The Review Committee for Internal Medicine will soon start the major revision of its Program Requirements, and invites program directors and other stakeholders in the internal medicine and graduate medical education community to review the current Program Requirements for Graduate Medical Education in Internal Medicine and provide recommendations for changes.

Unlike past revisions, the Review Committee requests that the community first review the report from a new, very different and thought-provoking process, and use the insights learned to guide comments on the requirements. This new process, scenario-based strategic planning, is a technique for managing uncertainty, risk, and opportunity. The intent with this technique is not to predict what the future will be and then build a master plan, but rather to ask what the future might hold and identify actions that can be taken today that are most likely to be valuable regardless of how the future turns out. The Review Committee hosted two scenario planning "Internal Medicine 2035" (IM2035) workshops in 2017 to rigorously and creatively think about what the specialty of medicine and the internist of the future could look like. The report from the two workshops contains key insights and themes.

Accordingly, this invitation for comments is two-fold:

- *First, review and provide the Review Committee feedback on the insights and themes from the IM2035 workshops* (link to Internal Medicine 2035 Executive Summary).

- *Second, while steeped in thinking about the future, review and provide the Review Committee with comments on which* **current specialty requirements** *should be edited or removed, and what new requirements should be introduced* (link to Current Internal Medicine Requirements within Proposed Common Program Requirements).

Use the GME 2035 Initial Comment Form to submit recommendations by July 1, 2018.

Please note that the *current* Program Requirements for Internal Medicine have been folded into the *proposed* Common Program Requirements, which have not yet been approved by the ACGME Board and are therefore not yet final. As such, when reviewing this document, comment *only* on the Internal Medicine-specific Requirements (indicated in blue font), *not on the proposed Common Program Requirements* (indicated in bold text).

On the behalf of ACGME and Review Committee for Internal Medicine, thank you in advance to the community for the thoughtful input on this new, innovative process for Program Requirement revision, and on the current Program Requirements.

Internal Medicine 2035 Executive Summary
May 2018

Overview

Every 10 years, Review Committees are required to review their specialty requirements to determine whether they need revision. The ACGME Board of Directors charged the Review Committee for Internal Medicine to pilot a new process for this required revision. This new process, scenario-based strategic planning, required the Committee and the internal medicine community to rigorously and creatively think about what the specialty will look like in the future (recognizing that the future is marked with significant uncertainty) prior to making its revisions.

What is scenario planning?

Scenario-based strategic planning is a technique by which organizations develop and test their readiness for the future using a range of alternative futures or scenarios. In this case, these scenarios are detailed, systematically-developed descriptions of operating environments that the US medical profession might face over the next 20-25 years or more. This is a technique for managing uncertainty, risk, and opportunity. It yields a strong strategic framework for understanding future needs and a practical basis for immediate action. The intent is not to predict what the future will be and then build a master plan, but rather to ask what the future might hold and identify actions that can be taken today that are most likely to be valuable regardless of how the future turns out. As a result, the technique relies far more on expert judgment and less on quantitative trend forecasts.

What has taken place so far?

In 2013, the Board of Directors engaged in its own scenario planning using four widely varied, plausible, internally consistent scenarios describing the range for the future context for health care delivery. The scenarios were:

- *Free Markets Unchained* (a world dominated by libertarian public policies)
- *BoomDoogle* (a world where Baby Boomers are in charge)
- *There's an App for That, Too?* (a world where most people's health is tracked via wearable/embeddable sensors)
- *Cloudburst* (a world where cyberattacks have disabled the Internet)

Those same scenarios were then used again during two Internal Medicine 2035 (IM2035) workshops in 2017.

- 52 participants representing the internal medicine community, other specialties (family medicine, pediatrics, and surgery), and related fields, including nursing, population health, simulation, informatics, and artificial intelligence attended a workshop in June. The focus of that workshop was to provide the Review Committee with insight regarding *what the practice of internal medicine could look like in each of the four different scenarios*.

- 20 of those participants joined the 24 members of the Review Committee at a second workshop in September, which focused on providing feedback on *what is necessary for preparing the internist and the specialty for the challenges and opportunities of the future.* (Appendix A lists all who participated in the June and September workshops).

Below is a summary of the results of those workshops—general insights about the practice of medicine in the future, followed by key insights about the internist in 2035 that worked well and were viable regardless of scenario, and finally recommendations for what residency programs should do to prepare the internal medicine resident to practice in 2035. The Review Committee will use this information as it considers the current Program Requirements and begins the major revision process.

General insights about the practice of medicine in the future

- The "commoditization" of health care services will continue and accelerate. It will include increasingly standardized (price-driven) services when the patient first seeks care, and shifting responsibilities and risks among health professionals in interprofessional team-based care. It will also affect former specialized procedures that can be rigorously standardized or automated.

- Economic and technology factors are likely to blur distinct responsibilities and delineations between generalists and subspecialists, as well as among members of interprofessional teams.

- There will be pressure on the vocation of medicine to de-professionalize in an effort to increase efficiency and practice value-based medicine.

- There will be a need for increased flexibility and process efficiency across the continuum of medical education, especially within graduate medical education.

- Patients will be shouldering more risk in terms of cost sharing, but also in terms of increasing personal responsibility for following therapy guidelines, and in some cases for lifestyle choices.

- Education, generally, will become modularized (competency-based rather than time-based) and divided into more discrete educational units that can be individualized, easily completed and updated.

- Significant disparities (from poverty, geography, technology, culture) in access to care will remain unresolved no matter the strength of the economy or the depth of the social contract.

- Information and knowledge networks, supported by artificial intelligence (AI), will disrupt and redefine patient care practice and business models. The ubiquity of information from competing sources will raise significant challenges to the verification and veracity of information.

- The combination of "big data" and AI will have a profound effect on how expertise is employed across many professions. Since automated data and analysis systems will

provide answers to many issues, the true expert will be called upon only to solve the most complex issues, or those requiring judgment, experience, or fine distinctions of ethics after other approaches have failed.

- The ubiquity of data from wearable/embedded sensors will accelerate the social and political tendencies to "medicalize" societal problems (e.g., job stress, lifestyle choices) and exacerbate the tendency for medicine to be subject to public policy interventions.

Key insights about the internist in 2035

- The health care system will become less reactive, more proactive, and concerned with prevention in terms of population health management and chronic and acute care for individual patients.
    - Non-emergency patients, upon entry into the health system, will often receive algorithm-based treatment (either by a medical information system that might include embedded sensors or by non-physician care team members).
    - The concept of "entry" into the medical system is a misnomer, since it implies an old-fashioned "batch" process, like office visits. Significant portions of the population will always be in the health care system in the sense that their wearable/embedded sensors are tracking their health, communicating with central data/diagnostic systems, and possibly providing established therapies automatically. Others will visit "big box" retail outlets or clinics for quick sensor checks. However, some patients will require expert care that goes beyond the capabilities of the algorithms and protocols. This high-value care will be delivered collaboratively by a "master clinician" within an interprofessional team.
- Some internists will pursue careers as "Master Clinicians."
    - The patient's first encounter with the health care system will rarely be with the Master Clinician. Typically, the Master Clinician will be the complex problem solver who sees the patient after initial screening and treatment attempts from automated systems or non-physician care team members have failed.
    - Master Clinicians will be "enhanced general internists" who have gained significant subspecialty education in residency and maintained or developed those skills through lifelong learning.
    - The Master Clinician's medical knowledge will be supplemented, enhanced, and validated by real-time AI support systems. Deep medical knowledge will become less of a defining characteristic for the Master Clinician than clinical skills, breadth of clinical experience, and problem-solving ability.
    - Along with relevant patient care and medical knowledge competencies, Master Clinicians will need to be competent in the following areas:
        - Leadership and collaborative leadership
        - Team dynamics and change management
        - Business of medicine

- Population and patient data applications
- Data management science
- Communication skills that include working with and explaining complex data
- Health care ethics
- Emotional intelligence
- Personal and team well-being
- Cost-conscious care

- Internists (Master Clinicians and subspecialists) will practice in either the inpatient or ambulatory setting within interprofessional care teams that have breadth of expertise beyond medicine, while specific patient care teams are dynamic and responsive to patient needs.

- Internists will deliver care regularly under conditions of no physical contact with patients.

- Internists will deliver patient-centered care in a system driven by economic pressures and algorithm-derived, protocol-driven diagnoses. This will include understanding patient needs within a managed population health context, aligning team expertise to patient needs, understanding the social determinants of health, and practicing value-based care delivery by evaluating therapies and associated costs.

- Internists will undergo continuous faculty development, particularly as generalist and subspecialty distinctions and responsibilities shift, and AI-based knowledge systems support immediate access to medical information and diagnoses. Internists in hospitals and community clinics will need to educate each other and their residents.

What residency programs should do to prepare internal medicine residents to practice in 2035

- The Program Requirements will need to be flexible to allow programs to individualize residents' experience, depending on interests and post-residency plans.

    - Requirements and programs will need to ensure that those residents who want more subspecialty experiences can have it. Residents will have more subspecialty experiences as the delineation between general medicine and subspecialty education and training blurs, general internists take on some current subspecialty responsibilities, AI-based knowledge systems support immediate access to medical information, and residents pursue Master Clinician positions.

    - Requirements and programs will need to allow residents interested in crossing medicine with traditionally non-clinical/non-medicine areas (like public policy, business administration, and law) the option of doing so.

    - Requirements and programs will need to allow residents interested primarily in either an inpatient/hospital or an outpatient/ambulatory setting to have significant portions of their education occur in that setting during residency.

    - New subspecialties will develop, some in response to technological advancements (bio-sensor stress or tech-related anxieties/disorders), others in response to global changes (climate-change medicine), and programs will need to allow residents to pursue such options.

- Programs will need to ensure that internal medicine residents can extract the maximum amount of learning from all clinical experiences knowing that internists will typically have little regular contact with patients whose care needs are "within the protocols." Residents will need to learn an entirely new approach to medicine and to maintaining their skills in a system in which they see fewer patients, but in which those they do see are far sicker or present with problems that are more complex. They will need to develop superb diagnostic and clinical skills usually developed through breadth of experience in a system designed to keep patients away from them.

- Programs will need to prepare residents to become well-informed consumers of data management science and AI-based analyses and decisions. Residents will need to develop expertise with advanced data management systems and be able to integrate systems-derived decisions and diagnoses into team-based clinical care, but also to critically evaluate the decisions and be able to identify those that are wrong or misleading.

- Programs will need to ensure that residents have educational experiences and develop competency with the physician literacies mentioned earlier. Specifically:

    - Leadership and collaborative leadership training
    - Team dynamics and change management
    - Business of medicine
    - Population and patient data applications
    - Data management science
    - Effective communication skills that include working with/explaining complex data
    - Health care ethics
    - Emotional intelligence
    - Personal and team well-being
    - Cost-conscious care

- Programs will need to teach residents that interprofessional, team-based care is the foundation of care delivery, and that internists are the interprofessional team's complex problem solvers, sometimes leading the team, sometimes engaging in collaborative leadership opportunities.

- Programs will need to emphasize population health, particularly in the context of prevention.

- Programs will need to reinforce the importance of patient-centered care in the face of economic pressures, protocol-driven diagnoses (both algorithm-based and non-physician), and situations where physicians have limited or no physical contact with patients. The patient-doctor relationship of the future will be more virtual than actual, and residents will need to develop new communication competencies.

ACGME

Current Internal Medicine Requirements within Proposed Common Program Requirements ACGME

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.

Note: Review Committees may further specify only where indicated by "The Review Committee may/must further specify."

Introduction

Int.A. ***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, professionalism, and scholarship.***

Graduate medical education transforms medical students into physician scholars who care for the patient, 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, and empathy required for autonomous practice. Graduate medical education results in the development of physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of all members of the community. Graduate medical education values the strength that a diverse group of physicians brings to medical care.

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. Internal medicine is a discipline encompassing the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age, during health and all stages of illness.

Intrinsic to the discipline are scientific knowledge, the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.

Int.C. An accredited residency program in internal medicine must provide 36 months of supervised graduate medical education. (Core) [Moved from IV.A.1.a)]

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. The Sponsoring Institution has the primary purpose of providing educational programs and may provide health care services.

When the Sponsoring Institution is not a rotation site for the program, the major 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, a consortium (including OPTIs), 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.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) **There must be a director who is accountable for resident education at each participating site.** (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. The requirements under I.B.3. are intended to ensure that this will be the case.

Suggested elements to be considered in PLAs will be found in the Program Director Guide.

I.C. **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 workforce inclusive of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community.** (Core)

Background and Intent: It is expected that the Sponsoring Institution will have developed policies and procedures related to recruitment and retention of underrepresented minorities in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.2.a).(5).(c).

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)

[The Review Committee must further specify]

I.D.1.a) The sponsoring institution must establish the internal medicine residency within a department of internal medicine. (Detail) [Moved from I.A.1.]

I.D.1.b) The Sponsoring Institution must provide the broad range of facilities and clinical support services required to provide comprehensive care of adult patients. (Core) [Moved from II.D.1.]

I.D.1.c) Residents must have clinical experiences in efficient, effective ambulatory and inpatient care settings. (Core) [Moved from II.D.1.]

I.D.1.d) The sponsoring institution and participating sites must provide access to an electronic health record. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation; (Core) [Moved from I.A.2.g)]

I.D.1.e) The sponsoring institution and participating sites must provide residents with access to training using simulation. (Detail) [Moved from I.A.2.f)]

I.D.1.f) Additional services must include those for: cardiac catheterization, bronchoscopy, gastrointestinal endoscopy, noninvasive cardiology studies, pulmonary function studies, hemodialysis, and imaging studies, including radionuclide, ultrasound, fluoroscopy, angiography, computerized tomography, and magnetic resonance imaging. (Detail) [Moved from II.D.2.]

I.D.1.g) Adequate clinical and teaching space must be available, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids, and office space for teaching staff. (Core) [Moved from II.D.3.]

I.D.1.h) The program director must supervise any internal medical subspecialty training programs sponsored by the institution and linked to their core program to ensure compliance with ACGME accreditation standards. (Core) [Moved from II.A.4.t]

I.D.1.i) ~~[The sponsoring institution and participating site must provide the resources to ensure the implementation of] inpatient and outpatient systems to prevent residents from performing routine clerical functions, such as scheduling tests and appointments, and retrieving records and letters;~~ ~~(Core)~~ (Delete current I.A.2.h)(1), superseded by CPR VI.B.2.b)

I.D.1.j) Patient Population [Moved from II.D.5]

I.D.1.j).(1) The patient population must have a variety of clinical problems and stages of disease. (Core) [Moved from II.D.5.a)]

I.D.1.j).(2) There must be patients of both sexes, with a broad age range, including geriatric patients. (Core) [Moved from II.D.5.b)]

I.D.1.k) There must be services available from other health care professionals such as nurses, social workers, case managers, language interpreters, dieticians, etc. to assist with patient care. (Detail) [Moved from II.D.6.]

I.D.1.l) Consultations from other clinical services must 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) [Moved from II.D.7.]

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: (Core)

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.

I.D.2.c) **clean and private facilities for lactation that have refrigeration capabilities and that are in close proximity to the residents' clinical responsibilities; and, (Core)**

Background and Intent: Breastfeeding is important for the developing infant, providing the best nutritional support while decreasing illness. 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.d).(1).

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

I.D.2.e) ~~When residents are assigned duty in the hospital, the institution must provide them with:~~[Delete current PR II.D.4., superseded by CPR I.D.2. and I.D.2.a) & b)]

~~I.D.2.e).(1) on-call facilities that are convenient and that afford privacy, safety, and a restful environment with a secure space for their belongings, and (Detail) :~~[Delete current PR II.D.4.a), superseded by CPR I.D.2. and I.D.2.a) & b)]

~~I.D.2.e).(2) sleeping rooms, lounge, and food facilities. (Detail) :~~[Delete current PR II.D.4.b), superseded by CPR I.D.2. and I.D.2.a) & b)]

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. **The program's educational and clinical resources must be adequate to support the number of residents appointed to the program.** (Core)

[The Review Committee may further specify]

I.F. **The presence of other learners and other care providers, including, but not limited to, residents from other specialties, subspecialty fellows, and advanced practice care providers, must not interfere with the appointed residents' education.** (Core)

I.F.1. **The program must report the presence of other learners to the DIO and Graduate Medical Education Committee (GMEC) in accordance with Sponsoring Institution guidelines.** (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)

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 made responsible for the residency. This individual will have dedicated time for the leadership of the residency, and it is this individual's responsibility to communicate with the residents, faculty members, DIO, GMEC, and the ACGME. The program director's nomination is reviewed and approved by the GMEC. Final appointment of program directors resides with the Review Committee.

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

[The Review Committee may further specify]

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. **At a minimum, the program director must be provided with the salary support required to devote 20 percent FTE (at least eight hours) per week of non-clinical time to the administration of the program.** (Core)

[The Review Committee may further specify]

II.A.2.a) The program director must dedicate no less than 50% (at least 20 hours per week) of his or her professional effort to the administrative and educational activities of the internal medicine educational program and receive institutional support for this time. (Detail) [Moved from II.A.4.q)]

II.A.2.b) ~~The sponsoring institution and participating sites must provide at least 50% salary support (at least 20 hours per week) for the program director.~~ [Deleted I.A.2.a, because redundant with above]

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)

II.A.3.a).(1) ~~which includes at least five years of participation as an active faculty member in an ACGME-accredited internal medicine residency program.~~ [Deleted current II.A.3.a)(1) superseded by CPR II.A.3.a) above]

II.A.3.a).(2) ~~at least three years of graduate medical education administrative experience prior to appointment.~~ (Detail) [Delete current II.A.3.a)(2) superseded by CPR II.A.3.a) above]

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 by the American Osteopathic Board of** Internal Medicine (AOBIM), **or specialty qualifications that are acceptable to the Review Committee;** (Core)

[The Review Committee may further specify acceptable specialty qualifications]

II.A.3.b).(1) The Review Committee only accepts current Board certification in internal medicine. (Core)

{RC Comment: The RC-IM plans to modify this requirement to clarify that only ABIM and AOBIM are acceptable forms of certification. This is not redundant with the Common Program Requirement (CPR) in lines 233-236 as it clarifies that only ABIM or AOBIM certification is acceptable—there are no other "specialty qualifications that are acceptable to the Review Committee."}

II.A.3.c) **must include current medical licensure and appropriate medical staff appointment; and,** (Core)

II.A.3.d) **must include ongoing clinical activity.** (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.

[The Review Committee may further specify additional program director qualifications]

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for administration, operations, teaching, scholarly activity, 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 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 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) **develop and oversee a process to evaluate candidates prior to appointment as program faculty members and at least annually thereafter, as outlined in V.B.; (Core)**

II.A.4.a).(5) **have the authority to appoint program faculty members at all sites; (Core)**

II.A.4.a).(6) **have the authority to remove program faculty members from participation in the educational program at all sites; (Core)**

II.A.4.a).(7) **have the authority to remove residents from supervising interactions 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.

II.A.4.a).(8) **submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)**

II.A.4.a).(9) **provide applicants with information related to eligibility for the relevant specialty Board examination(s); (Core)**

II.A.4.a).(10) **provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)**

II.A.4.a).(11) **ensure the program's compliance with the Sponsoring Institution's policies and procedures on probation, dismissal, grievance, and due process; (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).(12) **ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)**

II.A.4.a).(12).(a) **The program, in partnership with its Sponsoring Institution, must not require residents to sign a non-competition guarantee or restrictive covenant. (Core)**

II.A.4.a).(13) **document and provide upon request verification of residency education for all residents within 30 days of program completion; (Core)**

II.A.4.a).(14) **document and provide upon request summative evaluation of residency education for all residents, and; (Core)**

Background and Intent: Primary verification of graduate medical education training 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).(15)**~~ **obtain review and approval of the Sponsoring Institution's DIO before submitting information or requests to the ACGME, as required in the Institutional**

Requirements and outlined in the Program Director Guide. (Core)

~~II.A.4.a).(16)~~ ~~monitor resident stress, including mental or emotional conditions inhibiting performance or learning, and drug- or alcohol-related dysfunction.~~ (Core) [Delete current II.A.4.p), further specification not permitted]

~~II.A.4.a).(16).(a)~~ ~~Both the program director and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents.~~ (Detail) [Delete current II.A.4.p)(1), further specification not permitted]

~~II.A.4.a).(16).(b)~~ ~~Situations that demand excessive service or that consistently produce undesirable stress on residents must be evaluated and modified;~~ (Detail) [Delete current II.A.4.p)(2), further specification not permitted]

~~II.A.4.a).(17)~~ ~~be available and accessible to residents at the primary teaching site(s);~~ (Detail) [Delete current II.A.4.r), further specification not permitted]

~~II.A.4.a).(18)~~ ~~oversee development of an effective resident advising program;~~ (Detail) [Delete current II.A.4.s), further specification not permitted]

~~II.A.4.a).(19)~~ ~~have supervisory authority over all educational tracks in the internal medicine residency program;~~ (Detail) [Delete current II.A.4.u), further specification not permitted]

~~II.A.4.a).(20)~~ ~~conduct the internal medicine component of special educational tracks under the auspices of the Department of Internal Medicine; and,~~ (Detail) [Delete current II.A.4.v), further specification not permitted]

~~II.A.4.a).(21)~~ ~~ensure that the residency does not place excessive reliance on residents for service as opposed to education;~~ (Core) [Delete current II.A.4.w), further specification not permitted]

~~II.A.4.a).(22)~~ ~~participate in academic societies and in educational programs designed to enhance his or her educational and administrative skills.~~ (Detail) [Delete current II.A.4.x), further specification not permitted]

II.B. Faculty

Faculty 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, 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. 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 or salary support.

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

[The Review Committee may further specify]

II.B.1.a) Faculty with credentials appropriate to the care setting must supervise all clinical experiences. (Core) [Moved from IV.A.2.c).(1)]

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

II.B.2.a) **demonstrate commitment to the delivery of safe, 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.b) **demonstrate a strong interest in the education of residents;** (Core)

II.B.2.c) **devote 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; and,** (Core)

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

Background and Intent: Formal 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. Formal 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 associated with defined learning objectives.

II.B.2.e).(1) **as educators;** (Core)

II.B.2.e).(2) **in quality improvement and patient safety;** (Core)

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

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

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.

[The Review Committee may further specify additional faculty responsibilities]

II.B.2.f) provide advising for residents in the areas of educational goal-setting, career planning, patient care, and scholarship; (Detail) [Moved from II.B.1.c)]

II.B.2.g) meet professional standards of behavior. (Core) [Moved from II.B.1.d)]

II.B.3. Faculty Qualifications

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

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

[The Review Committee may further specify additional qualifications]

II.B.3.b) **Non-physician faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments.** (Core)

[The Review Committee may further specify]

II.B.3.b).(1) **Any non-physician faculty members who interact with residents must be designated by the program director.** (Core)

[The Review Committee may further specify]

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of the residents by the non-physician educators enables the resident to better manage patient care and provides valuable advancement of the knowledge by the resident. Furthermore, other individuals contribute to the education of the resident 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.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 and in assessing residents' progress toward achievement of competence in 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, including completion of the annual ACGME Faculty Survey.

II.B.4.a) **At a minimum, the core faculty must include the program faculty who are members of the Clinical Competency Committee and Program Evaluation Committee.** (Core)

II.B.4.a).(1) **Any additional core faculty members must be designated by the program director.** (Core)

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

[The Review Committee may specify the minimum number of core faculty and/or the core faculty-resident ratio]

II.B.4.c) The sponsoring institution and participating sites must provide support for core faculty based on program size according to the following faculty to resident ratio: (Core) [Moved from I.A.2.d)]

Residents	Core Faculty
<60	4
60-75	5
76-90	6
91-105	7
106-120	8
121-135	9
136-150	10
151-165	11
166-180	12
>180	13

{RC Comment: The RC plans to insert the word “physician” after the word “core” in line 502 to clarify that the minimum numbers in the table refer to *physician* faculty. When the word *core* appeared in the internal medicine requirements in the past, it was clear that it referred to *physician* faculty. However, now that the word appears in the CPRs and can include *physicians* and *non-physicians*, the RC feels it is important to clarify that this requirement refers to core *physician* faculty.}

II.B.4.d) ~~The residency program must include institutionally based core faculty in addition to the program director and associate program directors. The core faculty are the expert competency evaluators who work closely with the program director and associate program directors, who assist in developing and implementing the evaluation system, and who teach and advise residents.~~ ~~(Core)~~ [Delete current II.C.3, superseded by CPR, and further specification not permitted.]

II.B.4.e) ~~The core faculty must:~~

II.B.4.e).(1) ~~be ABIM-certified internists who are clinically active, either in direct patient care or in the supervision of patient care;~~ ~~(Core)~~ [Delete current II.C.3.a), further specification not permitted]

II.B.4.e).(2) ~~dedicate an average of at least 15 hours per individual per week throughout the year to residency training; (Core)~~ [Delete current II.C.3.b), further specification not permitted]

II.B.4.e).(3) ~~be specifically trained in the evaluation and assessment of the ACGME competencies; (Detail)~~ [Delete current II.C.3.c), further specification not permitted]

II.B.4.e).(4) ~~spend significant time in the evaluation of residents including the direct observation of residents with patients; and, (Detail)~~ [Delete current II.C.3.d), further specification not permitted]

II.B.4.e).(5) ~~advise residents with respect to their career and educational goals. (Detail)~~ [Delete current II.C.3.e), further specification not permitted]

II.C. Program Coordinator

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

II.C.2. At a minimum, the program coordinator must be supported at 50% FTE (at least 20 hours per week) for administrative time. (Core)

[The Review Committee may further specify]

II.C.3. ~~The sponsoring institution and participating sites must provide support for program administrator(s) and other support personnel required for operation of the program; (Core)~~ [Delete current I.A.2.e), superseded by CPR II.C.2.]

Background and Intent: Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with 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 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. Program coordinators are expected to develop unique knowledge of the ACGME and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, 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.

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)

[The Review Committee may further specify]

II.D.1. Associate Program Directors

Associate program directors (APDs) are faculty who assist the program director in the administrative and clinical oversight of the educational program. [Section Moved from II.C.1.]

II.D.1.d) The sponsoring institution and participating sites must: provide associate program directors (APD) based on program size. At a minimum, APDs are required at resident complements of 24 or greater according to the following parameters: (Core) [Moved from I.A.2.b)]

Residents	APDs
24-40	1
41-79	2
80-119	3
120-159	4
>159	5

{RC Comment: the RC plans to insert the word “physician” before “faculty” (line 535) to clarify that the minimum numbers in the table above refers to *physician* faculty. In the past, the requirements only defined expectations for *physician* faculty. Now that the new CPRs define expectations for *physicia*n and *non-physician* faculty, the RC would like to insert the word *physician* to clarify that APDs must be *physician* faculty.}

II.D.1.e) The sponsoring institution and participating sites must provide 20 hours per week salary support for each associate program director required to meet these program requirements. (Detail) [Moved from I.A.2.c)]

II.D.1.f) Qualifications of the associate program directors are as follows:

II.D.1.f).(1) must be clinicians with broad knowledge of, experience with, and commitment to internal medicine as a discipline, patient centered care, and to the generalist training of residents, and (Detail)

II.D.1.f).(2) must hold current certification from the American Board of Internal Medicine (ABIM) in either internal medicine or a subspecialty. (Core)
{RC Comment: The RC plans to insert the words “or AOBIM” after “ABIM” (in line 559) to reflect the new overarching CPR that recognizes AOA certification and to clarify that only those forms of certification are acceptable. The RC considers this an editorial change.}

II.D.1.g) Responsibilities for associate program directors are as follows:

II.D.1.g).(1) must dedicate an average of at least 20 hours per week to the administrative and educational aspects of the educational program, as delegated by the program director, and receive institutional support for this time; (Core)

II.D.1.g).(2) must report directly to the program director; and, (Detail)

II.D.1.g).(3) must participate in academic societies and in educational programs designed to enhance their educational and administrative skills. (Detail)

II.D.2. Subspecialty Education Coordinators [Section Moved from II.C.2.]

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

{RC Comment: the RC plans to insert the word “physician” before the word “Subspecialty” (line 588) to clarify that its current requirement refers to *physician* faculty. In the past, the requirements only defined expectations for the *physician* faculty. Now that the new CPRs define expectations for *physician* and *non-physician* faculty, the RC will insert the word *physician* to clarify RC what it has always expected, that SECs must be *physician* faculty.}

II.D.2.d) The Subspecialty Education Coordinator must be:

II.D.2.d).(1) currently certified in the subspecialty by the ABIM, and (Core)

II.D.2.d).(2) accountable to the program director for coordination of the residents’ subspecialty educational experiences in order to accomplish the goals and objectives in the subspecialty. (N.B.: Core Faculty may also serve as Subspecialty Education Coordinators.) (Detail)

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) **holds a currently-valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)**

III.A.1.b).(2) **holds 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, 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 after acceptance but prior to matriculation. (Core)**

[The Review Committee may further specify prerequisite postgraduate clinical education]

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.A.3. **A physician who has completed a residency program that was not accredited by ACGME, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-**

accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

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

[The Review Committee may further specify]

III.B.1. A program must have a minimum of 15 residents enrolled and participating in the training program at all times. (Detail) [Moved from III.B.2.]

Background and Intent: Temporary complement increases of less than eight weeks are automatically approved by the Review Committee for programs with a status of Continued Accreditation. If residents are not full-time with the program, the resident complement should reflect the FTE.

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 after acceptance, but prior to matriculation. (Core)

[The Review Committee may further specify]

III.C.1. A resident who has satisfactorily completed a preliminary training year should not be appointed to additional years as a preliminary resident. (Detail) [Moved from II.C.3.]

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.

In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and specialty-specific Program Requirements, it is recognized that within this framework, 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. **The curriculum must contain the following educational components:** (Core)

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; (Core)**

IV.A.1.a) **The program's aims must be made available to program applicants, residents, and faculty members. (Core)**

IV.A.1.b) **A program with additional ACGME recognition status must demonstrate how requirements associated with such recognition are integrated into the curriculum. (Core)**

IV.A.2. **competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to practice without supervision. These must be distributed, reviewed, and available to residents and faculty members; (Core)**

IV.A.2.a) ~~For each rotation or major learning experience, the competency-based goals and objectives (the written curriculum) must contain the educational plan, goals and objectives, educational methods, and the evaluation tools that the program will use to assess the resident's competence.~~ (Detail) [Delete current IV.A.2.a), superseded by CPRs IV.A.1. – IV.A.2.]

Background and Intent: The trajectory to autonomous practice is documented by Milestones evaluation. The Milestones detail the progress of a resident in attaining skill in each competency domain. They are developed by each specialty group and allow evaluation based on observable behaviors. Milestones are considered formative and should be used to identify learning needs. This 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. **advancement in the residents' knowledge of the basic principles of research, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care.** (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, including sub-competencies associated with additional ACGME recognition status, into the curriculum:** (Core)

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)

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 provider. 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.a).(1).(c) **respect for patient privacy and autonomy;** (Core)

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

IV.B.1.a).(1).(e) **respect and responsiveness to a broad patient population, including all manifestations of human diversity;** (Core)

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

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

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. (See the Institute of Medicine [IOM]'s *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001 and Berwick D, Nolan T, Whittington J. *The Triple Aim: care, cost, and quality. Health Affairs.* 2008;27(3):759-769.). 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.

These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.

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

[The Review Committee must further specify]

IV.B.1.b).(1).(a) Residents are expected to demonstrate the ability to manage patients:

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

IV.B.1.b).(1).(a).(ii) in the prevention, counseling, detection, and diagnosis and treatment of gender-specific diseases; (Outcome)

IV.B.1.b).(1).(a).(iii) in a variety of health care settings to include the inpatient ward, the critical care units, the emergency setting and the ambulatory setting; (Outcome)

IV.B.1.b).(1).(a).(iv) across the spectrum of clinical disorders seen in the practice of general internal medicine including the subspecialties of internal medicine and non-internal medicine specialties in both inpatient and ambulatory settings; (Outcome)

IV.B.1.b).(1).(a).(v) using clinical skills of interviewing and physical examination; and, (Outcome)

IV.B.1.b).(1).(a).(vi) by caring for a sufficient number of undifferentiated acutely and severely ill patients. (Outcome)

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)**

[The Review Committee may further specify]

IV.B.1.b).(2).(a) Residents are expected to demonstrate the ability to manage patients:

IV.B.1.b).(2).(a).(i) using the laboratory and imaging techniques appropriately; and, (Outcome)

IV.B.1.b).(2).(a).(ii) by demonstrating competence in the performance of procedures mandated by the ABIM. (Outcome)

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

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

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

[The Review Committee must further specify]

IV.B.1.c).(1) Residents are expected to demonstrate a level of expertise in the knowledge of those areas appropriate for an internal medicine specialist, specifically: (Outcome)

IV.B.1.c).(1).(a) knowledge of the broad spectrum of clinical disorders seen in the practice of general internal medicine; and, (Outcome)

IV.B.1.c).(1).(b) knowledge of the core content of general internal medicine which includes the internal medicine subspecialties, non-internal medicine specialties, and relevant non-clinical topics at a level sufficient to practice internal medicine. (Outcome)

IV.B.1.c).(2) Residents are expected to demonstrate sufficient knowledge to:

IV.B.1.c).(2).(a) evaluate patients with an undiagnosed and undifferentiated presentation; (Outcome)

IV.B.1.c).(2).(b) treat medical conditions commonly managed by internists; (Outcome)

IV.B.1.c).(2).(c) provide basic preventive care;(Outcome)

IV.B.1.c).(2).(d) interpret basic clinical tests and images; (Outcome)

IV.B.1.c).(2).(e) recognize and provide initial management of emergency medical problems; (Outcome))

IV.B.1.c).(2).(f) use common pharmacotherapy; and, (Outcome)

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

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)

Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

The intention of this Competency is to help a physician develop the habits of mind required to continuously pursue quality improvement, well past the completion of residency.

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, and implementing changes with the goal of practice improvement; (Core)

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

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

IV.B.1.d).(1).(g) using information technology to optimize learning. (Core)

[The Review Committee may further specify by adding to the list of sub-competencies]

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, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (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, families, students, 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 medical records, if applicable. (Core)

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

[The Review Committee may further specify by adding to the list of sub-competencies]

Background and Intent: When there are no more medications or interventions that can achieve a patient's goals or provide meaningful improvements in quality or length of life, a discussion about the patient's goals, values, and choices surrounding the end of life is one of the most important conversations that can occur. Residents must learn to participate effectively and compassionately in these meaningful human interactions, for the sake of their patients and themselves.

Programs may teach this skill through direct clinical experience, simulation, or other means of active learning.

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 social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. **(Core)**

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)**

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. Examples might include attention to hand hygiene, timely completion of medical records, etc.

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) **working in interprofessional teams to enhance patient safety and improve patient care quality; (Core)**

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

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

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

IV.B.1.f).(1).(h) work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients including the transition of care between settings; and, (Outcome) [Moved from IV.A.5.f).(7)]

IV.B.1.f).(1).(i) recognize and function effectively in high-quality care systems. (Outcome) [Moved from IV.A.5.f).(8)]

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

[The Review Committee may further specify by adding to the list of sub-competencies]

IV.C. Curriculum Organization and Resident Experiences

IV.C.1. **The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. (Core)**

[The Review Committee may further specify]

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.

[The Review Committee may specify required didactic and clinical experiences]

IV.C.2. Residency training is primarily an educational experience in patient-centered care. The educational efforts of faculty and residents should enhance the quality of patient care, and the education of the residents. At least 1/3 of the residency training must occur in the ambulatory setting and at least 1/3 must occur in the inpatient setting. Emergency medicine may count for no more than two weeks toward the required 1/3 ambulatory time. (Detail)

IV.C.3. The curriculum must ensure that each resident has sufficient clinical exposure to the diagnostic and therapeutic methods of each of the recognized internal medicine subspecialties. (Core)

IV.C.4. Educational venues and strategies

IV.C.5. ~~The sponsoring institution and participating sites must provide the resources to ensure the implementation of the following:~~

IV.C.6. Residents' service responsibilities must be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility. (N.B.: Teaching Service is defined as those patients for whom internal medicine residents [PGY 1, 2, or 3] routinely provide care). (Core) [Moved from I.A.2.h).(2)]

IV.C.6.a) Residents must not be assigned more than two months of night float during any year of training, or more than four months of night float over the three years of residency training. Residents must not be assigned to more than one month of consecutive night float rotation. (Core) [Moved from I.A.2.h).(3)]

IV.C.6.b) Residents should not be required to relate to an excessive number of physicians of record. (Core) [Moved from I.A.2.h).(4)]

IV.C.6.c) Residents from other specialties must not supervise internal medicine residents on any internal medicine inpatient rotation. (Core) [Moved from I.A.2.h).(5)]

IV.C.6.d) On inpatient rotations: [Moved from I.A.2.h)(6)(a-j)]

IV.C.6.d).(1) a first-year resident must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services; (Core)

IV.C.6.d).(2) a first-year resident must not be assigned more than eight new patients in a 48-hour period; (Core)

IV.C.6.d).(2).(a) a first-year resident must not be responsible for the ongoing care of more than 10 patients; (Core)

IV.C.6.d).(2).(b) when supervising more than one first-year resident, the supervising resident must not be responsible for

the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48-hour period; (Core)

IV.C.6.d).(2).(c) when supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients; (Core)

IV.C.6.d).(2).(d) when supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients; (Core)

IV.C.6.d).(2).(e) residents must write all orders for patients under their care, with appropriate supervision by the attending physician. In those unusual circumstances when an attending physician or subspecialty resident writes an order on a resident's patient, the attending or subspecialty resident must communicate his or her action to the resident in a timely manner; (Core)

IV.C.6.d).(2).(f) second- or third-year internal medicine residents or other appropriate supervisory physicians (e.g., subspecialty residents or attendings) with documented experience appropriate to the acuity, complexity, and severity of patient illness must be available at all times on site to supervise first-year residents; (Core)

IV.C.6.d).(2).(g) each physician of record has the responsibility to make management rounds on his or her patients and to communicate effectively with the residents participating in the care of these patients at a frequency appropriate to the changing care needs of the patients; (Core)

IV.C.6.d).(2).(h) total required transplant rotations in dedicated units should not exceed one month in three years. (Detail)

IV.C.6.d).(3) Experiences must include required critical care rotations (e.g., medical or respiratory intensive care units, cardiac care units). (Core) [Moved from IV.A.2.c)(1)(a)]

IV.C.6.d).(3).(a) These experiences cannot be fewer than three months and more than six months over the 36 months of training. (Detail) [Moved from IV.A.2.c)(1)(a)]

IV.C.6.d).(4) Experience must include exposure to each of the internal medicine subspecialties and neurology. (Core) [Moved from IV.A.2.c).(1).(b)]

IV.C.6.d).(5) Experience must include an assignment in geriatric medicine. (Core) [Moved from IV.A.2.c)(1)(c)]

IV.C.6.d).(6) Experience must include opportunities for experience in psychiatry, allergy/immunology, dermatology, medical ophthalmology, office gynecology, otorhinolaryngology, non-operative orthopedics, palliative medicine, sleep medicine, and rehabilitation medicine. (Detail) [Moved from IV.A.2.c)(1)(d)]

IV.C.6.d).(7) Experience must include opportunities to demonstrate competence in the performance of procedures listed by the ABIM as requiring only knowledge and interpretation; (Detail) [Moved from IV.A.2.c)(1)(e)]

IV.C.6.d).(8) Experience must include clinical experiences in outpatient chronic disease management, preventive health, patient counseling, and common acute ambulatory problems. (Core) [Moved from IV.A.2.c)(1)(f)]

IV.C.6.d).(9) Experiences must include a longitudinal continuity experience in which residents develop a continuous, long-term therapeutic relationship with a panel of general internal medicine patients. (Core) [Moved from IV.A.2.c).(1).(g)]

IV.C.6.d).(10) Programs must develop models and schedules for ambulatory training that minimize conflicting inpatient and outpatient responsibilities. (Detail) [Moved from IV.A.2.c).(1).(g).(i)]

IV.C.6.d).(11) Each resident's longitudinal continuity experience: [Moved from IV.A.2.c).(1).(g).(ii)]

IV.C.6.d).(11).(a) must include the resident serving as the primary physician for a panel of patients, with responsibility for chronic disease management, management of acute health problems, and preventive health care for their patients; (Detail) [Moved from IV.A.2.c).(1).(g).(ii).(a)]

IV.C.6.d).(11).(b) should not be interrupted by more than a month, not inclusive of vacation; (Detail) [Moved from IV.A.2.c).(1).(g).(ii).(b)]

IV.C.6.d).(11).(c) must include a minimum of 130 distinct half-day outpatient sessions, extending at least over a 30-

month period, devoted to longitudinal care of the residents' panel of patients; (Detail) [Moved from IV.A.2.c).(1).(g).(ii).(c)]

IV.C.6.d).(11).(d) must include evaluation of performance data for each resident's continuity panel of patients relating to both chronic disease management and preventive health care. Residents must receive faculty guidance for developing a data-based action plan and evaluate this plan at least twice a year; (Detail) [Moved from IV.A.2.c).(1).(g).(ii).(d)]

IV.C.6.d).(11).(e) must include resident participation in coordination of care across health care settings. Residents should be accessible to participate in the management of their continuity panel of patients between outpatient visits. There must be systems of care to provide coverage of urgent problems when a resident is not readily available; (Detail) [Moved from IV.A.2.c).(1).(g).(ii).(e)]

IV.C.6.d).(11).(f) must include supervision by faculty who develop a longitudinal relationship with residents throughout the duration of their continuity experience; (Detail) [Moved from IV.A.2.c).(1).(g).(ii).(f)]

IV.C.6.d).(11).(g) must maintain a ratio of residents or other learners to faculty preceptors not to exceed 4:1; (Detail) [Moved from IV.A.2.c).(1).(g).(ii).(g)]

IV.C.6.d).(11).(h) must have sufficient supervision and teaching; (Detail) [Moved from IV.A.2.c).(1).(g).(ii).(h)]

IV.C.6.d).(11).(h).(i) Faculty must not have other patient care duties while supervising more than two residents or other learners, and (Detail) [Moved from IV.A.2.c).(1).(g).(ii).(h).(i)]

IV.C.6.d).(11).(h).(ii) Other faculty responsibilities must not detract from the supervision and teaching of residents. (Detail) [Moved from IV.A.2.c).(1).(g).(ii).(h).(ii)]

IV.C.6.d).(12) Internal medicine residents must be assigned to emergency medicine ~~(Core)~~ for at least four weeks of direct experience in blocks of not less than two weeks. (Detail) [Moved and combined from IV.A.2.c)(1)(h) and IV.A.2.c)(1)(h)(i)]

IV.C.6.d).(13) Total required emergency medicine experience must not exceed two months in three years of training. (Detail) [Moved from IV.A.2.c).(1).(h).(iii)]

IV.C.6.d).(14) Internal medicine residents assigned to emergency medicine must have first-contact responsibility for a sufficient number of unselected patients to meet the educational needs of internal medicine residents. Triage by other physicians prior to this contact is unacceptable. (Detail) [Moved from IV.A.2.c)(1)(h)(ii)]

IV.C.6.d).(15) The core curriculum must include a didactic program that is based upon the core knowledge content of internal medicine. (Core) [Moved from IV.A.3.a)]

IV.C.6.d).(15).(a) The didactic program may include lectures, web-based content, pod casts, etc. The program must afford each resident an opportunity to review all of the core curriculum topics. (Detail) [Moved from IV.A.3.a).(1)]

IV.C.6.d).(15).(b) Residents must have the opportunity to participate in morning report, grand rounds, journal club, and morbidity and mortality (or quality improvement) conferences, all of which must involve faculty. (Detail) [Moved from IV.A.3.a).(2)]

IV.C.6.d).(15).(c) The program must provide opportunities for residents to interact with other residents and faculty in educational sessions at a frequency sufficient for peer-peer and peer-faculty interaction. (Detail) [Moved from IV.A.3.a).(3)]

IV.C.6.d).(16) Patient based teaching must include direct interaction between resident and attending, bedside teaching, discussion of pathophysiology, and the use of current evidence in diagnostic and therapeutic decisions. (Core) [Moved from IV.A.3.b)]

The teaching must be:

IV.C.6.d).(16).(a) formally conducted on all inpatient, outpatient and consultative services, and (Detail) [Moved from IV.A.3.b).(1)]

IV.C.6.d).(16).(b) conducted with a frequency and duration sufficient to ensure a meaningful and continuous teaching relationship between the assigned teaching attending and resident. (Detail) [Moved from IV.A.3.b).(1)]

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 must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities.** (Core)

[The Review Committee may further specify]

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

Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety. While some faculty members are responsible for fulfilling the traditional elements of scholarship through research, integration, and teaching, all faculty members are responsible for advancing residents' scholarly approach to patient care.

Elements of a scholarly approach to patient care include:

- **Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan**
- **Challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature**
- **When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)**
- **Improving resident learning by encouraging them to teach using a scholarly approach**

The scholarly approach to patient care begins with curiosity, is grounded in the principles of evidence-based medicine, expands the knowledge base through dissemination, and develops the habits of life-long learning by encouraging residents to be scholarly teachers.

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) **Among their scholarly activity, programs must have efforts 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:**

[Review Committee will choose to require either IV.D.2.b).(1) or both IV.D.2.b).(1) and IV.D.2.b).(2)]

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, 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)

IV.D.3. Resident Scholarly Activity

IV.D.3.a) **Residents must participate in scholarship. Each graduating resident should have a scholarly activity that is disseminated as further described in IV.D.2.b).(1) or IV.D.2.b).(2).**(Core)

[The Review Committee may further specify]

Background and Intent: While some Review Committees may accept local dissemination of resident scholarship, others may require external dissemination.

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

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 rotations of greater than two months in duration, evaluation must be documented at least every two 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.b).(3)~~ ~~The faculty must discuss this evaluation with the resident at the completion of the assignment.~~ ~~(Core)~~ [Delete current V.A.2.a)(1), superseded by CPR V.A.1.b)]

~~V.A.1.b).(4)~~ ~~Resident performance in continuity clinic must be reviewed with them verbally and in writing on at least a semiannual basis.~~ ~~(Detail)~~ [Delete current V.A.2.a)(2), superseded by CPR V.A.1.b)(2)]

V.A.1.c) **The program must be organized to 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).(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.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).(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's readiness to progress to the next year of the program. (Core)**
V.A.1.f)	**The evaluations of resident performance must be accessible for review by the resident. (Core)**
	[The Review Committee may further specify under any requirement in V.A.1.-V.A.1.f)]
V.A.1.g)	The program must assess the resident in data gathering, clinical reasoning, patient management and procedures in both the inpatient and outpatient setting. (Core) [Moved from V.A.2.b).(1).(a).(i)]
V.A.1.h)	The record of evaluation must include a logbook or an equivalent method to demonstrate that each resident has achieved competence in the performance of invasive procedures. (Detail) [Moved from V.A.2.d)]
~~V.A.1.h).(2)~~	~~Patient care:~~

~~V.A.1.h).(2).(a)~~ ~~This assessment must involve direct observation of resident-patient encounters.~~ ~~(Detail)~~ [Deleted current V.A.2.b).(1).(a).(ii), superseded by CPR V.A.1.a)]

V.A.1.h).(3) Medical knowledge: [Moved from V.A.2.b).(1).(b-f)]

~~V.A.1.h).(3).(a)~~ The program must use an objective validated formative assessment method (e.g., in-service training examination, chart stimulated recall). The same formative assessment method must be administered at least twice during the training program. (Detail)

V.A.1.h).(4) Practice-based learning and improvement:

The program must assess resident performance in:

~~V.A.1.h).(4).(a)~~ application of evidence to patient care, (Detail)

~~V.A.1.h).(4).(b)~~ practice improvement, (Detail)

~~V.A.1.h).(4).(c)~~ teaching skills involving peers and patients, and (Detail)

~~V.A.1.h).(4).(d)~~ scholarship. (Detail)

~~V.A.1.h).(4).(e)~~ Assessment of practice must include use of performance data. (Detail)

V.A.1.h).(5) Interpersonal and communication skills:

The program must assess resident performance in the following:

~~V.A.1.h).(5).(a)~~ communication with patient and family, (Detail)

~~V.A.1.h).(5).(b)~~ teamwork, (Detail)

~~V.A.1.h).(5).(c)~~ communication with peers, including transitions in care, and (Detail)

~~V.A.1.h).(5).(d)~~ record keeping. (Detail)

~~V.A.1.h).(5).(e)~~ Assessment must include both direct observation and multi-source evaluation (including at least patients, peers and non-physician team members). (Detail)

V.A.1.h).(6) Professionalism:

The program must assess the resident in the following:

~~V.A.1.h).(6).(a)~~ honesty and integrity, (Detail)

~~V.A.1.h).(6).(b)~~ ability to meet professional responsibilities, (Detail)

~~V.A.1.h).(6).(c)~~ ability to maintain appropriate professional relationships with patients and colleagues, and (Detail)

~~V.A.1.h).(6).(d)~~ commitment to self-improvement. (Detail)

~~V.A.1.h).(6).(e)~~ Assessment must include multi-source evaluation (including at least patients, peers, and non-physician team members). (Detail)

V.A.1.h).(7) Systems-based practice:

The program must assess the resident in the following:

~~V.A.1.h).(7).(a)~~ care coordination, including transition of care, (Detail)

~~V.A.1.h).(7).(b)~~ ability to work in interdisciplinary teams, (Detail)

~~V.A.1.h).(7).(c)~~ advocacy for quality of care, and (Detail)

~~V.A.1.h).(7).(d)~~ ability to identify system problems and participate in improvement activities. (Detail)

~~V.A.1.h).(7).(e)~~ Assessment must include multi-source evaluation (including at least peers, and non-physician team members). (Detail)

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 sufficient competence to enter practice without supervision; (Core)

V.A.2.a).(2).(c) consider recommendations from the Clinical Competency Committee; and, (Core)

V.A.2.a).(2).(d) 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 be composed of three members of the program faculty. (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. The program director has final responsibility for resident evaluation and promotion decisions.

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 and are eligible for specialty board certification 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 resident's semi-annual evaluation and advise the program director regarding each resident's progress. (Core)

V.B. Faculty Evaluation

V.B.1. **At least annually, the program must evaluate each faculty member's performance as it relates to the educational program.** (Core)

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 skills as an educator, clinical performance, professionalism, and scholarly activities.** (Core)

V.B.1.b) **This evaluation must include at least annual 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 evaluation should be used as a basis for faculty development plans.** (Core)

V.B.4. ~~Residents must have the opportunity to provide confidential written evaluations of each teaching attending at the end of a rotation.~~ (Detail) [Deleted current V.B.3.a), superseded by CPR V.B.1.b)]

V.B.5. ~~These evaluations must be reviewed annually with the attending.~~ (Detail) [Deleted current V.B.3.b), superseded by CPR V.B.2.]

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 programs' faculty for this purpose.

V.C. Program Evaluation and Improvement

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

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

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

V.C.1.b).(1) **evaluating educational activities of the program;** (Detail)†

V.C.1.b).(2) **reviewing and making recommendations for revision of competency-based curriculum goals and objectives; and,** (Detail)

V.C.1.b).(3) addressing areas of non-compliance with ACGME requirements. (Detail)

V.C.2. The Program Evaluation Committee must conduct and document the Annual Program Evaluation, including the plan for improvement. (Core)

Background and Intent: In order to achieve its mission and train the highest 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.

V.C.2.a) The Program Evaluation Committee must include the following elements in its assessment of the program:

V.C.2.a).(1) curriculum; (Core)

V.C.2.a).(2) outcomes from prior Annual Program Evaluation(s); (Core)

V.C.2.a).(3) ACGME letters of notification, including citations, Areas for Improvement, and comments; (Core)

V.C.2.a).(4) quality and safety of patient care; (Core)

V.C.2.a).(5) aggregate resident and faculty:

V.C.2.a).(5).(a) well-being; (Core)

V.C.2.a).(5).(b) recruitment and retention; (Core)

V.C.2.a).(5).(c) workforce diversity; (Core)

V.C.2.a).(5).(d) engagement in quality improvement and patient safety; (Core)

V.C.2.a).(5).(e) scholarly activity; (Core)

V.C.2.a).(5).(f) ACGME Resident and Faculty Surveys; and, (Core)

V.C.2.a).(5).(g) written evaluations of the program. (Core)

V.C.2.a).(6) aggregate resident:

V.C.2.a).(6).(a) achievement of Milestones; (Core)

V.C.2.a).(6).(b) in-training examinations (where applicable); (Core)

V.C.2.a).(6).(c) **Board pass and certification rates; and, (Core)**

V.C.2.a).(6).(d) **graduate clinical performance. (Core)**

V.C.2.a).(7) **aggregate faculty:**

V.C.2.a).(7).(a) **performance; and, (Core)**

V.C.2.a).(7).(b) **professional development. (Core)**

V.C.2.b) **The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)**

V.C.2.c) **The annual review, including the action plan, must:**

V.C.2.c).(1) **be distributed to and discussed with the members of the teaching faculty and the residents; and, (Core)**

V.C.2.c).(2) **be reviewed by the GMEC. (Core)**

V.C.2.d) ~~[The program must monitor and track resident performance,] including outcome assessment of the educational effectiveness of inpatient and ambulatory teaching. (Detail)~~ [Deleted current V.C.2.a).(1), superseded by CPR V.C.2.a)(5-6). Additionally, this section does not allow further specification.]

V.C.2.e) ~~[The program must monitor and track] the ability to retain qualified residents by graduating at least 80% of its entering categorical residents averaged over the most recent three-year period. (Outcome)~~ [Deleted current V.C.2.f), superseded by CPR V.C.2.a)(5).(b). Additionally, this section does not allow further specification.]

V.C.2.f) ~~The department should share appropriate inpatient and outpatient faculty performance data with the program director. (Core)~~ [Delete current V.C.4. Further specification not allowed]

V.C.2.g) ~~The program must organize representative program personnel, at a minimum to include the program director, representative faculty, and one resident, to review program goals and objectives, and the effectiveness with which they are achieved. (Detail)~~ [Delete current V.C.5. Further specification not allowed]

V.C.3. **The program must complete a Self-Study prior to its 10-year accreditation site visit. (Core)**

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the 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 Self-Study and the 10-year accreditation site visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the Self-Study process, as well as information on how to prepare for the 10-year accreditation site visit is available on the ACGME website.

V.C.4. ***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.***

V.C.4.a) **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.** (Core)

V.C.4.b) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, aggregate pass rate of program graduates taking the examination for the first time must be above the fifth percentile.** (Outcome)

V.C.4.c) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, aggregate pass rate of program graduates taking the examination for the first time must be above the fifth percentile for pass rate.** (Outcome)

V.C.4.d) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, aggregate pass rate of program graduates taking the examination for the first time must be above the fifth percentile.** (Outcome)

V.C.4.e) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, aggregate pass rate of program graduates taking the examination for the first time must be above the fifth percentile for pass rate.** (Outcome)

V.C.4.f) **For each of the exams referenced in V.C.4.b)-c), 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.** (Outcome)

~~V.C.4.f).(1)~~ ~~At least 80 percent of the program's graduates from the most recently defined three-year period must take the ABIM or the American Osteopathic Board of Internal Medicine (AOBIM) certification examination.~~ (Outcome)

[Deleted current V.C.2.c).(1), superseded by CPR V.C.4. section]

V.C.4.f).(2) ~~At least 80 percent of the program's graduates from the most recently defined three-year period who take either the ABIM or AOBIM certification examination for the first time must pass.~~ ~~(Outcome)~~ [Deleted current V.C.2.c).(2), superseded by CPR V.C.4. section]

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.4.f) is designed to address this.

V.C.4.g) **Programs must report in the Accreditation Data System (ADS) board certification rates annually for the cohort of 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.

Note: The Common Program Requirements in SECTION VI were approved in February 2017 and have been in effect since July 1, 2017.

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:***

  - ***the effacement of self-interest in a humanistic environment that supports the professional development of physicians***

  - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***

- ***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

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

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).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care. (Core)

VI.A.1.a).(2) **Education on Patient Safety**

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

VI.A.1.a).(3) **Patient Safety Events**

Reporting, investigation, and follow-up of adverse 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).(3).(a) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site; (Core)

VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, (Core)

VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution's patient safety reports. (Core)

VI.A.1.a).(3).(b) Residents must participate as team members in real and/or simulated interprofessional clinical patient safety 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).(4) **Resident Education and Experience in Disclosure of Adverse Events**

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a).(4).(a) **All residents must receive training in how to disclose adverse events to patients and families.** (Core)

VI.A.1.a).(4).(b) **Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.** (Detail)

VI.A.1.b) **Quality Improvement**

VI.A.1.b).(1) **Education in Quality Improvement**

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) **Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.** (Core)

VI.A.1.b).(2) **Quality Metrics**

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

VI.A.1.b).(2).(a) **Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.** (Core)

VI.A.1.b).(3) **Engagement in Quality Improvement Activities**

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a) **Residents must have the opportunity to participate in interprofessional quality improvement activities.** (Core)

VI.A.1.b).(3).(a).(i) **This should include activities aimed at reducing health care disparities.** (Detail)

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) **Each patient must 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.** **(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)**

VI.A.2.a).(1).(b) **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.b) ***Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.***

VI.A.2.b).(1) **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)**

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

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c).(1) **Direct Supervision – the supervising physician is physically present with the resident and patient. (Core)**

VI.A.2.c).(2) **Indirect Supervision:**

VI.A.2.c).(2).(a) **with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core)**

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

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

VI.A.2.e).(1).(a) **Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available.** (Core)

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 responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.** (Core)

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

VI.B.2.a) **be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events;** (Core)

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

VI.B.2.c) **ensure manageable patient care responsibilities.** (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)

VI.B.4. **Residents and faculty members must demonstrate an understanding of their personal role in the:**

VI.B.4.a) **provision of patient- and family-centered care;** (Outcome)

VI.B.4.b) **safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;** (Outcome)

VI.B.4.c) **assurance of their fitness for work, including:** (Outcome)

VI.B.4.c).(1) **management of their time before, during, and after clinical assignments; and,** (Outcome)

VI.B.4.c).(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)

VI.B.4.d) commitment to lifelong learning; (Outcome)

VI.B.4.e) monitoring of their patient care performance improvement indicators; and, (Outcome)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes 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 provider. (Outcome)

VI.B.6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. 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

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

VI.C.1. This responsibility must include:

VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

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

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

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

VI.C.1.d).(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.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

VI.C.1.e).(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, (Core)

VI.C.1.e).(3) provide 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)

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. (Core)

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

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

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D.3. 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.2. Teamwork

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

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-over 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-over process. (Outcome)

VI.E.3.d) **Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care.** (Core)

VI.E.3.e) **Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.** (Core)

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.

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)

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

VI.F.2.a) **The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.** (Core)

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

VI.F.2.b).(1) **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 must occur within the context of the 80-hour and the one-day-off-in-seven requirements.** (Detail)

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

VI.F.2.d) **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)

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.** (Core)

VI.F.3.a).(1).(a) **Additional patient care responsibilities must not be assigned to a resident during this time.** (Core)

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:**

VI.F.4.a).(1) **to continue to provide care to a single severely ill or unstable patient;** (Detail)

VI.F.4.a).(2) **humanistic attention to the needs of a patient or family; or,** (Detail)

VI.F.4.a).(3) **to attend unique educational events.** (Detail)

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

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 Committee for Internal Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.

VI.F.4.c).(1) **In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*.** (Core)

VI.F.4.c).(2) **Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO.** (Core)

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)

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.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.7.a) Internal Medicine fellowships must not average in-house call 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)

VI.F.8.b) **Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.** (Detail)

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***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

Appendix A: List of Participants of the June and September 2017 IM2035 Workshops

Eva Aagaard, MD ++, Washington University School of Medicine in St. Louis
Jennifer Adams, MD +, NYU School of Medicine
Neera Ahuja, MD +, Stanford University School of Medicine
Richard Alweis, MD ++, Rochester Regional Health
M. Hayes Baker, MD +, Magnolia Regional Health Center
Eileen Barrett, MD +, University of New Mexico
Robert Benz, MD *, Lankenau Medical Center, Review Committee member
Alexander Billioux, MD +, Johns Hopkins University School of Medicine
Pierre Bou-Khalil, MD +, American University of Beirut
Craig Brater, MD +, Indiana University School of Medicine
Diane Bronstein-Wayne, MD +, Northwestern University Feinberg School of Medicine
Dona Susie Buchter, MD +, Emory University School of Medicine
John Buckley, MD ++, Indiana University School of Medicine
Roger Bush, MD ++, Neighborcare Health
Christian Cable, MD, MHPE *, Scott & White Medical Center, Review Committee Chair
Kathy Chappell, PhD, RN +, American Nurses Credentialing Center
Saima Chaudhry, MD +, Memorial Healthcare System
Davoren Chick, MD *, American College of Physicians, ex-officio Review Committee member
E. Benjamin Clyburn, MD ++, Medical University of South Carolina College of Medicine
Alan Dalkin, MD *, University of Virginia, Review Committee member
Antigone Dempsey Med +, American Board of Internal Medicine, infectious disease board member
Andrew Dentino, MD *, University of Texas Rio Grande Valley School of Medicine, Review Committee member
Sanjay Desai, MD *, Johns Hopkins University School of Medicine, Review Committee member
Sima Desai, MD *, Oregon Health & Science University, Review Committee member
Jessica Deslauriers, MD *, Yale University**,** Review Committee resident member
Maria D'Oliveira +, Harvard Medical School, Brigham and Women's Hospital
J. Christopher Farmer, MD ++, Mayo Clinic, Rochester
Oren Fix, MD *, Swedish Medical Center**,** Review Committee member
Christin Giordano, MD *, Vanderbilt University, Review Committee resident member
James Herdegen, MD *, Rush University
Paul Grundy, MD, MPH +, HealthTeamWorks
David Han, MD ++, Penn State Children's Hospital (Hershey)
William Hersh, MD +, Oregon Health & Science University
Stacy Higgins, MD +, Emory University School of Medicine
Susan Hingle, MD +, Southern Illinois University School of Medicine
Eric Kasowski, DVM, MD, MPH +, Centers for Disease Control and Prevention
Russell Kolarik, MD *, University of South Caroline School of Medicine, Review Committee member
Thomas Lall, MD ++, Atlanta Medical Center

Susan Lane, MD ++, Stoney Brook Medicine
Ana Maria Lopez, MD, MPH ++, University of Utah School of Medicine
Monica Lypson, MD *, Department of VA Affairs Central Office, Review Committee member
Maria Maldonado, MD ++, Danbury Hospital
Brian Mandell, MD *, Cleveland Clinic, Review Committee Vice Chair
Leah Marcotte, MD ++, Iora Health, Seattle, Washington
Candice Mateja, DO ++, University of South Florida Morsani College of Medicine
John McConville, MD ++, University of Chicago Medical Center
Furman McDonald, MD *, American Board of Internal Medicine, ex-officio Review Committee member
Graham McMahon, MD ++, Accreditation Council for Continuing Medical Education
Neil Mehta, MD ++, Cleveland Clinic
Curtis Mirkes, DO ++, Scott & White Medical Center
Elaine Muchmore, MD *, University of California, San Diego, Review Committee member
Tina Moen, PharmD +, IBM Watson Health
Richard Murray, MD ++, formerly at Merck & Co, Inc.
Donald Nelinson, PhD *, American College of Osteopathic Internists, ex-officio Review Committee member
Cheryl O'Malley, MD *, University of Arizona, Review Committee member
Amy Oxentenko, MD *, Mayo Clinic, Rochester, Review Committee member
Jill Patton, DO *, Advocate Lutheran General Hospital, Review Committee member
Kristen Patton, MD *, University of Washington Medical Center, Review Committee member
David Pizzimenti, DO *, Magnolia Regional Health Center, Review Committee member
Stacy Potts, MD +, University of Massachusetts
David Rodgers, EdD ++, Penn State Health Milton S. Hershey Medical Center
Ilene Rosen, MD ++, University of Pennsylvania Health System
Joshua Safer, MD +, Icahn School of Medicine at Mount Sinai
William Salyers, Jr., MD, MPH +, University of Kansas School of Medicine
Nitin Seam, MD +, National Institutes of Health
Samuel Snyder, DO *, Nova Southeastern University, Review Committee member
Jacqueline Stocking, PhD *, UC Davis Health System, Review Committee public member
David Sweet, MD *, Summa Health System/NEOMED, Review Committee member
Sara Swenson, MD +, Sutter Health Medical Foundation
Blaine Takesue, MD +, Regenstrief Institute, Inc.
Dominick Tammaro, MD +, Warren Alpert Medical School of Brown University
M.N. Walsh, MD +, St. Vincent Heart Center of Indianapolis
Eric Warm, MD +, University of Cincinnati Health
Terri Weaver, PhD, RN +, University of Illinois Chicago
Steven Weinberger, MD +, formerly of the American College of Physicians

+ attended June workshop
** attended September workshop*
++ attended June and September workshops