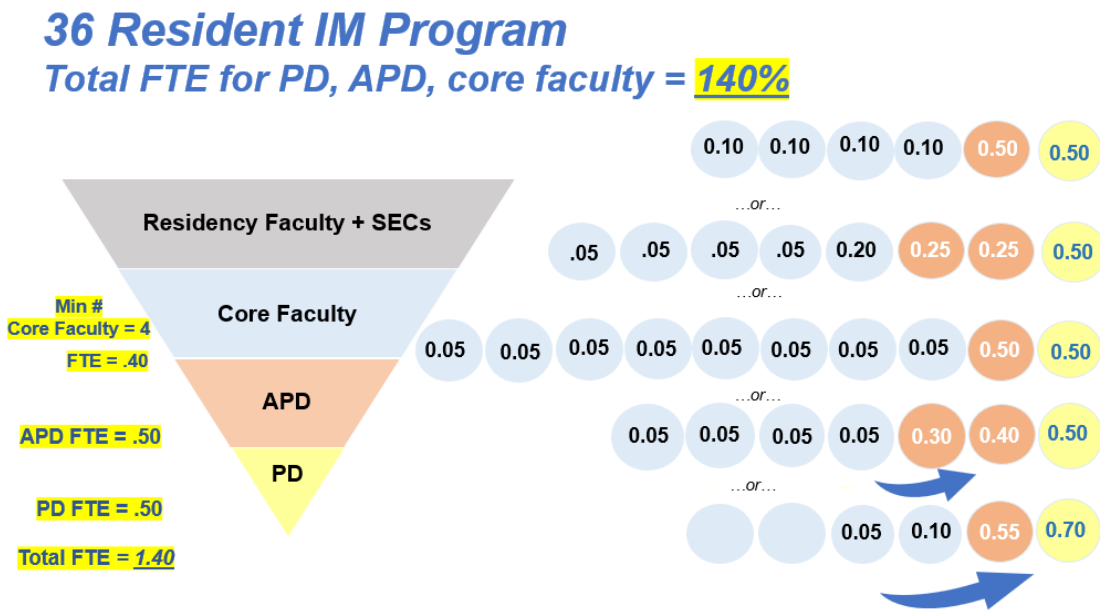
Frequently Asked Questions: Internal Medicine
Review Committee for Internal Medicine
ACGME

Question	Answer
Personnel	
Can one individual be the program director for both a core internal medicine program and a subspecialty program? *[Program Requirement 2.1.]*	No. The Review Committee does not allow one person to be the program director of an internal medicine program and a subspecialty program. The many administrative responsibilities and dedicated time associated with being program director of a single program preclude one person from holding this position in both a residency and subspecialty program.
For the program director, what board certification qualifications are acceptable to the Review Committee? *[Program Requirement 2.5.a.1.]*	The Review Committee accepts only current certification in internal medicine by the American Board of Internal Medicine (ABIM) or the American Osteopathic Board of Internal Medicine (AOBIM). The Review Committee may withhold accreditation of applications that are not led by ABIM- or AOBIM-certified internists. Individuals who are subspecialty certified can be program director if they maintain their internal medicine certification. Internal medicine program directors cannot let their internal medicine certification lapse and maintain only a subspecialty certificate. Note: ABIM requires verification of residents' clinical competence from an ABIM-certified program director. For additional information on this, contact the ABIM.

Can the minimum required dedicated time and support (FTE) specified for the administration of the program for program director, associate program director, and core faculty be distributed by the program, in partnership with the Sponsoring Institution, as they see fit? *[Program Requirements 2.4.a., 2.4.b., and 2.11.c.]*	Programs have a great deal of flexibility in terms of distributing the minimum required support. The example below highlights this flexibility. A program with an approved complement of 36 is required to have the following: • One program director (PD) at .50 FTE • At least one associate program director (APD) at .50 FTE • At least four core faculty members certified in internal medicine or a subspecialty of internal medicine with an aggregate FTE of .40 As the graphic shows, the program, in partnership with its Sponsoring Institution, could choose to operationalize the FTE for the associate program director(s) and core faculty members as they see fit. The 40 percent FTE can be operationalized as four ABIM- or AOBIM-certified faculty members each with 10 percent FTE support, or in the other ways noted below. The FTE for the associate program director(s) can also be distributed as the program and Sponsoring Institution see fit. It can distribute the 50 percent FTE among multiple associate program directors, but it can also allocate some of the FTE to the program director. The FTE for program director can be increased, but it can't be lower than what appears in the Program Requirements. 

Question	Answer
Can some of the program director's minimum required FTE specified for the administration of the program be allocated/distributed to the associate program director or core faculty members? *[Program Requirement 2.4.a.]*	No, the Review Committee does not support reducing or redistributing the minimum FTE for the program director.
Can non-ABIM/AOBIM-certified intensivists supervise internal medicine residents in multidisciplinary critical care units? *[Program Requirement 2.7.b.]*	The Review Committee expects that the majority of those educating and supervising residents in the critical care setting are internal medicine-critical care medicine (IM-CCM) physician faculty members, and that most of the residents' clinical experience is under the supervision of such faculty. Non-IM-CCM physician faculty members involved in resident education as teaching faculty need to be approved by the medical intensive care unit director and the internal medicine program director. The Review Committee recognizes that cross coverage between different types of critical care medicine specialists may occur, especially in smaller programs. The expectation does not preclude evening and weekend cross coverage by physicians certified in other critical care medicine disciplines, like anesthesiology or surgery. Although physicians certified in critical care medicine through anesthesiology or surgery can be involved in the residency program, they may not be subspecialty education coordinators (SECs) in internal medicine residency programs.
Can associate program directors, core faculty members, and subspecialty education coordinators be subspecialty-certified only? *[Program Requirements 2.8.f.2., 2.11.b., and 2.11.e.1.]*	Although the Review Committee accepts only ABIM or AOBIM certification for the minimum required number of associate program directors, core faculty members, and SECs, these individuals can be subspecialty certified only (i.e., they can allow their internal medicine certification to lapse).
Resident Appointments	
When must the program notify the Review Committee of a temporary change in its complement? *[Program Requirement 3.4.]*	Any extension in education and training that results in the program being over its approved complement for three months or less does not require approval by the Review Committee. Any extension over three months requires the program to submit a complement increase request in the Accreditation Data System (ADS).

Question	Answer
Educational Program	
What counts toward the 10 months of clinical experiences in the outpatient setting? Specifically, if a program uses an X+Y schedule, does the program director need to parse out the continuity clinic experiences and only count the clinic time toward the 10 months? *[Program Requirement 4.11.c.1.]*	The Review Committee has not established specific guidelines detailing what counts toward the outpatient requirement. Continuity clinic activities count toward the 10 months of clinical experiences in the outpatient setting but are not the only experiences that count toward meeting this requirement. Other examples include the following: • If residents spend two weeks on a rheumatology office/outpatient rotation, programs can count these two weeks toward the minimum outpatient requirement. • If residents are on rotations that involve both inpatient and outpatient experiences, programs will need to assess and determine what portion of the residents' assignments take place in each setting, much like they do when they complete the block diagram. • If residents are participating in subspecialty, continuity, or non-continuity clinic visits using telemedicine, programs can count that time toward the minimum outpatient requirement. • For a program using X + Y scheduling, if the residents' activities during the Y weeks ("ambulatory block rotations") are outpatient related, then the entire time can count toward the outpatient requirement. As such, all patient management activities and didactics related to outpatient topics during such ambulatory block rotations count toward the minimum.
Do emergency medicine experiences count toward fulfilling the inpatient or outpatient requirements? *[Program Requirement 4.11.c.1.]*	Emergency medicine assignments count toward fulfilling the requirements for 10 months of inpatient experiences. Clinical experiences in the following settings can be used to fulfill the 10 months of outpatient requirement: general internal medicine continuity clinics; internal medicine subspecialty clinics (e.g., HIV clinic); non-medicine clinics (e.g., dermatology or physical medicine and rehabilitation clinic); walk-in clinics; neighborhood health clinics; home care visit programs; urgent care clinics; and ambulatory block rotations.

Question	Answer
What is necessary to provide clinical experiences in each of the internal medicine subspecialties? Is a dedicated rotation in each of the subspecialties required? *[Program Requirement 4.11.c.3.]*	No, a dedicated rotation in each of the internal medicine subspecialties and geriatric medicine is not required. Programs need to establish a curriculum, identify an appropriately certified subspecialty education coordinator to oversee the experience, and ensure that residents are provided sufficient clinical exposure to the subspecialty. The Review Committee has not specified a minimum required amount of time for these experiences in the Program Requirements.
What is necessary to provide clinical experiences in hospice and palliative medicine, addiction medicine, emergency medicine, and neurology? Is a dedicated rotation in each required? *[Program Requirement 4.11.c.4.]*	No, dedicated rotations in hospice and palliative medicine, addiction medicine, emergency medicine, and neurology are not required. Programs need to establish a curriculum and ensure that residents are provided sufficient clinical exposure to the subspecialty. The Review Committee has not specified a minimum required amount of time for these experiences in the Program Requirements.
Can patients admitted to a teaching service be transferred to a non-teaching service? *[Program Requirement 4.11.e.1.]*	Transfers may occur between teaching and non-teaching services when such transfers enhance the educational value of the experience. Such transfers are expected to be infrequent. Programs need to develop policies that govern transfers from teaching to non-teaching services and to monitor the impact of these policies on resident education. The Review Committee does not believe it is appropriate for residents to be used as admitting coverage for non-teaching services.

Question	Answer
Can nurse practitioners or physician assistants supervise residents on inpatient rotations? What about outpatient rotations? *[Program Requirements 2.7.a. and 4.11.e.3.]*	Although it is important for residents to acquire experience leading and participating in health care teams in the inpatient setting with non-physicians (e.g., nurse practitioners or physician assistants), overall supervision of clinical care rendered by residents is the responsibility of the physician faculty and attending physician of record. Non-physicians are not permitted to independently supervise residents on inpatient rotations. The attending physician may delegate an appropriately qualified non-physician to assist a resident in performing a procedure. Supervision of residents by non-physicians is allowed in specialized outpatient settings for specific learning experiences (e.g., gynecology clinic, sexually transmitted disease clinic, wound care clinic, home visits, nursing homes), where the non-physicians have the appropriate qualifications and been granted authority by applicable institutional and state regulations to perform and supervise the clinical activity. Non-physicians are not allowed to supervise residents in the continuity clinic, other general medical clinics, or medicine subspecialty clinics (e.g., pulmonary clinic, general infectious disease clinic, hematology-oncology clinic).
How does the Review Committee define transfer patients? *[Program Requirement 4.11.e.7.a.]*	The Review Committee defines transfer patients as those admitted from the night-float team or from other medical services (e.g., the critical care unit or medical intensive care unit), or bounce-back admissions within the same rotation month.
Are patients admitted by a night float team and then “turned over” the following day to the daytime inpatient team counted toward the PGY-1 resident’s “new patient in an admitting day” cap? *[Program Requirements 4.11.e.7., 4.11.e.7.a., and 4.11.e.10.]*	Patients admitted by the night float resident and “turned over” the following day to the inpatient team are considered transfer patients. The PGY-1 resident can be assigned up to two transfer patients (from night float or other services) in addition to five new patients per admitting day. Any additional transfer patients are counted as new patients. The supervising resident can be assigned up to four transfer patients in addition to 10 new patients per admitting day.

Question	Answer
If an admitting resident supervises only one PGY-1 resident, can that supervising resident admit patients on their own? *[Program Requirements 4.11.e.10. - 4.11.e.11.]*	Yes. The supervising resident may supervise or admit a maximum of 10 new patients in an admitting day. In other words, the supervising resident may supervise five PGY-1 admissions and admit another five patients without the first-year resident. The supervising resident may also supervise or admit up to four additional transfer patients.
Is there a cap on consults? *[Program Requirements 4.11.e.7.-4.11.e.12.]*	Consults are not admissions. There are no program requirements limiting the number of consults for a resident. The Review Committee cannot prescriptively and explicitly create program requirements for every patient care situation. As such, program directors need to proactively and regularly monitor the number of consults residents are asked to perform to ensure they are not burdensome or compromise education. The Review Committee does not believe that residents can adequately complete consults in addition to performing inpatient admitting responsibilities.

What are the patient census limits for different sized inpatient teams?

[Program Requirements 4.11.e.7.-4.11.e.12.]

The following table summarizes the census limits the Review Committee has specified in the Program Requirements.

Daily Inpatient Caps	New Patients	In-House Transfers	Ongoing Care *(total includes new patients and in-house transfers)*
PGY-1	5 *(max 8 in 48 hours)*	2	10
PGY-2 or PGY-3 supervising 0 PGY-1s	*Not specified in Program Requirements*	*Not specified in Program Requirements*	*Not specified in Program Requirements*
PGY-2 or PGY-3 supervising 1 PGY-1	*Not specified in Program Requirements*	*Not specified in Program Requirements*	14
PGY-2 or PGY-3 supervising >1 PGY-1	10 *(this includes PGY-1s' new patients; max 16 in 48 hours)*	4	20

The Review Committee acknowledges that it has established census limits for PGY-1 residents and the most common or traditional teams, a PGY-2 or PGY-3 resident with one or more PGY-1 residents. As it noted in the Background and Intent box associated with the limits, the committee cannot prescriptively and explicitly assign patient census limits for every possible educational scenario or circumstance given the variability in clinical settings and the complexity and acuity of the patients in them. Instead, it asks program and institutional leadership teams to proactively and regularly monitor the census, complexity, and acuity of patients assigned to resident-comprised health care teams, and the structure and composition of the team, particularly the knowledge, skills, and abilities of the team members, to determine the appropriate patient team size for

Question	Answer
	the situation. In assessing the appropriateness of clinical workload for non-traditional teams, the program should solicit and appropriately consider feedback from residents and faculty members regarding wellness and manageable patient care responsibilities. Programs are encouraged to review findings from the ACGME Resident Survey, which asks residents to respond to questions related to compliance with patient census limits. Although the Review Committee limits the number of new patients PGY-2 and PGY-3 residents with supervisory responsibilities of PGY-1 resident(s) can be assigned per admitting day (Program Requirements 4.11.e.10.-4.11.e.12., programs can exercise flexibility and deviate from these limits for PGY-3 residents who have significant experience in the inpatient setting and are interested in hospitalist medicine careers after completing residency.
What are the patient census limits in the medical intensive care unit? *[Program Requirements 4.11.e.7.-4.11.e.12.]*	The Review Committee has not specified separate census limits for the medical intensive care unit. It asks programs to use the limits for the inpatient units noted in Program Requirements 4.11.e.7.- 4.11.e.12. as a starting point for establishing appropriate caps on the medical intensive care unit. It also cautions programs that the limits may need to be lower in the medical intensive care unit depending on the severity and acuity of patients and the structure and composition of the resident-comprised health care team, particularly the knowledge, skills, and abilities of the team members.