occur in the context of a learning and working environment that emphasizes the following principles:***

- ***Excellence in the safety and quality of care rendered to patients by residents today***
- ***Excellence in the safety and quality of care rendered to patients by today's residents in their future practice***
- ***Excellence in professionalism through faculty modeling of:***
- ***Appreciation for the privilege of providing care for patients***
- ***Commitment to the well-being of the students, residents, faculty members, and all members of the health care team***

### VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

#### VI.A.1. Patient Safety and Quality Improvement

**VI.A.1.a)** **Patient Safety**

**VI.A.1.a).(1)** **Culture of Safety**


 

***A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.***

**VI.A.1.a).(1).(a)** **The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.** **(Core)**

**VI.A.1.a).(2)** **Patient Safety Events**

***Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.***

**VI.A.1.a).(2).(a)** **Residents, fellows, faculty members, and other clinical staff members must:**

**VI.A.1.a).(2).(a).(i)** **know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and,** **(Core)**

**VI.A.1.a).(2).(a).(ii)** **be provided with summary information of their institution's patient safety reports.** **(Core)**

**VI.A.1.a).(2).(b)** **Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.** **(Core)**

**VI.A.1.a).(3)** **Quality Metrics**

***Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.***


 

**VI.A.1.a).(3).(a)** **Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.** (Core)

**VI.A.2.** **Supervision and Accountability**

**VI.A.2.a)** ***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.***

***Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.***

**VI.A.2.a).(1)** **Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.** (Core)

**VI.A.2.a).(1).(a)** **This information must be available to residents, faculty members, other members of the health care team, and patients.** (Core)

**Background and Intent: Each patient will have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.**

**VI.A.2.a).(2)** **The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.** (Core)

**Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of resident-patient interactions, training locations, and resident skills and abilities, even at the same level of the educational program. The degree of supervision for a resident is expected to evolve progressively as the resident gains more experience, even with the same patient condition or procedure. The level of supervision for each resident is commensurate with that resident's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables.**


 

**VI.A.2.b)** **Levels of Supervision**

**To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:**

**VI.A.2.b).(1)** **Direct Supervision:**

**VI.A.2.b).(1).(a)** **the supervising physician is physically present with the resident during the key portions of the patient interaction; or,**

**VI.A.2.b).(1).(a).(i)** **PGY-1 residents must initially be supervised directly, only as described in VI.A.2.b).(1).(a).** (Core)

VI.A.2.b).(1).(a).(i).(a) After the assessment of a PGY-1 resident's performance, the program may approve the resident's ability to be supervised indirectly. (Core)

Specialty-Specific Background and Intent: While on pediatric assignments, PGY-1 residents may not take "parent concern calls" from home but may make/take "parent concern calls" during their clinical and educational work hours in the hospital or from another clinical site where supervision is either direct or indirect with direct supervision immediately available.

**VI.A.2.b).(1).(b)** **the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.**

**VI.A.2.b).(2)** **Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.**

**VI.A.2.b).(3)** **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**

**VI.A.2.c)** **The program must define when physical presence of a supervising physician is required.** (Core)

**VI.A.2.d)** **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.** (Core)


 

**VI.A.2.d).(1)** **The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.** (Core)

**VI.A.2.d).(2)** **Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.** (Core)

**VI.A.2.d).(3)** **Senior residents or fellows should serve in a supervisory role to 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.A.2.e)** **Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).** (Core)

**VI.A.2.e).(1)** **Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.** (Outcome)

**Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.**

**VI.A.2.f)** **Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.** (Core)

## VI.B. Professionalism

**VI.B.1.** **Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients.** (Core)

**Background and Intent: This requirement emphasizes the professional responsibility of residents and faculty members to arrive for work adequately rested and ready to care for patients. It is also the responsibility of residents, faculty members, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies. This includes recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team, and the recognition that under**

**certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested practitioner.**

**VI.B.2.** **The learning objectives of the program must:**

**VI.B.2.a)** **be accomplished without excessive reliance on residents to fulfill non-physician obligations; (Core)**

**Background and Intent: Routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education.**

**VI.B.2.b)** **ensure manageable patient care responsibilities; and, (Core)**

VI.B.2.b).(1) Patient care responsibilities must be structured to support the well-being of the entire care team while supporting clinical, scholarly, personal, and professional development. (Core)

**Background and Intent: The Common Program Requirements do not define "manageable patient care responsibilities" as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.**

**VI.B.2.c)** **include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)**

**VI.B.3.** **The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)**

**Background and Intent: The accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data are the responsibility of the program leadership, residents, and faculty.**

**VI.B.4.** **Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted**

**to their care, including the ability to report unsafe conditions and safety events.** (Core)

**VI.B.5.** **Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff.** (Core)

**Background and Intent: Psychological safety is defined as an environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.**

**VI.B.6.** **Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.** (Core)

**VI.C.** **Well-Being**

***Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.***

***Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.***

**VI.C.1.** **The responsibility of the program, in partnership with the Sponsoring Institution, must include:**

**VI.C.1.a)** **attention to scheduling, work intensity, and work compression that impacts resident well-being;** (Core)

**VI.C.1.b)** **evaluating workplace safety data and addressing the safety of residents and faculty members;** (Core)

**Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after safety events.**

**VI.C.1.c)** **policies and programs that encourage optimal resident and faculty member well-being; and, (Core)**

**Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise. The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.**

**VI.C.1.c).(1)** **Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)**

**VI.C.1.d)** **education of residents and faculty members in:**

**VI.C.1.d).(1)** **identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)**

**VI.C.1.d).(2)** **recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)**

**VI.C.1.d).(3)** **access to appropriate tools for self-screening. (Core)**

**Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials to create systems for identification of burnout, depression, and substance use disorders. Materials and more information are available in Learn at ACGME (https://dl.acgme.org/pages/well-being-tools-resources).**

**Individuals experiencing burnout, depression, a substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions and may be concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the**

**program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness/well-being programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.**

**VI.C.1.e)** **providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.** (Core)

**Background and Intent: The intent of this requirement is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.**

**The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.**

**VI.C.2.** **There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities.** (Core)

**VI.C.2.a)** **The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care.** (Core)

**VI.C.2.b)** **These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work.** (Core)

**Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.**

**VI.D. Fatigue Mitigation**

**VI.D.1.** **Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes.** (Detail)

**Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice. It is expected that programs adopt fatigue mitigation**

**processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.**

**Strategies that may be used include but are not limited to strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.**

**VI.D.2.** **The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.** (Core)

**VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care**

**VI.E.1. Clinical Responsibilities**

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

VI.E.1.a) Residents must be ~~responsible for~~assigned an appropriate patient load. Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on residents for service obligations, which may jeopardize the educational experience. (Core)

**Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an environment that has safe patient care and a sense of resident well-being. It is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.**

Specialty-Specific Background and Intent: It is the responsibility of the program director, along with the core faculty members who oversee required experiences, to ensure that each resident has an appropriate workload that protects patient safety, resident well-being, and graduated educational opportunities. Programs are encouraged to use patient caps or other interventions to achieve these goals as appropriate for their care models and to create processes for real-time response and adaptation when clinical workload hinders patient safety, resident well-being, and educational opportunities.

**VI.E.2. Teamwork**

**Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system.** (Core)


 

VI.E.2.a) The program must provide educational experiences that allow residents to interact with and learn from other health care professionals, including physicians in other specialties, advanced practice practitioners, nurses, social workers, physical therapists, case managers, language interpreters, and dieticians, in order to achieve effective, interdisciplinary, and interprofessional team-based care. (Core)

**Background and Intent: Effective programs will have a structure that promotes safe, interprofessional, team-based care. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.**

Specialty-Specific Background and Intent: Family-centered bedside rounds are encouraged to foster interprofessional care inclusive of the pediatric patient and the patient's family. Programs will ensure that the roles and responsibilities of all team members are clearly defined, with attention to the interface between residents and advanced practice practitioners.

**VI.E.3. Transitions of Care**

**VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)**

**VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)**

**VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)**

**VI.F. Clinical Experience and Education**

***Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.***

**Background and Intent: The terms "clinical experience and education," "clinical and educational work," and "clinical and educational work hours" replace the terms "duty hours," "duty periods," and "duty." These terms are used in response to concerns that the previous use of the term "duty" in reference to number of hours worked may have led some to conclude that residents' duty to "clock out" on time superseded their duty to their patients.**

**VI.F.1. Maximum Hours of Clinical and Educational Work per Week**


 

**Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.** (Core)

**Background and Intent: Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing residents to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.**

***Work from Home***

**While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident's supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.**

**Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.**

**VI.F.2. Mandatory Time Free of Clinical Work and Education**

**VI.F.2.a) Residents should have eight hours off between scheduled clinical work and education periods.** (Detail)

**Background and Intent: There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This occurs within the context of the 80-hour and the one-day-off-in-seven requirements. While it is expected that resident schedules will be structured to ensure that residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain**


 

**beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.**

**VI.F.2.b)** **Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.** (Core)

**Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.**

**VI.F.2.c)** **Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.** (Core)

**Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some residents may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide residents with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes resident well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."**

**VI.F.3.** **Maximum Clinical Work and Education Period Length**

**VI.F.3.a)** **Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.** (Core)

**VI.F.3.a).(1)** **Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.** (Core)

**Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours**

**and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.**

**VI.F.4. Clinical and Educational Work Hour Exceptions**

**VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)**

**VI.F.4.b) These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)**

**Background and Intent: This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.**

**VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.**

The Review Committees for Internal Medicine and Pediatrics will not consider requests for exceptions to the 80-hour limit to the residents' work week.

**VI.F.5. Moonlighting**

**VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)**

**VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)**

**VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)**


 

**Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements).**

**VI.F.6. In-House Night Float**

**Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)**

VI.F.6.a) ~~Internal Medicine-Pediatrics residency programs must not average in-house call over a four-week period. (Core)~~

**VI.F.7. Maximum In-House On-Call Frequency**

**Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)**

**VI.F.8. At-Home Call**

**VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly 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 clinical work and education, when averaged over four weeks. (Core)**

**VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)**

**Background and Intent: As noted in VI.F.1., clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This acknowledges the often significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.**

**In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.**


 