



ACGME International

**Advanced Specialty Program Requirements for
Graduate Medical Education in
Internal Medicine**

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Graduate Medical Education
in Internal Medicine**

I. Introduction

I.A. Definition and Scope of the Specialty

Internal medicine is a discipline encompassing the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age, during health and all stages of illness. Intrinsic to the discipline are scientific knowledge, the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values.

I.B. Duration of Education

I.B.1. The education in internal medicine must be 36 or 48 months in length.

II. Institutions

II.A. Sponsoring Institution

See International Foundational Requirements, Section I.A.

II.B. Participating Sites

See International Foundational Requirements, Section I.B.

III. Program Personnel and Resources

III.A. Program Director

See International Foundational Requirements, Section II.A.

III.B. Faculty

III.B.1. The program must have associate program directors who are:

III.B.1.a) faculty members who assist the program director in the administrative and clinical oversight of the educational program; and,

III.B.1.b) clinicians with broad knowledge of, experience with, and commitment to internal medicine as a discipline, patient-centered care, and to the generalist training of residents.

III.B.1.c) Associate program directors must:

III.B.1.c).(1) dedicate on average at least 20 hours per week to the administrative and educational aspects of the educational program, as delegated by the program director, and receive institutional support for this time;

III.B.1.c).(2) report directly to the program director; and,

III.B.1.c).(3) participate in academic societies and in educational programs designed to enhance their professional development

III.B.2. In conjunction with division chiefs, the program director must identify qualified individuals as Subspecialty Education Coordinators (SECs).

III.B.2.a) SECs must be identified for each of the following subspecialties of internal medicine: cardiology, critical care, endocrinology, hematology, gastroenterology, geriatric medicine, infectious diseases, nephrology, oncology, pulmonary disease, and rheumatology.

III.B.2.b) SECs must be accountable to the program director for coordination of the residents' subspecialty educational experiences in order to accomplish the goals and objectives in the subspecialty.

III.C. Other Program Personnel

See International Foundational Requirements, Section II.C.

III.D. Resources

III.D.1. There must be services for: cardiac catheterization, bronchoscopy, gastrointestinal endoscopy, non-invasive cardiology studies, pulmonary function studies, hemodialysis, and imaging studies, including radionuclide, ultrasound, fluoroscopy, angiography, computerized tomography, and magnetic resonance imaging.

IV. Resident Appointment

IV.A. Eligibility Criteria

See International Foundational Requirements, Section III.A.

IV.B. Number of Residents

IV.B.1. There must be a minimum of 15 residents enrolled and participating in the educational program at all times.

IV.B.2. Residency positions must be allocated to either categorical or preliminary positions.

- IV.B.2.a) A resident who has satisfactorily completed a preliminary training year must not be appointed to additional years as a preliminary resident.
- IV.B.2.b) The number of preliminary positions must not exceed the total number of approved post-graduate year one (PGY-1) categorical positions.
- IV.B.2.c) Documentation of continuation in graduate medical education for the preliminary residents must be provided at the time of a site visit.
- IV.B.2.d) The program director must counsel and assist preliminary residents in obtaining future positions.

V. Specialty-Specific Educational Program

V.A. Regularly Scheduled Didactic Sessions

- V.A.1. The core curriculum must include a didactic program that is based upon the core knowledge content of internal medicine.
- V.A.2. The program must provide opportunities for residents to interact with other residents and faculty in educational sessions at a frequency sufficient for peer-peer and peer-faculty interaction.
- V.A.3. Patient based teaching must include direct interaction between resident and the attending physician, bedside teaching, discussion of pathophysiology, and the use of current evidence in diagnostic and therapeutic decisions. The teaching must be:
 - V.A.3.a) formally conducted on all inpatient and consultative services; and,
 - V.A.3.b) conducted with a frequency and duration sufficient to ensure a meaningful and continuous teaching relationship between the assigned teaching attending and resident.

V.B. Clinical Experiences

- V.B.1. Residents' clinical experiences must include:
 - V.B.1.a) critical care rotations (e.g., medical or respiratory intensive care units, cardiac care units) of at least three months and no more than six months;
 - V.B.1.b) exposure to each of the internal medicine subspecialties, dermatology, and neurology;
 - V.B.1.c) an assignment in geriatric medicine;

- V.B.1.d) an assignment to an ambulatory/outpatient setting;
- V.B.1.e) opportunities to demonstrate competence in the performance of the following procedures:
 - V.B.1.e).(1) abdominal paracentesis;
 - V.B.1.e).(2) advanced cardiac life support;
 - V.B.1.e).(3) arterial line placement;
 - V.B.1.e).(4) arthrocentesis;
 - V.B.1.e).(5) central venous line placement;
 - V.B.1.e).(6) drawing venous blood;
 - V.B.1.e).(7) drawing arterial blood;
 - V.B.1.e).(8) electrocardiogram;
 - V.B.1.e).(9) incision and drainage of an abscess;
 - V.B.1.e).(10) lumbar puncture;
 - V.B.1.e).(11) nasogastric intubation;
 - V.B.1.e).(12) placing a peripheral venous line;
 - V.B.1.e).(13) pulmonary artery catheter placement; and,
 - V.B.1.e).(14) thoracentesis.
- V.B.2. Residents must not be assigned more than two months of night float during any year of training, or more than four months of night float over three years of residency.
- V.B.3. Residents must not be assigned to more than one month of consecutive night float rotation.
- V.B.4. Inpatient Rotations
 - V.B.4.a) The number of admissions for a PGY-1 resident must not preclude meaningful reflections on the learning issues (e.g., developing a differential diagnosis and treatment plan).
 - V.B.4.b) A PGY-1 resident must not provide on-going care for more than 15 patients.

- V.B.4.c) When supervising more than one PGY-1 resident, a supervising resident must not be responsible for the ongoing care of more than 30 patients.
- V.B.4.d) Residents must write all orders for patients under their care, with appropriate supervision by the attending physician.
- V.B.4.d).(1) In those unusual circumstances when an attending physician or subspecialty resident writes an order on a resident's patient, the attending or subspecialty resident must communicate his or her action to the resident in a timely manner.
- V.B.4.e) Second- or third-year internal medicine residents or other appropriate supervisory physicians (e.g., subspecialty residents or attendings) with documented experience appropriate to the acuity, complexity, and severity of patient illness must be available on-site at all times to supervise PGY-1 residents.
- V.B.4.f) Each physician of record must make management rounds on his or her patients and communicate effectively with the residents participating in the care of these patients at a frequency appropriate to the changing care needs of the patients.
- V.B.4.g) Residents from other specialties must not supervise internal medicine residents on any internal medicine inpatient rotation.
- V.B.5. Emergency Medicine Rotations
- V.B.5.a) Residents must be assigned to a minimum of four weeks of direct experience in blocks of not less than two weeks.
- V.B.5.b) Residents must have first-contact responsibility for a sufficient number of unselected patients to meet their educational needs.
- V.B.5.b).(1) Other physicians must not triage such patients prior to this contact.
- V.B.5.c) Total required emergency medicine experience must not exceed three months in three years of training.
- V.B.6. Residents should not be required to relate to an excessive number of physicians of record.

V.C. Resident Scholarly Activities

See International Foundational Requirements, Section IV. B.

V.D. Duty Hour and Work Limitations

See International Foundational Requirements, Section VI.

VI. ACGME-I Competencies

VI.A. Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents must demonstrate proficiency in:

- VI.A.1. a variety of roles to include serving as the direct provider, the leader or member of a multi-disciplinary team of providers, a consultant to other physicians, and a teacher to the patient and other physicians;
- VI.A.2. the prevention, counseling, detection, and diagnosis and treatment of gender-specific diseases;
- VI.A.3. managing patients in a variety of health care settings, including the inpatient ward, the critical care units, and the emergency setting;
- VI.A.4. managing patients across the spectrum of clinical disorders as seen in the practice of general internal medicine, including the subspecialties of internal medicine and non-internal medicine specialties;
- VI.A.5. using clinical skills of interviewing and physical examination;
- VI.A.6. using the laboratory and imaging techniques appropriately; and,
- VI.A.7. providing care for a sufficient number of undifferentiated acutely and severely ill patients.

VI.B. Medical Knowledge

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

- VI.B.1. evaluating patients with an undiagnosed and undifferentiated presentation;
- VI.B.2. treating medical conditions commonly managed by internists;
- VI.B.3. providing basic preventive care;
- VI.B.4. interpreting basic clinical tests and images;
- VI.B.5. recognizing and providing initial management of emergency medical problems;
- VI.B.6. using common pharmacotherapy; and,

- VI.B.7. appropriately using and performing diagnostic and therapeutic procedures.

VI.C. Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on continuous self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

- VI.C.1. identify strengths, deficiencies, and limits in one's knowledge and expertise;
- VI.C.2. set learning and improvement goals;
- VI.C.3. identify and perform appropriate learning activities;
- VI.C.4. systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- VI.C.5. incorporate formative evaluation feedback into daily practice;
- VI.C.6. locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- VI.C.7. use information technology to optimize learning; and,
- VI.C.8. participate in the education of patients, families, students, residents, and other health professionals.

VI.D. Interpersonal and Communication Skills

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

- VI.D.1. communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- VI.D.2. communicate effectively with physicians, other health professionals, and health-related agencies;
- VI.D.3. work effectively as a member or leader of a health care team or other professional group;
- VI.D.4. act in a consultative role to other physicians and health professionals; and,

VI.D.5. maintain comprehensive, timely, and legible medical records.

VI.E. Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents must demonstrate:

VI.E.1. compassion, integrity, and respect for others;

VI.E.2. responsiveness to patient needs that supersedes self-interest;

VI.E.3. respect for patient privacy and autonomy;

VI.E.4. accountability to patients, society and the profession; and,

VI.E.5. sensitivity and responsiveness to a diverse patient population, including to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

VI.F. Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents must:

VI.F.1. work effectively in various health care delivery settings and systems relevant to their clinical specialty;

VI.F.2. coordinate patient care within the health care system relevant to their clinical specialty;

VI.F.3. incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

VI.F.4. advocate for quality patient care and optimal patient care systems;

VI.F.5. work in inter-professional teams to enhance patient safety and improve patient care quality; and,

VI.F.6. participate in identifying system errors and implementing potential systems solutions.