

**ACGME Program Requirements for
Graduate Medical Education
in Rheumatology**

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1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Rheumatology**

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4 **Common Program Requirements (Fellowship) are in BOLD**

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6 Where applicable, text in italics describes the underlying philosophy of the requirements in that
7 section. These philosophic statements are not program requirements and are therefore not
8 citable.
9

Background and Intent: These fellowship requirements reflect the fact that these learners have already completed the first phase of graduate medical education. Thus, the Common Program Requirements (Fellowship) are intended to explain the differences.

10
11 **Introduction**

12
13 **Int.A.** *Fellowship is advanced graduate medical education beyond a core*
14 *residency program for physicians who desire to enter more specialized*
15 *practice. Fellowship-trained physicians serve the public by providing*
16 *subspecialty care, which may also include core medical care, acting as a*
17 *community resource for expertise in their field, creating and integrating*
18 *new knowledge into practice, and educating future generations of*
19 *physicians. Graduate medical education values the strength that a diverse*
20 *group of physicians brings to medical care.*

21
22 *Fellows who have completed residency are able to practice independently*
23 *in their core specialty. The prior medical experience and expertise of*
24 *fellows distinguish them from physicians entering into residency training.*
25 *The fellow’s care of patients within the subspecialty is undertaken with*
26 *appropriate faculty supervision and conditional independence. Faculty*
27 *members serve as role models of excellence, compassion,*
28 *professionalism, and scholarship. The fellow develops deep medical*
29 *knowledge, patient care skills, and expertise applicable to their focused*
30 *area of practice. Fellowship is an intensive program of subspecialty clinical*
31 *and didactic education that focuses on the multidisciplinary care of*
32 *patients. Fellowship education is often physically, emotionally, and*
33 *intellectually demanding, and occurs in a variety of clinical learning*
34 *environments committed to graduate medical education and the well-being*
35 *of patients, residents, fellows, faculty members, students, and all members*
36 *of the health care team.*

37
38 *In addition to clinical education, many fellowship programs advance*
39 *fellows’ skills as physician-scientists. While the ability to create new*
40 *knowledge within medicine is not exclusive to fellowship-educated*
41 *physicians, the fellowship experience expands a physician’s abilities to*
42 *pursue hypothesis-driven scientific inquiry that results in contributions to*
43 *the medical literature and patient care. Beyond the clinical subspecialty*
44 *expertise achieved, fellows develop mentored relationships built on an*
45 *infrastructure that promotes collaborative research.*

46
47 **Int.B.** **Definition of Subspecialty**

48
49 Rheumatology is the subspecialty of internal medicine that focuses on the
50 diagnosis and treatment of medical diseases of the joints, muscles, and
51 connective tissues.
52

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

54
55 The educational program in rheumatology must be 24 months in length. ^{(Core)*}
56

57 **I. Oversight**

58
59 **I.A. Sponsoring Institution**

60
61 *The Sponsoring Institution is the organization or entity that assumes the*
62 *ultimate financial and academic responsibility for a program of graduate*
63 *medical education consistent with the ACGME Institutional Requirements.*
64

65 *When the Sponsoring Institution is not a rotation site for the program, the*
66 *most commonly utilized site of clinical activity for the program is the*
67 *primary clinical site.*
68

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

69
70 **I.A.1. The program must be sponsored by one ACGME-accredited**
71 **Sponsoring Institution.** ^{(Core)*}
72

73 **I.B. Participating Sites**

74
75 *A participating site is an organization providing educational experiences or*
76 *educational assignments/rotations for fellows.*
77

78 **I.B.1. The program, with approval of its Sponsoring Institution, must**
79 **designate a primary clinical site.** ^(Core)
80

81 I.B.1.a) A rheumatology fellowship must function as an integral part of an
82 ACGME-accredited residency in internal medicine. ^(Core)
83

84 I.B.1.b) The Sponsoring Institution must establish the rheumatology
85 fellowship within a department of internal medicine or an
86 administrative unit whose primary mission is the advancement of
87 internal medicine subspecialty education and patient care. ^(Detail)
88

89 I.B.1.c) The Sponsoring Institution must ensure that there is a reporting

relationship with the program director of the parent internal medicine residency program to ensure compliance with ACGME accreditation requirements. ^(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) At each participating site there must be one faculty member, designated by the program director, who is accountable for fellow education for that site, in collaboration with the program director. ^(Core)

Background and Intent: While all fellowship 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 designate a faculty member responsible for ensuring the quality of the educational experience. In some circumstances, the person charged with this responsibility may not be physically present at the site, but remains responsible for fellow education occurring at the site. 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 ACGME Program Director's Guide to the Common Program Requirements. These include:

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

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

120 **I.C. The program, in partnership with its Sponsoring Institution, must engage in**
121 **practices that focus on mission-driven, ongoing, systematic recruitment**
122 **and retention of a diverse and inclusive workforce of residents (if present),**
123 **fellows, faculty members, senior administrative staff members, and other**
124 **relevant members of its academic community.** ^(Core)
125

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership 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.1.c).(5).(c).

126
127 **I.D. Resources**
128

129 **I.D.1. The program, in partnership with its Sponsoring Institution, must**
130 **ensure the availability of adequate resources for fellow education.**
131 ^(Core)
132

133 I.D.1.a) Space and Equipment

134
135 There must be space and equipment for the program, including
136 meeting rooms, examination rooms, computers, visual and other
137 educational aids, and work/study space. ^(Core)
138

139 I.D.1.b) Facilities

140
141 I.D.1.b).(1) Inpatient and outpatient systems must be in place to
142 prevent fellows from performing routine clerical functions,
143 such as scheduling tests and appointments, and retrieving
144 records and letters ^(Detail)
145

146 I.D.1.b).(2) The Sponsoring Institution must provide the broad range of
147 facilities and clinical support services required to provide
148 comprehensive care of adult patients. ^(Core)
149

150 I.D.1.b).(3) Fellows must have access to a lounge facility during
151 assigned duty hours. ^(Detail)
152

153 I.D.1.b).(4) When fellows are in the hospital, assigned night duty, or
154 called in from home, they must be provided with a secure
155 space for their belongings. ^(Detail)
156

157 I.D.1.c) Laboratory Services

158
159 The following must be present at the primary clinical site or
160 participating site(s):
161

162 I.D.1.c).(1) access to clinical immunology lab services; and, ^(Core)

163
164 I.D.1.c).(2) computerized tomography (CT), bone densitometry,

- 165 magnetic resonance imaging (MRI), and angiography. ^(Core)
- 166
- 167 I.D.1.d) Other Support Services
- 168
- 169 I.D.1.d).(1) Fellows must have access to a compensated polarized
- 170 light microscope. ^(Core)
- 171
- 172 I.D.1.d).(2) Fellows must have access to facilities for rehabilitation
- 173 medicine. ^(Core)
- 174
- 175 I.D.1.d).(3) There should be:
- 176
- 177 I.D.1.d).(3).(a) orthopaedic surgery services for obtaining synovial
- 178 biopsies and consultations for joint arthroplasty;
- 179 ^(Core)
- 180
- 181 I.D.1.d).(3).(b) other consultation services for obtaining indicated
- 182 biopsies of muscle, nerve, skin, and arteries; ^(Core)
- 183
- 184 I.D.1.d).(3).(c) access to pathology services for evaluation of
- 185 muscle, vascular, and synovial biopsy materials;
- 186 and, ^(Core)
- 187
- 188 I.D.1.d).(3).(d) a meaningful working relationship, including
- 189 availability for teaching and consultation, with a
- 190 radiologist and orthopaedic surgeon. ^(Core)
- 191
- 192 I.D.1.e) Medical Records
- 193
- 194 Access to an electronic health record should be provided. In the
- 195 absence of an existing electronic health record, institutions must
- 196 demonstrate institutional commitment to its development and
- 197 progress toward its implementation. ^(Core)
- 198
- 199 **I.D.2. The program, in partnership with its Sponsoring Institution, must**
- 200 **ensure healthy and safe learning and working environments that**
- 201 **promote fellow well-being and provide for:** ^(Core)
- 202
- 203 **I.D.2.a) access to food while on duty;** ^(Core)
- 204
- 205 **I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available**
- 206 **and accessible for fellows with proximity appropriate for safe**
- 207 **patient care;** ^(Core)
- 208

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that fellows function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while fellows are working. Fellows should have access to refrigeration where food may be stored. Food should be available when fellows are required to be in the hospital

overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued fellow.

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

Background and Intent: Sites must provide private and clean locations where fellows 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 fellow 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 fellow and the fellow's family, as outlined in VI.C.1.d).(1).

214

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

215
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217

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

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- I.D.3. Fellows must have ready access to subspecialty-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)

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- I.D.4. The program's educational and clinical resources must be adequate to support the number of fellows appointed to the program. (Core)

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- I.D.4.a) Patient Population

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230

- I.D.4.a).(1) The patient population must have a variety of clinical problems and stages of diseases. (Core)

231
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- I.D.4.a).(2) There must be patients of each gender, with a broad age range, including geriatric patients. (Core)

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- I.D.4.a).(3) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. (Core)

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- I.E. *A fellowship program usually occurs in the context of many learners and other care providers and limited clinical resources. It should be structured to optimize education for all learners present.*

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- I.E.1. Fellows should contribute to the education of residents in core programs, if present. (Core)

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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 fellows' education is not compromised by the presence of other providers and learners, and that fellows' education does not compromise core residents' education.

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II. Personnel

II.A. Program Director

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

II.A.1.a) The Sponsoring Institution's Graduate Medical Education Committee (GMEC) must approve a change in program director. ^(Core)

II.A.1.b) Final approval of the program director resides with the Review Committee. ^(Core)

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

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

II.A.2.a) ~~At a minimum, the program director must be provided with the salary support required to devote 20-50 percent FTE of non-clinical time to the administration of the program. ^(Core)~~

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

<u>Number of Approved Fellow Positions</u>	<u>Minimum Support Required (FTE)</u>
<u>≤7</u>	<u>.2</u>
<u>7-9</u>	<u>.25</u>
<u>10-12</u>	<u>.3</u>
<u>13-15</u>	<u>.35</u>
<u>16-18</u>	<u>.4</u>

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II.A.2.b) Programs must appoint at least one of the subspecialty-certified core faculty members to be associate program director(s). The associate program directors(s) must be provided with support

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equal to a dedicated minimum time for administration of the program as follows: ^(Core)

<u>Number of Approved Fellow Positions</u>	<u>Minimum Support Required (FTE)</u>
<u><7</u>	<u>0</u>
<u>7-9</u>	<u>.13</u>
<u>10-12</u>	<u>.14</u>
<u>13-15</u>	<u>.15</u>
<u>16-18</u>	<u>.16</u>

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

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

The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the fellowship program, as defined in II.A.4.-II.A.4.a).(16). Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.

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

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Subspecialty-Specific Background and Intent: For instance, a program with an approved complement of 12 fellows is required to have at least 30 percent FTE support for the Program Director and at least 14 percent FTE support for the associate program director(s). Because an associate program director is also a core faculty member, the minimum dedicated time requirements for associate program directors are inclusive of core faculty activities. An additional 10 percent FTE for the core faculty position is not required. For example, if one core faculty member is named the associate program director for a 12-fellow program, the required minimum support for that position is 14 percent FTE. Further, the Review Committee allows the minimum required FTE support to be shared among multiple associate program directors, as delegated by and at the discretion of the program director.

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

II.A.3.a) must include subspecialty expertise and qualifications acceptable to the Review Committee; and, ^(Core)

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292 II.A.3.a).(1) The program director must have administrative experience
293 and at least three years of participation as an active faculty
294 member in an ACGME-accredited internal medicine
295 residency or rheumatology fellowship. (Core)
296

297 **II.A.3.b)** **must include current certification in the subspecialty for**
298 **which they are the program director by the American Board**
299 **of Internal Medicine (ABIM) or by the American Osteopathic**
300 **Board of Internal Medicine (AOBIM), or subspecialty**
301 **qualifications that are acceptable to the Review Committee.**
302 (Core)
303

304 II.A.3.b).(1) The Review Committee only accepts current ABIM or
305 AOBIM certification in rheumatology. (Core)
306

307 **II.A.4. Program Director Responsibilities**
308

309 **The program director must have responsibility, authority, and**
310 **accountability for: administration and operations; teaching and**
311 **scholarly activity; fellow recruitment and selection, evaluation, and**
312 **promotion of fellows, and disciplinary action; supervision of fellows;**
313 **and fellow education in the context of patient care. (Core)**
314

315 **II.A.4.a) The program director must:**
316

317 **II.A.4.a).(1) be a role model of professionalism; (Core)**
318

Background and Intent: The program director, as the leader of the program, must serve as a role model to fellows in addition to fulfilling the technical aspects of the role. As fellows 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.

319
320 **II.A.4.a).(2) design and conduct the program in a fashion**
321 **consistent with the needs of the community, the**
322 **mission(s) of the Sponsoring Institution, and the**
323 **mission(s) of the program; (Core)**
324

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.

325

326 II.A.4.a).(3) administer and maintain a learning environment
327 conducive to educating the fellows in each of the
328 ACGME Competency domains; ^(Core)
329

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Fellowship 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.

330
331 II.A.4.a).(4) develop and oversee a process to evaluate candidates
332 prior to approval as program faculty members for
333 participation in the fellowship program education and
334 at least annually thereafter, as outlined in V.B.; ^(Core)
335

336 II.A.4.a).(5) have the authority to approve program faculty
337 members for participation in the fellowship program
338 education at all sites; ^(Core)
339

340 II.A.4.a).(6) have the authority to remove program faculty
341 members from participation in the fellowship program
342 education at all sites; ^(Core)
343

344 II.A.4.a).(7) have the authority to remove fellows from supervising
345 interactions and/or learning environments that do not
346 meet the standards of the program; ^(Core)
347

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

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

348
349 II.A.4.a).(8) submit accurate and complete information required
350 and requested by the DIO, GMEC, and ACGME; ^(Core)
351

352 II.A.4.a).(9) provide applicants who are offered an interview with
353 information related to the applicant's eligibility for the
354 relevant subspecialty board examination(s); ^(Core)
355

356 II.A.4.a).(10) provide a learning and working environment in which
357 fellows have the opportunity to raise concerns and
358 provide feedback in a confidential manner as
359 appropriate, without fear of intimidation or retaliation;
360 ^(Core)
361

- 362 II.A.4.a).(11) ensure the program’s compliance with the Sponsoring
 363 Institution’s policies and procedures related to
 364 grievances and due process; ^(Core)
 365
 366 II.A.4.a).(12) ensure the program’s compliance with the Sponsoring
 367 Institution’s policies and procedures for due process
 368 when action is taken to suspend or dismiss, not to
 369 promote, or not to renew the appointment of a fellow;
 370 ^(Core)
 371

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 fellows.

- 372
 373 II.A.4.a).(13) ensure the program’s compliance with the Sponsoring
 374 Institution’s policies and procedures on employment
 375 and non-discrimination; ^(Core)
 376
 377 II.A.4.a).(13).(a) Fellows must not be required to sign a non-
 378 competition guarantee or restrictive covenant.
 379 ^(Core)
 380
 381 II.A.4.a).(14) document verification of program completion for all
 382 graduating fellows within 30 days; ^(Core)
 383
 384 II.A.4.a).(15) provide verification of an individual fellow’s
 385 completion upon the fellow’s request, within 30 days;
 386 and, ^(Core)
 387

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

- 388
 389 II.A.4.a).(16) obtain review and approval of the Sponsoring
 390 Institution’s DIO before submitting information or
 391 requests to the ACGME, as required in the Institutional
 392 Requirements and outlined in the ACGME Program
 393 Director’s Guide to the Common Program
 394 Requirements. ^(Core)
 395
 396 **II.B. Faculty**
 397
 398 *Faculty members are a foundational element of graduate medical education*
 399 *– faculty members teach fellows how to care for patients. Faculty members*
 400 *provide an important bridge allowing fellows to grow and become practice*
 401 *ready, ensuring that patients receive the highest quality of care. They are*
 402 *role models for future generations of physicians by demonstrating*

403 *compassion, commitment to excellence in teaching and patient care,*
404 *professionalism, and a dedication to lifelong learning. Faculty members*
405 *experience the pride and joy of fostering the growth and development of*
406 *future colleagues. The care they provide is enhanced by the opportunity to*
407 *teach. By employing a scholarly approach to patient care, faculty members,*
408 *through the graduate medical education system, improve the health of the*
409 *individual and the population.*

410
411 *Faculty members ensure that patients receive the level of care expected*
412 *from a specialist in the field. They recognize and respond to the needs of*
413 *the patients, fellows, community, and institution. Faculty members provide*
414 *appropriate levels of supervision to promote patient safety. Faculty*
415 *members create an effective learning environment by acting in a*
416 *professional manner and attending to the well-being of the fellows and*
417 *themselves.*
418

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

419
420 **II.B.1.** For each participating site, there must be a sufficient number of
421 faculty members with competence to instruct and supervise all
422 fellows at that location. ^(Core)
423

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

425
426 **II.B.2.a)** be role models of professionalism; ^(Core)
427

428 **II.B.2.b)** demonstrate commitment to the delivery of safe, quality,
429 cost-effective, patient-centered care; ^(Core)
430

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.

431
432 **II.B.2.c)** demonstrate a strong interest in the education of fellows; ^(Core)
433

434 **II.B.2.d)** devote sufficient time to the educational program to fulfill
435 their supervisory and teaching responsibilities; ^(Core)
436

437 **II.B.2.e)** administer and maintain an educational environment
438 conducive to educating fellows; ^(Core)
439

440 **II.B.2.f)** regularly participate in organized clinical discussions,
441 rounds, journal clubs, and conferences; and, ^(Core)
442

443 **II.B.2.g)** pursue faculty development designed to enhance their skills
444 at least annually. ^(Core)
445

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

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II.B.3. Faculty Qualifications

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

II.B.3.b) Subspecialty physician faculty members must:

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

II.B.3.c) Any non-physician faculty members who participate in fellowship program education must be approved by the program director. (Core)

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

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

II.B.4. Core Faculty

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

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

- 481
482 **II.B.4.a) Core faculty members must be designated by the program**
483 **director.** ^(Core)
484
485 **II.B.4.b) Core faculty members must complete the annual ACGME**
486 **Faculty Survey.** ^(Core)
487
488 II.B.4.c) In addition to the program director, there must be at least one core
489 faculty member certified in rheumatology by the ABIM or the
490 AOBIM. ^(Core)
491
492 II.B.4.d) In programs approved for more than three fellows, there must be
493 at least one core faculty member certified in rheumatology by the
494 ABIM or the AOBIM for every 1.5 fellows. ^(Core)
495
496 II.B.4.e) At a minimum, the required core faculty members, in aggregate
497 and excluding members of the program leadership, must be
498 provided with support equal to an average dedicated minimum of
499 .1 FTE for educational and administrative responsibilities that do
500 not involve direct patient care. ^(Core)
501

~~Specialty Background and Intent: The program must have a minimum number of ABIM- or AOBIM-certified rheumatology faculty members who devote significant time to teaching, supervising, and advising residents, and working closely with the program director. One way the rheumatology certified faculty members can demonstrate they are devoting a significant portion of their effort to resident education is by dedicating an average of 10 hours per week to the program.~~

502

Subspecialty-Specific Background and Intent: For instance, a program with an approved complement of 12 fellows is required to have a minimum of eight ABIM- or AOBIM-subspecialty-certified faculty members and an FTE of 10 percent each. Because an associate program director is also a core faculty member, the minimum dedicated time requirements for associate program directors are inclusive of core faculty activities. An additional 10 percent FTE for the core faculty position is not required. For example, if one core faculty member is

named the associate program director for a 12-fellow program, the required minimum support for that position is 14 percent FTE.

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II.C. Program Coordinator

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

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

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

<u>Number of Approved Fellow Positions</u>	<u>Minimum FTE Required for Coordinator Support</u>	<u>Additional Aggregate FTE Required for Administration of the Program</u>
<u>1-3</u>	<u>.3</u>	<u>0</u>
<u>4-6</u>	<u>.3</u>	<u>.2</u>
<u>7-9</u>	<u>.3</u>	<u>.38</u>
<u>10-12</u>	<u>.3</u>	<u>.44</u>
<u>13-15</u>	<u>.3</u>	<u>.50</u>
<u>16-18</u>	<u>.3</u>	<u>.56</u>

517

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

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

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

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

518

Subspecialty-Specific Background and Intent: For instance, a program with an approved complement of 12 fellows is required to have at least 74 percent FTE administrative support: 30 percent FTE for the program coordinator; and an additional 44 percent FTE aggregate support. This additional support may be for the program coordinator only or divided among the program coordinator and one or more other administrative personnel. The Review Committee has not specified how the FTE should be distributed to allow programs, in partnership with their Sponsoring Institution, to allocate the FTE as they see fit.

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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)

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.

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

II.D.2. There must be appropriate and timely consultation from other specialties. ^(Detail)

III. Fellow Appointments

III.A. Eligibility Criteria

III.A.1. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency program located in Canada. ^(Core)

Background and Intent: Eligibility for ABMS or AOA Board certification may not be satisfied by fellowship training. Applicants must be notified of this at the time of application, as required in II.A.4.a).(9).

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III.A.1.a) Fellowship programs must receive verification of each entering fellow's level of competence in the required field, upon matriculation, using ACGME, ACGME-I, or CanMEDS Milestones evaluations from the core residency program. ^(Core)

554
555 III.A.1.b) Prior to appointment in the fellowship, fellows should have
556 completed an internal medicine program that satisfies the
557 requirements in III.A.1. ^(Core)
558
559 III.A.1.b).(1) Fellows who did not complete an internal medicine
560 program that satisfies the requirements in III.A.1. must
561 have completed at least three years of internal medicine
562 education prior to starting the fellowship as well as met all
563 of the criteria in the “Fellow Eligibility Exception” section
564 below. ^(Core)
565
566 **III.A.1.c) Fellow Eligibility Exception**
567
568 **The Review Committee for Internal Medicine will allow the**
569 **following exception to the fellowship eligibility requirements:**
570
571 **III.A.1.c).(1) An ACGME-accredited fellowship program may accept**
572 **an exceptionally qualified international graduate**
573 **applicant who does not satisfy the eligibility**
574 **requirements listed in III.A.1., but who does meet all of**
575 **the following additional qualifications and conditions:**
576 ^(Core)
577
578 **III.A.1.c).(1).(a) evaluation by the program director and**
579 **fellowship selection committee of the**
580 **applicant’s suitability to enter the program,**
581 **based on prior training and review of the**
582 **summative evaluations of training in the core**
583 **specialty; and, ^(Core)**
584
585 **III.A.1.c).(1).(b) review and approval of the applicant’s**
586 **exceptional qualifications by the GMEC; and,**
587 ^(Core)
588
589 **III.A.1.c).(1).(c) verification of Educational Commission for**
590 **Foreign Medical Graduates (ECFMG)**
591 **certification. ^(Core)**
592
593 **III.A.1.c).(2) Applicants accepted through this exception must have**
594 **an evaluation of their performance by the Clinical**
595 **Competency Committee within 12 weeks of**
596 **matriculation. ^(Core)**
597

<p>Background and Intent: An exceptionally qualified international graduate applicant has (1) completed a residency program in the core specialty outside the continental United States that was not accredited by the ACGME, AOA, ACGME-I, RCPSC or CFPC, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; and/or</p>

(c) demonstrated leadership during or after residency. Applicants being considered for these positions must be informed of the fact that their training may not lead to certification by ABMS member boards or AOA certifying boards.

In recognition of the diversity of medical education and training around the world, this early evaluation of clinical competence required for these applicants ensures they can provide quality and safe patient care. Any gaps in competence should be addressed as per policies for fellows already established by the program in partnership with the Sponsoring Institution.

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

III.B.1. All complement increases must be approved by the Review Committee. ^(Core)

III.B.2. The number of available fellow positions in the program must be at least one per year. ^(Detail)

III.C. Fellow Transfers

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

IV. Educational Program

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

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

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 that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and subspecialty-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)

640
641 **IV.A.1.a) The program's aims must be made available to program**
642 **applicants, fellows, and faculty members.** (Core)

643
644 **IV.A.2. competency-based goals and objectives for each educational**
645 **experience designed to promote progress on a trajectory to**
646 **autonomous practice in their subspecialty. These must be**
647 **distributed, reviewed, and available to fellows and faculty members;**
648 (Core)

649
650 **IV.A.3. delineation of fellow responsibilities for patient care, progressive**
651 **responsibility for patient management, and graded supervision in**
652 **their subspecialty;** (Core)
653

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.

654
655 **IV.A.4. structured educational activities beyond direct patient care; and,**
656 (Core)
657

Background and Intent: Patient care-related educational activities, such as morbidity and mortality conferences, tumor boards, surgical planning conferences, case discussions, etc., allow fellows to gain medical knowledge directly applicable to the patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected. Further specification can be found in IV.C.

658
659 **IV.A.5. advancement of fellows' knowledge of ethical principles**
660 **foundational to medical professionalism.** (Core)

661
662 **IV.B. ACGME Competencies**
663

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 subspecialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each subspecialty. The focus in fellowship is on subspecialty-specific patient care and medical knowledge, as well as refining the other competencies acquired in residency.

664
665 **IV.B.1. The program must integrate the following ACGME Competencies**
666 **into the curriculum:** (Core)

667
668 **IV.B.1.a) Professionalism**
669

670 Fellows must demonstrate a commitment to professionalism
671 and an adherence to ethical principles. (Core)

672
673 **IV.B.1.b) Patient Care and Procedural Skills**
674

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.

675
676 **IV.B.1.b).(1) Fellows must be able to provide patient care that is**
677 **compassionate, appropriate, and effective for the**
678 **treatment of health problems and the promotion of**
679 **health. (Core)**

680
681 **IV.B.1.b).(1).(a)** Fellows must demonstrate competence in the
682 practice of health promotion, disease prevention,
683 diagnosis, care, and treatment of patients of each
684 gender, from adolescence to old age, during health
685 and all stages of illness; and, (Core)

686
687 **IV.B.1.b).(1).(b)** Fellows must demonstrate competence in treating
688 the following disorders:

689
690 **IV.B.1.b).(1).(b).(i)** crystal induced synovitis; (Core)

691
692 **IV.B.1.b).(1).(b).(ii)** infection of joints and soft tissues; (Core)

693
694 **IV.B.1.b).(1).(b).(iii)** metabolic diseases of bone; (Core)

695
696 **IV.B.1.b).(1).(b).(iv)** non-articular rheumatic diseases, including
697 fibromyalgia; (Core)

698
699 **IV.B.1.b).(1).(b).(v)** pediatric rheumatic diseases, it is suggested
700 that programs with the qualified faculty
701 members and facilities provide training; (Core)

702
703 **IV.B.1.b).(1).(b).(vi)** nonsurgical, exercise-related (sports) injury;
704 (Core)

705
706 **IV.B.1.b).(1).(b).(vii)** polymyositis; (Core)

707
708 **IV.B.1.b).(1).(b).(viii)** osteoarthritis; (Core)

709

710	IV.B.1.b).(1).(b).(ix)	osteoporosis; (Core)
711		
712	IV.B.1.b).(1).(b).(x)	regional musculoskeletal pain syndromes, acute and chronic musculoskeletal pain syndromes, and exercise-related syndromes; (Core)
713		
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717	IV.B.1.b).(1).(b).(xi)	rheumatoid arthritis; (Core)
718		
719	IV.B.1.b).(1).(b).(xii)	scleroderma/systemic sclerosis; (Core)
720		
721	IV.B.1.b).(1).(b).(xiii)	Sjögren's Syndrome; (Core)
722		
723	IV.B.1.b).(1).(b).(xiv)	spondyloarthropathies; (Core)
724		
725	IV.B.1.b).(1).(b).(xv)	systemic diseases with rheumatic manifestations; (Core)
726		
727		
728	IV.B.1.b).(1).(b).(xvi)	systemic lupus erythematosus; and, (Core)
729		
730	IV.B.1.b).(1).(b).(xvii)	vasculitis. (Core)
731		
732	IV.B.1.b).(2)	Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)
733		
734		
735		
736	IV.B.1.b).(2).(a)	Fellows must demonstrate competence in:
737		
738	IV.B.1.b).(2).(a).(i)	the examination and interpretation of synovial fluid under conventional and polarized light microscopy; (Core)
739		
740		
741		
742	IV.B.1.b).(2).(a).(ii)	the interpretation of radiographs of normal and diseased joints, bones, periarticular structures, and prosthetic joints; (Core)
743		
744		
745		
746	IV.B.1.b).(2).(a).(iii)	musculoskeletal pain assessment and management; and, (Core)
747		
748		
749	IV.B.1.b).(2).(a).(iv)	performing arthrocentesis of peripheral joints and periarticular/soft tissue injections. (Core)
750		
751		
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753	IV.B.1.c)	Medical Knowledge
754		
755		Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. (Core)
756		
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760	IV.B.1.c).(1)	Fellows must demonstrate knowledge of the scientific

761		method of problem solving and evidence-based decision
762		making. ^(Core)
763		
764	IV.B.1.c).(2)	Fellows must demonstrate knowledge of indications,
765		contraindications, limitations, complications, techniques,
766		and interpretation of results of those diagnostic and
767		therapeutic procedures integral to the discipline, including
768		the appropriate indications for and use of screening
769		tests/procedures. ^(Core)
770		
771	IV.B.1.c).(2).(a)	This must include knowledge of the indications for
772		and interpretation of:
773		
774	IV.B.1.c).(2).(a).(i)	arthroscopy; ^(Core)
775		
776	IV.B.1.c).(2).(a).(ii)	biopsy specimens, including histochemistry
777		and immunofluorescence of tissues relevant
778		to the diagnosis of rheumatic diseases; ^(Core)
779		
780	IV.B.1.c).(2).(a).(iii)	bone densitometry; ^(Core)
781		
782	IV.B.1.c).(2).(a).(iv)	CT of lungs and paranasal sinuses for
783		patients with suspected or confirmed
784		rheumatic disorders; ^(Core)
785		
786	IV.B.1.c).(2).(a).(v)	electromyograms and nerve conduction
787		studies for patients with suspected or
788		confirmed rheumatic disorders; ^(Core)
789		
790	IV.B.1.c).(2).(a).(vi)	MRI of the central nervous system (brain
791		and spinal cord) for patients with suspected
792		or confirmed rheumatic disorders; ^(Core)
793		
794	IV.B.1.c).(2).(a).(vii)	plain radiography, arthrography,
795		ultrasonography, radionuclide scans, CT,
796		and MRI of joints, bones and periarticular
797		structures; ^(Core)
798		
799	IV.B.1.c).(2).(a).(viii)	arteriograms (conventional and MRI/MRA)
800		for patients with suspected or confirmed
801		vasculitis; ^(Core)
802		
803	IV.B.1.c).(2).(a).(ix)	Schirmer's and rose Bengal tests; and, ^(Core)
804		
805	IV.B.1.c).(2).(a).(x)	parotid scans and salivary flow studies. ^(Core)
806		
807	IV.B.1.c).(3)	Fellows must demonstrate knowledge of:
808		
809	IV.B.1.c).(3).(a)	the anatomy, basic immunology, genetic basis, cell
810		biology and metabolism pertaining to rheumatic
811		diseases, disorders of connective tissue, metabolic

812		disease of bone, osteoporosis, and musculoskeletal
813		pain syndromes; ^(Core)
814		
815	IV.B.1.c).(3).(b)	the pathogenesis, epidemiology, clinical
816		expression, treatments, and prognosis of the full
817		range of rheumatic and musculoskeletal diseases;
818		^(Core)
819		
820	IV.B.1.c).(3).(c)	the physical and biologic basis of the range of
821		diagnostic testing in rheumatology, and the clinical
822		test characteristics of these procedures; ^(Core)
823		
824	IV.B.1.c).(3).(d)	the pharmacokinetics, metabolism, adverse events,
825		interactions, and relative costs of drug therapies
826		used in the management of rheumatic disorders;
827		^(Core)
828		
829	IV.B.1.c).(3).(e)	the aging influences on musculoskeletal function
830		and responses to prescribed therapies for
831		rheumatic diseases; and, ^(Core)
832		
833	IV.B.1.c).(3).(f)	the essential components of quality experimental
834		design, clinical trial design, data analysis, and
835		interpretation of results, and the importance of
836		adherence to ethical standards of experimentation.
837		^(Core)
838		
839	IV.B.1.c).(4)	Fellows must demonstrate knowledge of the appropriate
840		employment of principles of physical medicine and
841		rehabilitation in the care of patients with rheumatic
842		disorders. ^(Core)
843		
844	IV.B.1.c).(5)	Fellows must demonstrate a knowledge of the indications
845		for surgical and orthopaedic consultation, including
846		indications for arthroscopy and joint
847		replacement/arthroplasty. ^(Core)
848		
849	IV.B.1.d)	Practice-based Learning and Improvement
850		
851		Fellows must demonstrate the ability to investigate and
852		evaluate their care of patients, to appraise and assimilate
853		scientific evidence, and to continuously improve patient care
854		based on constant self-evaluation and lifelong learning. ^(Core)
855		

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 fellow refine the habits of mind required to continuously pursue quality improvement, well past the completion of fellowship.

- 856
857 **IV.B.1.e) Interpersonal and Communication Skills**
858
859 **Fellows must demonstrate interpersonal and communication**
860 **skills that result in the effective exchange of information and**
861 **collaboration with patients, their families, and health**
862 **professionals. (Core)**
863
864 **IV.B.1.f) Systems-based Practice**
865
866 **Fellows must demonstrate an awareness of and**
867 **responsiveness to the larger context and system of health**
868 **care, including the social determinants of health, as well as**
869 **the ability to call effectively on other resources to provide**
870 **optimal health care. (Core)**
871
872 **IV.C. Curriculum Organization and Fellow Experiences**
873
874 **IV.C.1. The curriculum must be structured to optimize fellow educational**
875 **experiences, the length of these experiences, and supervisory**
876 **continuity. (Core)**
877
878 **IV.C.1.a)** Assignment of rotations must be structured to minimize the
879 frequency of rotational transitions, and rotations must be of
880 sufficient length to provide a quality educational experience,
881 defined by continuity of patient care, ongoing supervision,
882 longitudinal relationships with faculty members, and meaningful
883 assessment and feedback. (Core)
884
885 **IV.C.1.b)** Clinical experiences should be structured to facilitate learning in a
886 manner that allows fellows to function as part of an effective
887 interprofessional team that works together towards the shared
888 goals of patient safety and quality improvement. (Core)
889
890 **IV.C.2. The program must provide instruction and experience in pain**
891 **management if applicable for the subspecialty, including recognition**
892 **of the signs of addiction. (Core)**
893
894 **IV.C.3.** A minimum of 12 months must be devoted to clinical experience. (Core)
895
896 **IV.C.4.** Fellows must participate in training using simulation. (Detail)
897
898 **IV.C.5. Experience with Continuity Ambulatory Patients**
899
900 **IV.C.5.a)** Fellows must have continuity ambulatory clinic experience that
901 exposes them to the breadth and depth of the subspecialty. (Core)
902
903 **IV.C.5.b)** This experience should average one half-day each week. (Detail)
904

905	IV.C.5.c)	The program must include a minimum of two half-days of ambulatory care per week, averaged over the two years of education, which includes the continuity ambulatory experience. (Detail)
906		
907		
908		
909		
910	IV.C.5.d)	Three half-days per week of ambulatory care are suggested. (Detail)
911		
912	IV.C.5.e)	This experience must include an appropriate distribution of patients of each gender and a diversity of ages, (Core)
913		
914		
915		This should be accomplished through either:
916		
917	IV.C.5.e).(1)	a continuity clinic which provides fellows the opportunity to learn the course of disease; or, (Detail)
918		
919		
920	IV.C.5.e).(2)	selected blocks of at least six months which address specific areas of rheumatologic diseases. (Detail)
921		
922		
923	IV.C.5.f)	Each fellow should, on average, be responsible for four to eight patients during each half-day session. (Detail)
924		
925		
926	IV.C.5.g)	The continuity patient care experience should not be interrupted by more than one month, excluding a fellow's vacation. (Detail)
927		
928		
929	IV.C.5.h)	Fellows should be informed of the status of their continuity patients when such patients are hospitalized, as clinically appropriate. (Detail)
930		
931		
932		
933	IV.C.6.	Procedures and Technical Skills
934		
935	IV.C.6.a)	Direct supervision of procedures performed by each fellow must occur until proficiency has been acquired and documented by the program director. (Core)
936		
937		
938		
939	IV.C.6.b)	Faculty members must teach and supervise the fellows in the performance and interpretation of procedures, which must be documented in each fellow's record, including indications, outcomes, diagnoses, and supervisor(s). (Core)
940		
941		
942		
943		
944	IV.C.7.	Fellows must have experience in the role of a rheumatology consultant in both the inpatient and outpatient settings. (Core)
945		
946		
947	IV.C.8.	The core curriculum must include a didactic program based upon the core knowledge content in the subspecialty area. (Core)
948		
949		
950	IV.C.8.a)	The program must afford each fellow an opportunity to review topics covered in conferences that he or she was unable to attend. (Detail)
951		
952		
953		
954	IV.C.8.b)	Fellows must participate in clinical case conferences, journal clubs, research conference, and morbidity and mortality or quality
955		

- 956 improvement conferences. ^(Detail)
- 957
- 958 IV.C.8.c) All core conferences must have at least one faculty member
- 959 present, and must be scheduled as to ensure peer-peer and peer-
- 960 faculty interaction. ^(Detail)
- 961
- 962 IV.C.9. Patient-based teaching must include direct interaction between fellows
- 963 and faculty members, bedside teaching, discussion of pathophysiology,
- 964 and the use of current evidence in diagnostic and therapeutic decisions.
- 965 ^(Core)
- 966
- 967 The teaching must be:
- 968
- 969 IV.C.9.a) formally conducted on all inpatient, outpatient, and consultative
- 970 services; and, ^(Detail)
- 971
- 972 IV.C.9.b) conducted with a frequency and duration that ensures a
- 973 meaningful and continuous teaching relationship between the
- 974 assigned supervising faculty member(s) and fellows. ^(Detail)
- 975
- 976 IV.C.10. Fellows must receive instruction in practice management relevant to
- 977 rheumatology. ^(Detail)
- 978
- 979 **IV.D. Scholarship**
- 980
- 981 ***Medicine is both an art and a science. The physician is a humanistic***
- 982 ***scientist who cares for patients. This requires the ability to think critically,***
- 983 ***evaluate the literature, appropriately assimilate new knowledge, and***
- 984 ***practice lifelong learning. The program and faculty must create an***
- 985 ***environment that fosters the acquisition of such skills through fellow***
- 986 ***participation in scholarly activities as defined in the subspecialty-specific***
- 987 ***Program Requirements. Scholarly activities may include discovery,***
- 988 ***integration, application, and teaching.***
- 989
- 990 ***The ACGME recognizes the diversity of fellowships and anticipates that***
- 991 ***programs prepare physicians for a variety of roles, including clinicians,***
- 992 ***scientists, and educators. It is expected that the program's scholarship will***
- 993 ***reflect its mission(s) and aims, and the needs of the community it serves.***
- 994 ***For example, some programs may concentrate their scholarly activity on***
- 995 ***quality improvement, population health, and/or teaching, while other***
- 996 ***programs might choose to utilize more classic forms of biomedical***
- 997 ***research as the focus for scholarship.***
- 998
- 999 **IV.D.1. Program Responsibilities**
- 1000
- 1001 **IV.D.1.a) The program must demonstrate evidence of scholarly**
- 1002 **activities, consistent with its mission(s) and aims. ^(Core)**
- 1003
- 1004 **IV.D.1.b) The program in partnership with its Sponsoring Institution,**
- 1005 **must allocate adequate resources to facilitate fellow and**
- 1006 **faculty involvement in scholarly activities. ^(Core)**

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IV.D.2. Faculty Scholarly Activity

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

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

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

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program’s effectiveness in the creation of an environment of inquiry that advances the fellows’ scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

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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).(1).(a) At least 50 percent of the core faculty members who are certified in rheumatology by the ABIM or AOBIM (see Program Requirements II.B.4.c)-d) must annually engage in a variety of scholarly activities, as listed in Program Requirement IV.D.2.b).(1). *(Core)*

1048 **IV.D.3. Fellow Scholarly Activity**

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1050 IV.D.3.a) While in the program, at least 50 percent of a program's fellows
1051 must engage in more than one of the following scholarly activities:
1052 participation in grand rounds, posters, workshops, quality
1053 improvement presentations, podium presentations, grant
1054 leadership, non-peer-reviewed print/electronic resources, articles
1055 or publications, book chapters, textbooks, webinars, service on
1056 professional committees, or serving as a journal reviewer, journal
1057 editorial board member, or editor. (Outcome)

1058
1059 **V. Evaluation**

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1061 **V.A. Fellow Evaluation**

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1063 **V.A.1. Feedback and Evaluation**

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Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower fellows 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 fellow learning* and providing ongoing feedback that can be used by fellows to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

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

Summative evaluation is *evaluating a fellow's learning* by comparing the fellows 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 fellows or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the fellowship program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a new specialist to one with growing subspecialty expertise.

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1066 **V.A.1.a) Faculty members must directly observe, evaluate, and**
1067 **frequently provide feedback on fellow performance during**
1068 **each rotation or similar educational assignment. (Core)**
1069

1070 V.A.1.a).(1) The faculty must discuss this evaluation with each fellow at
1071 the completion of each assignment. (Core)

1072
1073 V.A.1.a).(2) Assessment of procedural competence should include a
1074 formal evaluation process and not be based solely on a
1075 minimum number of procedures performed. ^(Detail)
1076

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Fellows 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 fellows who have deficiencies that may result in a poor final rotation evaluation.

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1078 V.A.1.b) Evaluation must be documented at the completion of the
1079 assignment. ^(Core)
1080

1081 V.A.1.b).(1) For block rotations of greater than three months in
1082 duration, evaluation must be documented at least
1083 every three months. ^(Core)
1084

1085 V.A.1.b).(2) Longitudinal experiences such as continuity clinic in
1086 the context of other clinical responsibilities must be
1087 evaluated at least every three months and at
1088 completion. ^(Core)
1089

1090 V.A.1.c) The program must provide an objective performance
1091 evaluation based on the Competencies and the subspecialty-
1092 specific Milestones, and must: ^(Core)
1093

1094 V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers,
1095 patients, self, and other professional staff members);
1096 and, ^(Core)
1097

1098 V.A.1.c).(2) provide that information to the Clinical Competency
1099 Committee for its synthesis of progressive fellow
1100 performance and improvement toward unsupervised
1101 practice. ^(Core)
1102

Background and Intent: The trajectory to autonomous practice in a subspecialty is documented by the subspecialty-specific Milestones evaluation during fellowship. These Milestones detail the progress of a fellow in attaining skill in each competency domain. It is expected that the most growth in fellowship education occurs in patient care and medical knowledge, while the other four domains of competency must be ensured in the context of the subspecialty. They are developed by a subspecialty group and allow evaluation based on observable behaviors. The 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 fellow.

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1104 V.A.1.d) The program director or their designee, with input from the
1105 Clinical Competency Committee, must:
1106

- 1107 **V.A.1.d).(1)** meet with and review with each fellow their
 1108 documented semi-annual evaluation of performance,
 1109 including progress along the subspecialty-specific
 1110 Milestones. ^(Core)
 1111
- 1112 **V.A.1.d).(2)** assist fellows in developing individualized learning
 1113 plans to capitalize on their strengths and identify areas
 1114 for growth; and, ^(Core)
 1115
- 1116 **V.A.1.d).(3)** develop plans for fellows failing to progress, following
 1117 institutional policies and procedures. ^(Core)
 1118

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a fellow'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. Fellows 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, fellows should develop an individualized learning plan.

Fellows 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 fellow, will take a variety of forms based on the specific learning needs of the fellow. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of fellow progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

- 1119
- 1120 **V.A.1.e)** At least annually, there must be a summative evaluation of
 1121 each fellow that includes their readiness to progress to the
 1122 next year of the program, if applicable. ^(Core)
 1123
- 1124 **V.A.1.f)** The evaluations of a fellow's performance must be accessible
 1125 for review by the fellow. ^(Core)
 1126
- 1127 **V.A.2.** Final Evaluation
- 1128
- 1129 **V.A.2.a)** The program director must provide a final evaluation for each
 1130 fellow upon completion of the program. ^(Core)
 1131
- 1132 **V.A.2.a).(1)** The subspecialty-specific Milestones, and when
 1133 applicable the subspecialty-specific Case Logs, must
 1134 be used as tools to ensure fellows are able to engage
 1135 in autonomous practice upon completion of the
 1136 program. ^(Core)
 1137
- 1138 **V.A.2.a).(2)** The final evaluation must:
 1139

- 1140 **V.A.2.a).(2).(a)** become part of the fellow’s permanent record
 1141 maintained by the institution, and must be
 1142 accessible for review by the fellow in
 1143 accordance with institutional policy; ^(Core)
 1144
- 1145 **V.A.2.a).(2).(b)** verify that the fellow has demonstrated the
 1146 knowledge, skills, and behaviors necessary to
 1147 enter autonomous practice; ^(Core)
 1148
- 1149 **V.A.2.a).(2).(c)** consider recommendations from the Clinical
 1150 Competency Committee; and, ^(Core)
 1151
- 1152 **V.A.2.a).(2).(d)** be shared with the fellow upon completion of
 1153 the program. ^(Core)
 1154
- 1155 **V.A.3.** **A Clinical Competency Committee must be appointed by the**
 1156 **program director.** ^(Core)
 1157
- 1158 **V.A.3.a)** **At a minimum the Clinical Competency Committee must**
 1159 **include three members, at least one of whom is a core faculty**
 1160 **member. Members must be faculty members from the same**
 1161 **program or other programs, or other health professionals**
 1162 **who have extensive contact and experience with the**
 1163 **program’s fellows.** ^(Core)
 1164
- 1165 **V.A.3.b)** **The Clinical Competency Committee must:**
 1166
- 1167 **V.A.3.b).(1)** **review all fellow evaluations at least semi-annually;**
 1168 ^(Core)
 1169
- 1170 **V.A.3.b).(2)** **determine each fellow’s progress on achievement of**
 1171 **the subspecialty-specific Milestones; and,** ^(Core)
 1172
- 1173 **V.A.3.b).(3)** **meet prior to the fellows’ semi-annual evaluations and**
 1174 **advise the program director regarding each fellow’s**
 1175 **progress.** ^(Core)
 1176
- 1177 **V.B. Faculty Evaluation**
 1178
- 1179 **V.B.1.** **The program must have a process to evaluate each faculty**
 1180 **member’s performance as it relates to the educational program at**
 1181 **least annually.** ^(Core)
 1182

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term faculty may be applied to physicians within a given institution for other reasons, it is applied to fellowship program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the fellow and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with fellows desire feedback

on their education, clinical care, and research. If a faculty member does not interact with fellows, feedback is not required. With regard to the diverse operating environments and configurations, the fellowship program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the fellows in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

- 1183
 1184 **V.B.1.a)** This evaluation must include a review of the faculty member's
 1185 clinical teaching abilities, engagement with the educational
 1186 program, participation in faculty development related to their
 1187 skills as an educator, clinical performance, professionalism,
 1188 and scholarly activities. (Core)
 1189
 1190 **V.B.1.b)** This evaluation must include written, confidential evaluations
 1191 by the fellows. (Core)
 1192
 1193 **V.B.2.** Faculty members must receive feedback on their evaluations at least
 1194 annually. (Core)
 1195
 1196 **V.B.3.** Results of the faculty educational evaluations should be
 1197 incorporated into program-wide faculty development plans. (Core)
 1198

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

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 1200 **V.C. Program Evaluation and Improvement**
 1201
 1202 **V.C.1.** The program director must appoint the Program Evaluation
 1203 Committee to conduct and document the Annual Program
 1204 Evaluation as part of the program's continuous improvement
 1205 process. (Core)
 1206
 1207 **V.C.1.a)** The Program Evaluation Committee must be composed of at
 1208 least two program faculty members, at least one of whom is a
 1209 core faculty member, and at least one fellow. (Core)
 1210
 1211 **V.C.1.b)** Program Evaluation Committee responsibilities must include:
 1212
 1213 **V.C.1.b).(1)** acting as an advisor to the program director, through
 1214 program oversight; (Core)
 1215

- 1216 **V.C.1.b).(2)** review of the program’s self-determined goals and
 1217 progress toward meeting them; ^(Core)
 1218
 1219 **V.C.1.b).(3)** guiding ongoing program improvement, including
 1220 development of new goals, based upon outcomes;
 1221 and, ^(Core)
 1222
 1223 **V.C.1.b).(4)** review of the current operating environment to identify
 1224 strengths, challenges, opportunities, and threats as
 1225 related to the program’s mission and aims. ^(Core)
 1226

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

- 1227
 1228 **V.C.1.c)** The Program Evaluation Committee should consider the
 1229 following elements in its assessment of the program:
 1230
 1231 **V.C.1.c).(1)** curriculum; ^(Core)
 1232
 1233 **V.C.1.c).(2)** outcomes from prior Annual Program Evaluation(s);
 1234 ^(Core)
 1235
 1236 **V.C.1.c).(3)** ACGME letters of notification, including citations,
 1237 Areas for Improvement, and comments; ^(Core)
 1238
 1239 **V.C.1.c).(4)** quality and safety of patient care; ^(Core)
 1240
 1241 **V.C.1.c).(5)** aggregate fellow and faculty:
 1242
 1243 **V.C.1.c).(5).(a)** well-being; ^(Core)
 1244
 1245 **V.C.1.c).(5).(b)** recruitment and retention; ^(Core)
 1246
 1247 **V.C.1.c).(5).(c)** workforce diversity; ^(Core)
 1248
 1249 **V.C.1.c).(5).(d)** engagement in quality improvement and patient
 1250 safety; ^(Core)
 1251
 1252 **V.C.1.c).(5).(e)** scholarly activity; ^(Core)
 1253
 1254 **V.C.1.c).(5).(f)** ACGME Resident/Fellow and Faculty Surveys
 1255 (where applicable); and, ^(Core)
 1256
 1257 **V.C.1.c).(5).(g)** written evaluations of the program. ^(Core)
 1258
 1259 **V.C.1.c).(6)** aggregate fellow:
 1260

- 1261 V.C.1.c).(6).(a) achievement of the Milestones; ^(Core)
1262
1263 V.C.1.c).(6).(b) in-training examinations (where applicable);
1264 ^(Core)
1265
1266 V.C.1.c).(6).(c) board pass and certification rates; and, ^(Core)
1267
1268 V.C.1.c).(6).(d) graduate performance. ^(Core)
1269
1270 V.C.1.c).(7) aggregate faculty:
1271
1272 V.C.1.c).(7).(a) evaluation; and, ^(Core)
1273
1274 V.C.1.c).(7).(b) professional development ^(Core)
1275
1276 V.C.1.d) The Program Evaluation Committee must evaluate the
1277 program's mission and aims, strengths, areas for
1278 improvement, and threats. ^(Core)
1279
1280 V.C.1.e) The annual review, including the action plan, must:
1281
1282 V.C.1.e).(1) be distributed to and discussed with the members of
1283 the teaching faculty and the fellows; and, ^(Core)
1284
1285 V.C.1.e).(2) be submitted to the DIO. ^(Core)
1286
1287 V.C.2. The program must participate in a Self-Study prior to its 10-Year
1288 Accreditation Site Visit. ^(Core)
1289
1290 V.C.2.a) A summary of the Self-Study must be submitted to the DIO.
1291 ^(Core)
1292

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 fellowship 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.

- 1293
1294 V.C.3. *One goal of ACGME-accredited education is to educate physicians*
1295 *who seek and achieve board certification. One measure of the*
1296 *effectiveness of the educational program is the ultimate pass rate.*
1297
1298 *The program director should encourage all eligible program*
1299 *graduates to take the certifying examination offered by the*

- 1300 *applicable American Board of Medical Specialties (ABMS) member*
 1301 *board or American Osteopathic Association (AOA) certifying board.*
 1302
- 1303 **V.C.3.a)** For subspecialties in which the ABMS member board and/or
 1304 AOA certifying board offer(s) an annual written exam, in the
 1305 preceding three years, the program’s aggregate pass rate of
 1306 those taking the examination for the first time must be higher
 1307 than the bottom fifth percentile of programs in that
 1308 subspecialty. ^(Outcome)
 1309
- 1310 **V.C.3.b)** For subspecialties in which the ABMS member board and/or
 1311 AOA certifying board offer(s) a biennial written exam, in the
 1312 preceding six years, the program’s aggregate pass rate of
 1313 those taking the examination for the first time must be higher
 1314 than the bottom fifth percentile of programs in that
 1315 subspecialty. ^(Outcome)
 1316
- 1317 **V.C.3.c)** For subspecialties in which the ABMS member board and/or
 1318 AOA certifying board offer(s) an annual oral exam, in the
 1319 preceding three years, the program’s aggregate pass rate of
 1320 those taking the examination for the first time must be higher
 1321 than the bottom fifth percentile of programs in that
 1322 subspecialty. ^(Outcome)
 1323
- 1324 **V.C.3.d)** For subspecialties in which the ABMS member board and/or
 1325 AOA certifying board offer(s) a biennial oral exam, in the
 1326 preceding six years, the program’s aggregate pass rate of
 1327 those taking the examination for the first time must be higher
 1328 than the bottom fifth percentile of programs in that
 1329 subspecialty. ^(Outcome)
 1330
- 1331 **V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program
 1332 whose graduates over the time period specified in the
 1333 requirement have achieved an 80 percent pass rate will have
 1334 met this requirement, no matter the percentile rank of the
 1335 program for pass rate in that subspecialty. ^(Outcome)
 1336

Background and Intent: Setting a single standard for pass rate that works across subspecialties 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 subspecialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

- 1337
 1338 **V.C.3.f)** Programs must report, in ADS, board certification status
 1339 annually for the cohort of board-eligible fellows that
 1340 graduated seven years earlier. ^(Core)

Background and Intent: It is essential that fellowship programs demonstrate knowledge and skill transfer to their fellows. 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 fellowship 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.

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VI. The Learning and Working Environment

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

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- *Excellence in the safety and quality of care rendered to patients by fellows today*

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- *Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice*

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1354

- *Excellence in professionalism through faculty modeling of:*

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

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1359

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

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- *Commitment to the well-being of the students, residents, fellows, faculty members, and all members of the health care team*

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1363

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and fellows more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and fellows to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, fellow education, and fellow well-being. The requirements are intended to support the development of a sense of professionalism by encouraging fellows to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for fellows to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and fellow and faculty member well-being. The requirements are intended to support programs and fellows as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and fellows. With this flexibility comes a responsibility for fellows and faculty members to recognize the need to hand off care of a patient to another provider when a fellow is too fatigued to provide safe, high quality care and for programs to ensure that fellows remain within the 80-hour maximum weekly limit.

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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 fellows 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 fellows 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.

Fellows 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 fellows will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for fellows 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)

1405 VI.A.1.a).(1).(b) The program must have a structure that
1406 promotes safe, interprofessional, team-based
1407 care. ^(Core)
1408

1409 VI.A.1.a).(2) Education on Patient Safety
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1411 Programs must provide formal educational activities
1412 that promote patient safety-related goals, tools, and
1413 techniques. ^(Core)
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Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

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1416 VI.A.1.a).(3) Patient Safety Events
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1418 *Reporting, investigation, and follow-up of adverse*
1419 *events, near misses, and unsafe conditions are pivotal*
1420 *mechanisms for improving patient safety, and are*
1421 *essential for the success of any patient safety*
1422 *program. Feedback and experiential learning are*
1423 *essential to developing true competence in the ability*
1424 *to identify causes and institute sustainable systems-*
1425 *based changes to ameliorate patient safety*
1426 *vulnerabilities.*
1427

1428 VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other
1429 clinical staff members must:

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1431 VI.A.1.a).(3).(a).(i) know their responsibilities in reporting
1432 patient safety events at the clinical site;
1433 ^(Core)
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1435 VI.A.1.a).(3).(a).(ii) know how to report patient safety
1436 events, including near misses, at the
1437 clinical site; and, ^(Core)
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1439 VI.A.1.a).(3).(a).(iii) be provided with summary information
1440 of their institution's patient safety
1441 reports. ^(Core)
1442

1443 VI.A.1.a).(3).(b) Fellows must participate as team members in
1444 real and/or simulated interprofessional clinical
1445 patient safety activities, such as root cause
1446 analyses or other activities that include
1447 analysis, as well as formulation and
1448 implementation of actions. ^(Core)
1449

1450 VI.A.1.a).(4) Fellow Education and Experience in Disclosure of
1451 Adverse Events
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1453		<i>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 fellows to develop and apply.</i>
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1459	VI.A.1.a).(4).(a)	All fellows must receive training in how to disclose adverse events to patients and families. ^(Core)
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1463	VI.A.1.a).(4).(b)	Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated. ^{(Detail)†}
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1467	VI.A.1.b)	Quality Improvement
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1469	VI.A.1.b).(1)	Education in Quality Improvement
1470		
1471		<i>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.</i>
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1476	VI.A.1.b).(1).(a)	Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)
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1480	VI.A.1.b).(2)	Quality Metrics
1481		
1482		<i>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</i>
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1486	VI.A.1.b).(2).(a)	Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)
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1490	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1491		
1492		<i>Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.</i>
1493		
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1496	VI.A.1.b).(3).(a)	Fellows must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)
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1500	VI.A.1.b).(3).(a).(i)	This should include activities aimed at reducing health care disparities. ^(Detail)
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1503	VI.A.2.	Supervision and Accountability

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1505 **VI.A.2.a)** *Although the attending physician is ultimately responsible for*
1506 *the care of the patient, every physician shares in the*
1507 *responsibility and accountability for their efforts in the*
1508 *provision of care. Effective programs, in partnership with*
1509 *their Sponsoring Institutions, define, widely communicate,*
1510 *and monitor a structured chain of responsibility and*
1511 *accountability as it relates to the supervision of all patient*
1512 *care.*
- 1513
1514 *Supervision in the setting of graduate medical education*
1515 *provides safe and effective care to patients; ensures each*
1516 *fellow's development of the skills, knowledge, and attitudes*
1517 *required to enter the unsupervised practice of medicine; and*
1518 *establishes a foundation for continued professional growth.*
1519
- 1520 **VI.A.2.a).(1)** **Each patient must have an identifiable and**
1521 **appropriately-credentialed and privileged attending**
1522 **physician (or licensed independent practitioner as**
1523 **specified by the applicable Review Committee) who is**
1524 **responsible and accountable for the patient's care.**
1525 (Core)
- 1526
1527 **VI.A.2.a).(1).(a)** **This information must be available to fellows,**
1528 **faculty members, other members of the health**
1529 **care team, and patients.** (Core)
- 1530
1531 **VI.A.2.a).(1).(b)** **Fellows and faculty members must inform each**
1532 **patient of their respective roles in that patient's**
1533 **care when providing direct patient care.** (Core)
- 1534
1535 **VI.A.2.b)** *Supervision may be exercised through a variety of methods.*
1536 *For many aspects of patient care, the supervising physician*
1537 *may be a more advanced fellow. Other portions of care*
1538 *provided by the fellow can be adequately supervised by the*
1539 *appropriate availability of the supervising faculty member or*
1540 *fellow, either on site or by means of telecommunication*
1541 *technology. Some activities require the physical presence of*
1542 *the supervising faculty member. In some circumstances,*
1543 *supervision may include post-hoc review of fellow-delivered*
1544 *care with feedback.*
1545

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

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1547	VI.A.2.b).(1)	The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow’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)
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1554	VI.A.2.b).(2)	The program must define when physical presence of a supervising physician is required. ^(Core)
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1557	VI.A.2.c)	Levels of Supervision
1558		
1559		To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: ^(Core)
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1563	VI.A.2.c).(1)	Direct Supervision:
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1565	VI.A.2.c).(1).(a)	the supervising physician is physically present with the fellow during the key portions of the patient interaction; or, ^(Core)
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1569	VI.A.2.c).(1).(b)	the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. ^(Core)
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1575	VI.A.2.c).(2)	Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision. ^(Core)
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1581	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)
1582		
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1585	VI.A.2.d)	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. ^(Core)
1586		
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1590	VI.A.2.d).(1)	The program director must evaluate each fellow’s abilities based on specific criteria, guided by the Milestones. ^(Core)
1591		
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1594	VI.A.2.d).(2)	Faculty members functioning as supervising physicians must delegate portions of care to fellows
1595		

1596 based on the needs of the patient and the skills of
1597 each fellow. ^(Core)

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1599 **VI.A.2.d).(3)** Fellows should serve in a supervisory role to junior
1600 fellows and residents in recognition of their progress
1601 toward independence, based on the needs of each
1602 patient and the skills of the individual resident or
1603 fellow. ^(Detail)

1604
1605 **VI.A.2.e)** Programs must set guidelines for circumstances and events
1606 in which fellows must communicate with the supervising
1607 faculty member(s). ^(Core)

1608
1609 **VI.A.2.e).(1)** Each fellow must know the limits of their scope of
1610 authority, and the circumstances under which the
1611 fellow is permitted to act with conditional
1612 independence. ^(Outcome)

1613

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

1614
1615 **VI.A.2.f)** Faculty supervision assignments must be of sufficient
1616 duration to assess the knowledge and skills of each fellow
1617 and to delegate to the fellow the appropriate level of patient
1618 care authority and responsibility. ^(Core)

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1620 **VI.B. Professionalism**

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1622 **VI.B.1.** Programs, in partnership with their Sponsoring Institutions, must
1623 educate fellows and faculty members concerning the professional
1624 responsibilities of physicians, including their obligation to be
1625 appropriately rested and fit to provide the care required by their
1626 patients. ^(Core)

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1628 **VI.B.2.** The learning objectives of the program must:

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1630 **VI.B.2.a)** be accomplished through an appropriate blend of supervised
1631 patient care responsibilities, clinical teaching, and didactic
1632 educational events; ^(Core)

1633
1634 **VI.B.2.b)** be accomplished without excessive reliance on fellows to
1635 fulfill non-physician obligations; and, ^(Core)

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Background and Intent: Routine reliance on fellows to fulfill non-physician obligations increases work compression for fellows and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests;

routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that fellows may be expected to do any of these things on occasion when the need arises, these activities should not be performed by fellows routinely and must be kept to a minimum to optimize fellow education.

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

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

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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. Fellows 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)

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the fellow.

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

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and fellows to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, fellows, and other members of the care team to be observant, to intervene, and/or to escalate their concern about fellow and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

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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)

- 1667 VI.B.4.e) monitoring of their patient care performance improvement
 1668 indicators; and, (Outcome)
 1669
- 1670 VI.B.4.f) accurate reporting of clinical and educational work hours,
 1671 patient outcomes, and clinical experience data. (Outcome)
 1672
- 1673 VI.B.5. All fellows and faculty members must demonstrate responsiveness
 1674 to patient needs that supersedes self-interest. This includes the
 1675 recognition that under certain circumstances, the best interests of
 1676 the patient may be served by transitioning that patient's care to
 1677 another qualified and rested provider. (Outcome)
 1678
- 1679 VI.B.6. Programs, in partnership with their Sponsoring Institutions, must
 1680 provide a professional, equitable, respectful, and civil environment
 1681 that is free from discrimination, sexual and other forms of
 1682 harassment, mistreatment, abuse, or coercion of students, fellows,
 1683 faculty, and staff. (Core)
 1684
- 1685 VI.B.7. Programs, in partnership with their Sponsoring Institutions, should
 1686 have a process for education of fellows and faculty regarding
 1687 unprofessional behavior and a confidential process for reporting,
 1688 investigating, and addressing such concerns. (Core)
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- 1690 VI.C. Well-Being
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- 1692 *Psychological, emotional, and physical well-being are critical in the*
 1693 *development of the competent, caring, and resilient physician and require*
 1694 *proactive attention to life inside and outside of medicine. Well-being*
 1695 *requires that physicians retain the joy in medicine while managing their*
 1696 *own real-life stresses. Self-care and responsibility to support other*
 1697 *members of the health care team are important components of*
 1698 *professionalism; they are also skills that must be modeled, learned, and*
 1699 *nurtured in the context of other aspects of fellowship training.*
 1700
- 1701 *Fellows and faculty members are at risk for burnout and depression.*
 1702 *Programs, in partnership with their Sponsoring Institutions, have the same*
 1703 *responsibility to address well-being as other aspects of resident*
 1704 *competence. Physicians and all members of the health care team share*
 1705 *responsibility for the well-being of each other. For example, a culture which*
 1706 *encourages covering for colleagues after an illness without the expectation*
 1707 *of reciprocity reflects the ideal of professionalism. A positive culture in a*
 1708 *clinical learning environment models constructive behaviors, and prepares*
 1709 *fellows with the skills and attitudes needed to thrive throughout their*
 1710 *careers.*
 1711

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and

collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website: www.acgme.org/physicianwellbeing.

The ACGME also created a repository for well-being materials, assessments, presentations, and more on the [Well-Being Tools and Resources page](#) in Learn at ACGME for programs seeking to develop or strengthen their own well-being initiatives. There are many activities that programs can implement now to assess and support physician well-being. These include the distribution and analysis of culture of safety surveys, ensuring the availability of counseling services, and paying attention to the safety of the entire health care team.

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- VI.C.1.** The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:
- VI.C.1.a)** efforts to enhance the meaning that each fellow 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 fellow well-being; ^(Core)
- VI.C.1.c)** evaluating workplace safety data and addressing the safety of fellows and faculty members; ^(Core)

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

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

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

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

Background and Intent: The intent of this requirement is to ensure that fellows have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Fellows must be provided with

time away from the program as needed to access care, including appointments scheduled during their working hours.

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VI.C.1.e) attention to fellow and faculty member burnout, depression, and substance use disorder. The program, in partnership with its Sponsoring Institution, must educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance use disorder, including means to assist those who experience these conditions. Fellows 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)

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

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

Background and Intent: Individuals experiencing burnout, depression, substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that fellows and faculty members are able to report their concerns when another fellow or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Fellows and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

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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)

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

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

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- VI.C.2.** There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for fellows unable to perform their patient care responsibilities. ^(Core)
 - VI.C.2.a)** The program must have policies and procedures in place to ensure coverage of patient care. ^(Core)
 - VI.C.2.b)** These policies must be implemented without fear of negative consequences for the fellow who is or was unable to provide the clinical work. ^(Core)

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

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- VI.D. Fatigue Mitigation**
 - VI.D.1. Programs must:**
 - VI.D.1.a)** educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; ^(Core)
 - VI.D.1.b)** educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, ^(Core)
 - VI.D.1.c)** encourage fellows to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. ^(Detail)

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares fellows for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

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

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- VI.D.2. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2–VI.C.2.b), in the event that a fellow 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 fellows 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 fellow must be based on PGY level, patient safety, fellow ability, severity and complexity of patient illness/condition, and available support services. (Core)**

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on fellows. Faculty members and program directors need to make sure fellows function in an environment that has safe patient care and a sense of fellow well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor fellow workload. Workload should be distributed among the fellow team and interdisciplinary teams to minimize work compression.

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- VI.E.2. Teamwork**
 - Fellows 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 subspecialty 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)**

- 1831 VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,
 1832 must ensure and monitor effective, structured hand-over
 1833 processes to facilitate both continuity of care and patient
 1834 safety. ^(Core)
 1835
- 1836 VI.E.3.c) Programs must ensure that fellows are competent in
 1837 communicating with team members in the hand-over process.
 1838 ^(Outcome)
 1839
- 1840 VI.E.3.d) Programs and clinical sites must maintain and communicate
 1841 schedules of attending physicians and fellows currently
 1842 responsible for care. ^(Core)
 1843
- 1844 VI.E.3.e) Each program must ensure continuity of patient care,
 1845 consistent with the program’s policies and procedures
 1846 referenced in VI.C.2-VI.C.2.b), in the event that a fellow may
 1847 be unable to perform their patient care responsibilities due to
 1848 excessive fatigue or illness, or family emergency. ^(Core)
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- 1850 VI.F. Clinical Experience and Education
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 1852 *Programs, in partnership with their Sponsoring Institutions, must design*
 1853 *an effective program structure that is configured to provide fellows with*
 1854 *educational and clinical experience opportunities, as well as reasonable*
 1855 *opportunities for rest and personal activities.*
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Background and Intent: In the new requirements, the terms “clinical experience and education,” “clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty.” These changes have been made in response to concerns that the previous use of the term “duty” in reference to number of hours worked may have led some to conclude that fellows’ duty to “clock out” on time superseded their duty to their patients.

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- 1858 VI.F.1. Maximum Hours of Clinical and Educational Work per Week
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 1860 Clinical and educational work hours must be limited to no more than
 1861 80 hours per week, averaged over a four-week period, inclusive of all
 1862 in-house clinical and educational activities, clinical work done from
 1863 home, and all moonlighting. ^(Core)
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Background and Intent: Programs and fellows have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing fellows to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling
 While the ACGME acknowledges that, on rare occasions, a fellow may work in excess of 80 hours in a given week, all programs and fellows utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-

week period. Programs that regularly schedule fellows to work 80 hours per week and still permit fellows to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that fellows are scheduled to work fewer than 80 hours per week, which would allow fellows to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight

With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for fellows to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home

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

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a fellow spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the fellow need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by fellows. The new requirements are not an attempt to micromanage this process. Fellows are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual fellow. Programs will need to factor in time fellows are spending on clinical work at home when schedules are developed to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that fellows report their time from home and that schedules

are structured to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks.

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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 fellows with educational opportunities, as well as reasonable opportunities for rest and personal well-being. ^(Core)

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

VI.F.2.b).(1) There may be circumstances when fellows 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)

Background and Intent: While it is expected that fellow schedules will be structured to ensure that fellows are provided with a minimum of eight hours off between scheduled work periods, it is recognized that fellows may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for fellows to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

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

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

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

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and fellow needs. It is strongly recommended that fellows' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some fellows may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide fellows with a weekend, or two

consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes fellow well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as “one (1) continuous 24-hour period free from all administrative, clinical, and educational activities.”

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

VI.F.3.a) Clinical and educational work periods for fellows 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 fellow education. ^(Core)

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

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the fellow continue to function as a member of the team in an environment where other members of the team can assess fellow fatigue, and that supervision for post-call fellows is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

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

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a fellow, 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)

Background and Intent: This requirement is intended to provide fellows with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a fellow may remain to attend a conference, or return for a conference later in

the day, only if the decision is made voluntarily. Fellows must not be required to stay. Programs allowing fellows to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the fellow and that fellows are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

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- 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 fellows' work week.
- VI.F.5.** **Moonlighting**
- VI.F.5.a)** **Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow's fitness for work nor compromise patient safety. ^(Core)**
- VI.F.5.b)** **Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. ^(Core)**

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

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- 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)**

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

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- VI.F.7.** **Maximum In-House On-Call Frequency**
- Fellows 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 fellows on at-home call must count toward the 80-hour maximum weekly limit.**

1967		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)
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1972	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 fellow. ^(Core)
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1976	VI.F.8.b)	Fellows 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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Background and Intent: This requirement has been modified to specify that clinical work done from home when a fellow is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time fellows devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in fellows routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

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

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1984		*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.
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1987		†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.
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1992		‡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.
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1996		Osteopathic Recognition
1997		For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).
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