



BASIC STANDARDS FOR RESIDENCY TRAINING IN INTERNAL MEDICINE

American Osteopathic Association

and the

American College of Osteopathic Internists

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**Basic Standards for Residency Training
In Internal Medicine**

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INTRODUCTION

These are the Basic Standards for Residency Training in Internal Medicine as established by the American College of Osteopathic Internists (ACOI) and approved by the American Osteopathic Association (AOA). These standards are designed to provide the osteopathic resident with advanced and concentrated training in internal medicine and to prepare the resident for examination for certification in internal medicine.

STANDARD I – MISSION

The mission of the osteopathic internal medicine training program is to provide residents with comprehensive structured cognitive and procedural clinical education in both inpatient and outpatient settings that will enable them to become competent, proficient and professional osteopathic internists.

STANDARD II – EDUCATIONAL PROGRAM GOALS

The specialty of internal medicine consists of the prevention, diagnosis and treatment of diseases with emphasis on internal organs of the body in the adolescent and adult patient. The goals of the osteopathic internal medicine program are to achieve mastery of the following core competencies:

1. Osteopathic Philosophy And Osteopathic Manipulative Medicine
 - a. Integrate osteopathic principles into the diagnosis and management of patient clinical presentations.
 - b. Apply osteopathic manipulative therapy in patient management where applicable.
2. Medical Knowledge
 - a. Demonstrate competency in the understanding and application of clinical medicine to patient care.
 1. Demonstrate thorough knowledge of the complex differential diagnoses and treatment options of internal medicine.
 2. Integrate the sciences applicable in internal medicine with clinical experiences.
 - b. Understand and apply the foundations of behavioral medicine appropriate to internal medicine.
 1. Demonstrate ability to provide end of life care.
 2. Identify and address socioeconomic, ethnic, religious, and cultural aspects of illness and their impact on patient clinical presentation and subsequent management
3. Patient Care

- a. Demonstrate ability to rapidly evaluate, initiate and provide appropriate treatment for patients who are critically ill.
- b. Demonstrate ability to thoroughly evaluate, initiate treatment and provide appropriate long-term therapeutic recommendations to patients with chronic medical problems in both hospital and ambulatory settings.
- c. Demonstrate ability to make appropriate recommendations to promote health maintenance and disease prevention.
- d. Demonstrate ability to gather appropriate essential medical information from patient interview, relevant medical records, examination and testing.

4. Interpersonal And Communication Skills

- a. Exercise effective patient interview skills.
- b. Demonstrate appropriate verbal communication with clarity, sensitivity, and respect.
- c. Create well organized, clear, succinct but thorough and legible medical record entries.
- d. Demonstrate the ability to interact with support staff in hospital and ambulatory settings in a constructive, positive and effective manner.
- e. Identify methods to communicate with non-english speaking patients, and with those having sensory deficits (verbal, visual, and auditory).

5. Professionalism

- a. Identify the role of internal medicine as it relates to other medical disciplines.
- b. Develop the principles of appropriate ethical conduct and integrity in dealing with patients and the medical community.
 1. Identify potential areas of conflict of interest inherent in medical practice.
 2. Demonstrate appropriate, judicious and efficient utilization of medical therapies, procedures, and testing without consideration of personal gain.
 3. Demonstrate understanding of the implicit position of trust and authority into which patients often place their physician; recognize the ethical requirement to avoid exploitation of this trust either intentionally or unintentionally.
- c. Complete training in personal health information protection policies, and recognize their application in daily medical practice.
- d. Recognize the elements of religion, race, ethnicity, or cultural background in individual patients, and address them properly.
- e. Recognize the need for continuous quality care in all patient populations, and demonstrate lack of discrimination.
- f. Provide medical care to those seeking it.

6. Practice-Based Learning And Improvement
 - a. Develop professional leadership and practice management skills.
 - b. Evaluate the progress of the training of the resident by using continuous assessment tools.
 1. Utilize systematic evaluation to include self study and assessment, individual trainee assessment, and outcomes analysis.
 2. Participate in quality improvement programs and assessment activities in the hospital and ambulatory setting.
 - c. Expose the resident to research methodology in internal medicine.
 - d. Identify information technology applicable to the practice of medicine and research. Demonstrate ability to effectively utilize such technology.
 - e. Develop in the resident teaching skills in internal medicine.
 - f. Promote the development of the attitude and commitment to habits of lifelong learning and scholarly pursuit in internal medicine.
 - g. Prepare the resident to meet the eligibility requirements of the AoA to take the certification examination administered by the American Osteopathic Board of Internal Medicine.

7. Systems-Based Practice
 - a. Develop in the resident the skills needed to practice within a system-based health care environment and to use the resources to deliver quality care.
 - b. Understand the national and local health care delivery systems and how they impact on patient care and professional practice. advocate for the patient in obtaining quality health care in complex systems.

STANDARD III – INSTITUTIONAL REQUIREMENTS

- A. In order to provide an osteopathic internal medicine training program, an institution must meet all of the requirements of the AOA as formulated in the *Basic Documents for Postdoctoral Training* and must have an AOA approved residency program in internal medicine. The number of specialty interns and residents in the internal medicine training program may not exceed the number approved by the AOA.

- B. An institution must provide resources sufficient to maintain a quality training program, particularly in the areas of faculty development, curriculum, evaluation methodology and osteopathic principles. Additionally, the institution must commit to an equitable and reasonable balance between

education and service. The institution must have available sufficient faculty to ensure adequate exposure for the residents in appropriate patient care and to provide adequate supervision of each resident.

- C. The institution must provide a sufficient patient load to properly train a minimum of three (3) residents in internal medicine. No program may accept a new resident unless at least one other resident is also in the program. New programs must have a minimum of three (3) approved positions to begin. Any program without advanced-level, functioning residents (R-2; R-3) for three (3) consecutive years shall be considered lapsed in accordance with AOA policy.
- D. The institution's department of internal medicine shall have at least one (1) physician certified in internal medicine by the AOA and one other physician certified in internal medicine by the AOA or the American Board of Medical Specialties. One of the AOA-certified physicians shall be designated as the program director. The program director shall be appointed for an appropriate period of time to assure program continuity.
- E. The training institution must immediately notify the ACOI and the AOA of any change in program director status and of any major changes in leadership, governance, affiliation, or fiscal arrangements that affect the educational program.
- F. Library resources must be provided that meet the requirements of the institutional, clinical and educational resources of residency training programs as described in the AOA *Basic Documents for Postdoctoral Training*. The institution and/or OPTI shall provide internet access and electronic mail (e-mail) addresses for the program director and all residents in the program.
- G. Adequate study, learning resource and on-call sleep facilities must be made available to the resident for assigned day and night duty hours. The training institution must provide an on-call room for residents which is clean, safe and comfortable so as to permit rest during call. A telephone should be present in the on-call room. Toilet and shower facilities should be present in or convenient to the room. Nourishment shall be available during the on-call hours of the night.
- H. The institution must maintain a program description that includes, at a minimum, goals and objectives of the training program, curricular and rotational structure, program director responsibilities, and resident qualifications and responsibilities. The program description must be reviewed and updated annually.
- I. The institution must provide an opportunity for exposure in a supervised ambulatory site for continuity of care training which will suit the needs of the tracks offered. Institutional clinics or internists' offices may be used.

- J. The institution must have a written policy and procedures manual for the residents that defines work hours, leave, vacation, call and academic or disciplinary dismissal policies.
- K. The institution must provide a written policy and procedures for the selection of residents which should be in accordance with AOA requirements as stated in the *Basic Documents for Postdoctoral Training*. The selection criteria shall be included in the institutional policy and procedures manual.
- L. The institution shall execute a contract with each resident in accordance with the AOA *Basic Documents for Postdoctoral Training*.
- M. Upon satisfactory completion of the training program, the institution shall award the resident an appropriate certificate. The certificate shall confirm the fulfillment of program requirements, starting and completion dates of the program and the name(s) of the training institution(s) and the program director(s).
- N. The training institution must comply with the work hours policy as described in the AOA *Basic Documents for Postdoctoral Training* (see Appendix C).
- O. The base institution must maintain a file for each resident containing ambulatory and monthly rotational logs, evaluation forms, resident patient evaluations, in-service exam scores and research requirements. All educational activities must also be documented. The residents' files and all educational documentation must be available for review at the time of a scheduled AOA on-site survey. Although permanent maintenance of resident logs is a resident responsibility, institutions must retain resident logs and other records for a minimum of five years beyond the resident's completion of his/her program.
- P. The institution is responsible for the timely submission of materials for program review. Failure to do so may result in the program receiving a one-year, probationary approval without the ability to recruit new residents.
- Q. The institution must obtain and maintain appropriate affiliation agreements to ensure the complete education of the resident and to broaden the scope of training. Affiliation agreements must be submitted and approved for all rotations regularly scheduled in outside institutions. The affiliation agreements must include discussion of the responsibilities of the base and host institutions for delivery of the clinical and didactic requirements of the rotation and for evaluation of the resident. The agreements must be signed by an official representative of each institution. Other information (legal, administrative and financial) may be included at the discretion of the institution.
- R. The institution shall provide the necessary resources for the chief resident, or at least one senior resident, to attend the annual convention and scientific

sessions of the ACOI each year.

- S. The institution shall provide a proctor for the administration of the ACOI in-service exam. The exam must be kept in a secure place and must be administrated within the institution.

STANDARD IV - PROGRAM REQUIREMENTS AND CONTENT

- A. The residency training program shall commence only after it has received the approval of the AOA Executive Committee of the Council on Postdoctoral Training (ECCOPT).
- B. The residency training program in internal medicine shall be thirty-six (36) months in duration. The training shall consist of: thirty-six (36) months of general internal medicine, the first twelve (12) months of which may be an AOA-approved specialty track internship in internal medicine taken in an institution in which an AOA-approved internal medicine residency exists and which meets the criteria for approval by the ACOI and the AOA; or, thirty-six (36) months of general internal medicine after any other AOA-approved internship. Twenty-four (24) months of general internal medicine and twelve months (12) of training in a subspecialty of internal medicine after a traditional, AOA-approved rotating internship can also be used to complete the requirements, but this option will expire in July, 2005.
- C. At least 80 percent of the graduates of each AOA-approved internal medicine residency program, averaged on a three-year rolling basis, must take the certifying examination of the American Osteopathic Board of Internal Medicine.
- D. Advanced Placement
 - 1. Advanced placement from non-internal medicine fields. A maximum of one-month of credit may be awarded for each month of training in general internal medicine or its subspecialties taken under the direction of an internist or medical subspecialist in an AOA- or ACGME-approved program.
 - 2. Advanced placement from ACGME-approved internal medicine programs. A maximum of one (1) month of credit may be granted for each month of postgraduate training satisfactorily completed in general or subspecialty internal medicine in an ACGME-approved program as verified by the osteopathic program director.
 - 3. Advanced placement from traditional osteopathic internship. One-month of credit may be awarded for each month of training in internal medicine or a medical subspecialty taken under the supervision of an

internist during an AOA rotating internship in an institution with an AOA or ACGME approved internal medicine residency. A maximum of six months credit may be granted under this provision.

4. Mechanism to request advanced placement. A request for advanced placement must be received from both the resident and the program director at the advanced placement institution. This request must include the program director's assessment of the resident's academic status/equivalency and the resident's academic level in comparison to other residents at the training level if advanced placement were to occur. Determination of advanced placement within these guidelines shall be made by the Council on Education and Evaluation of the ACOI and reported to the COPT.

E. The general educational content of the program must include:

1. The neuromuscular component of disease and the distinctive osteopathic concept of evaluating and treating the whole patient in inpatient and ambulatory care settings. This component shall be provided in both didactic and clinical formats. (CORE COMPETENCY 1)
2. Development of basic cognitive skills and knowledge as pertaining to normal physiology and pathophysiology of the body systems and the correlating clinical applications of medical diagnosis and management. (CORE COMPETENCY 2)
3. A written curriculum for the program must be provided for all residents. A sample curriculum developed by the ACOI is available at www.acoi.org. (CORE COMPETENCY 2)
4. A formal didactic structure, including journal clubs, morning reports, case conferences and other programs. Attendance at these didactic meetings must be documented. This documentation must be made available during an on-site program review. (CORE COMPETENCY 2)
5. Development of bio-psychosocial knowledge and skills in both formal and informal settings throughout the residency. Medical sociology, doctor/patient/family communication, crisis recognition and intervention, the impact of behavioral and emotional components on health states and the immune system, interviewing skills, recognition and management of uncomplicated behavioral disorders, i.e. stress, anxiety and depression and substance abuse care are subjects that can be offered to meet this requirement. (CORE COMPETENCY 2)

6. Internal medicine board review for each resident, either in the form of weekly programs (such as Cecil's or Harrison's Clubs, or MKSAP review), or by sponsoring the resident's attendance at an internal medicine board review course. (CORE COMPETENCY 2)
7. Sufficient training and experience in comprehensive histories and physicals, including structural examinations, pelvic exams, rectal exams, breast exams and male genital exams, to ensure a high degree of proficiency. The resident's skill in these examinations must be evaluated semi-annually as part of the ambulatory clinic evaluation. Proficiency in performing a comprehensive history and physical is also measured by the successful completion of the required Resident Patient Evaluation (See Appendix B). (CORE COMPETENCY 3)
8. A list of learning objectives to indicate learning expectations and measure learning achievements at yearly training levels.
9. Sufficient training and experience in the interpretation of electrocardiograms, chest roentgenograms, and flat and upright abdominal films to ensure a high degree of proficiency in performing these interpretations. (CORE COMPETENCY 3)
10. Training in appropriate patient communication, and assessment in actual patient interactions. These communications must include routine patient encounters and also those involving communication barriers such as sensory impairment, dementia, or language differences. (CORE COMPETENCY 4)
11. Training in the special cultural influences and needs present in care of various patient populations must be incorporated. In addition, training in hippa compliance as well as ethics must be incorporated during the training period. (CORE COMPETENCY 5)
12. Appropriate training in teaching skills must be available. Residents must participate in the training of students and interns on a regular basis, and those sessions must be evaluated. (CORE COMPETENCY 6)
13. Training in information technology so that the resident can effectively meet the teaching , learning and research requirements of these standards. (CORE COMPETENCY 6)
14. Training in and exposure to quality improvement services and programs. (CORE COMPETENCY 6)
15. Opportunity throughout for exposure to issues which the resident will face as a practicing clinician, including health policy, managed care,

health administration, medical ethics, medical liability and practice management. (CORE COMPETENCY 7)

16. **PROCEDURES** - Sufficient experience and training in the following procedures and development of appropriate interpretation skills. In order to ensure exposure to the required procedures and interpretations, the ACOI Council on Education and Evaluation has established minimum numbers, which appear in parentheses with the procedures and interpretations listed below. These numbers must be performed by each resident prior to the completion of the second year of residency and must be verified by the program director. As these minimum numbers do not define competency, competency in performing a procedure can only be determined by the program director or supervising faculty.
- a. Required procedures: arterial puncture for ABGS (10); central venous line insertion (10); peripheral venous line insertion (5); endotracheal intubation (10); nasogastric tube insertion (5); osteopathic manipulative treatment (20); urinary bladder catheterization (5); arthrocentesis/joint injection (5).
 - b. Required interpretations: Blood smears (10); exercise stress tests (10); Holter monitor (10); lumbar puncture (5); spirometry (10); sputum gram stain (10); urine microscopic (20) vaginal wet mounts (6).
 - c. Recommended procedures: arterial line insertion; flexible sigmoidoscopy; paracentesis; Swan Ganz catheterization; thoracentesis; skin biopsy (punch) skin lesion removal; laceration repair.
 - d. Optional procedures: bone marrow aspiration and biopsy; elective cardioversion; chest tube insertion; colonoscopy; esophagogastroduodenoscopy.
 - e. Optional interpretation: echocardiograms.
 - f. Logs of required procedures and interpretations must be kept by each resident until the minimum number of each procedure has been performed. The ACOI will provide a log book to each resident that must be completed by the resident and submitted to the ACOI by the end of the second training year. The residency requirements will not be considered complete unless this log book has been submitted. Information that must be included in the log book is as follows: the date of the procedure, a patient identifier, the type of procedure performed and the signature of the supervising physician. In addition, the ACOI highly recommends that residents keep their own

records of all procedures performed beyond the required minimum in order to document the experience when applying for hospital privileges after training has been completed.

- F. At least thirty-four (34) months of training must include meaningful patient responsibility and no more than six (6) months of training can be assigned in non-internal medicine services. Meaningful responsibility implies supervised judgment and decision-making in patient management. A maximum of two (2) months of non-clinical rotations may be assigned. Elective training may be included and can be offered as inpatient or ambulatory experience in general internal medicine, medical subspecialty or certain non-medical specialties in accordance with program requirements for content.
- G. **RESEARCH** - The program shall provide adequate exposure to medical research/review skills and methods of presentation, including information related to changes in the health care delivery system. Documentation of research activities must be kept on file. Options for meeting the research requirement shall be determined by the program director and may include, but not be limited to, any of the following:
1. Original research studies (basic science, clinical studies, health services research), and writing (see Appendix A), once per training program;
 2. Retrospective studies (medical records analysis) (see Appendix A) once per training program;
 3. Entry into the ACOI Annual Resident Medical Writing/Research Competition (see Appendix A) once per training program;
 4. Presentation of a scientific poster/abstract at the ACOI Convention, once per training program;
 5. Resident education program on research types and methodology, ongoing throughout the training program;
 6. Resident education program on biostatistics, ongoing throughout the training program;
 7. Formal written critique by the program director or designee of resident presentations of journal club articles/literature review (i.e., credibility of material, data, statistics and study design), twice annually;
 8. Educational program for residents in health services research, policies, administration (i.e., access of population groups to health care, compliance issues, public policies, and managed care), ongoing throughout the training program;

9. Educational program on "How to Read and Understand the Medical Literature," ongoing throughout the training program;
10. Formal written critique by the program director or designee of medical resident lecture presentation of researched topic, twice annually.

H. **AMBULATORY CLINIC** - The program must provide exposure in a supervised ambulatory site for continuity of care training that fulfills the requirements of the specialty tracks offered. The ambulatory clinic must meet the following requirements:

1. The ambulatory site must provide for comprehensive continuous general internal medicine (not subspecialty) patient care where residents can function as the primary care giver for the patient. The site may be in a clinic (free-standing or in-hospital) or in a private practice setting.
2. The training site must have the presence of an attending internist for supervision of residents. If the supervisor is also seeing patients, he/she should not be so busy with patient care that supervision and training cannot be provided. The resident/faculty ratio in the continuity site cannot exceed 4:1.
3. Continuity ambulatory experience must exist a minimum of 44 weeks per year. Residents must be scheduled a minimum of two half-days per week if in a primary care track and one half-day per week if in a traditional track.
4. An educational program and schedule must occur in the clinic with active participation between the supervisor and the resident. Cases should be discussed and all charts should be reviewed.
5. The resident must be exposed to a broad spectrum of medical diagnoses in adult and adolescent patients, and should be taught to apply the concepts of disease prevention and health maintenance.
6. Specific ambulatory logs must be maintained and available for review by the clinic supervisor, resident program director and AOA on-site reviewer. Logs must contain patient identification, diagnosis and the activity and/or procedure performed on each visit.
7. A resident in a teaching ambulatory setting must see an average of 4-8 patients per half-day period, depending on the level and progress of the resident and the nature of the patient (new physical or repeat visit).
8. Approximately fifty (50) patients per year should be accrued into each resident panel of patients, or approximately 150 patients per resident

by the end of three (3) years. The emphasis on development of the panel should occur during the first and second years.

9. Separate resident performance evaluations must be conducted by the ambulatory supervisor at least semiannually and reviewed between the resident, ambulatory supervisor and program director.
10. In addition to clinical exposure in the ambulatory training site, the resident should also be exposed to osteopathic concepts, behavioral and psycho-social aspects of medical care, medical ethics, medical-legal implications and practice management.
11. An opportunity must exist for the resident to be involved and participate in the ongoing care of his/her clinic patients when they are hospitalized at the base hospital facility and through all phases of their care (under supervision).
12. The resident's abilities to perform comprehensive history and physical examinations, including structural examination for somatic dysfunction, pelvic exam, rectal exam, breast exam and male genital exam, must be assessed semi-annually during the ambulatory clinic evaluation.

I. PROGRAM TRACKS

1. Thirty-six (36) Month Program Including the Internal Medicine Specialty Track Internship.
 - a. The Internal Medicine Specialty Track Internship serves as the first year of residency training. This training year comprises the following required elements:
 - i. Four (4) months or sixteen (16) weeks of general internal medicine and medical subspecialties under the supervision of an internist or medical subspecialist. This must include a minimum of four (4) months or sixteen (16) weeks of general internal medicine. The requirement for general internal medicine should be met through rotations with general internists, or through rotations with internal medicine subspecialists whose practices include an emphasis on general internal medicine. Documentation of the subspecialists' general internal medicine practice emphasis must be available at the time of on-site program review;
 - ii. One month or four (4) weeks of critical care (ICU/CCU), or ongoing supervised exposure to critical

- care throughout the training program;
- iii. One month or four (4) weeks of cardiology;
 - iv. One month or four (4) weeks of primary care ambulatory experience to be selected from among the following: family practice; female reproductive medicine/ambulatory gynecology; or ambulatory pediatrics/adolescent medicine;
 - v. One month or four (4) weeks of pulmonary medicine;
 - vi. One month or four (4) weeks of care of the surgical patient to be selected from one of the following: general surgery; perioperative medicine; surgical ICU. The perioperative medicine rotation may be supervised by an internist only if the rotation is designed exclusively to provide perioperative co-management of surgical patients;
 - vii. One month or four (4) weeks of emergency medicine;
 - viii. Two (2) months or eight (8) weeks selected from among the following: ambulatory surgical specialty; anesthesiology; dermatology; OMM; psychiatry; radiology; any nonmedical ambulatory specialty, or internal medicine block nights. No more than one (1) month of any of the selected rotations may be used. For the specialty track internship year only, internal medicine block nights may be used if one of the following criteria is met: 1) 13 four-week blocks are scheduled and the other 12 required rotations are completed; or 2) as one of 12 monthly rotations, provided that the block nights rotation includes a minimum of five hours of structured education per week, to include medicine morning report or medicine lectures, and one book or journal club per month. In addition, all medicine admissions must be reviewed and documented with an attending physician. Documentation of these activities must be available at the time of the on-site survey.
 - ix. Continuity ambulatory experience must exist a minimum of half a day per week for a minimum of forty-four (44) weeks in internal medicine under the supervision of an onsite internist;

- x. Any time remaining after completion of the required rotations may be scheduled at the discretion of the training institution. If the program has been scheduled in months, this discretionary period will not be available.
 - xi. The Internal Medicine Specialty Track Internship may occur only in an institution with an AOA-approved internal medicine residency. The residency must be functional with advanced residents (R-2, or R-3). The residency may not enroll specialty track interns after three years without advanced residents.
- b. Residency Years Two and Three (R-2, R-3). For the second and third years of the residency, either a primary care track or a traditional (hospitalist) track must be selected.
- i. General Internal Medicine. Regardless of the track selected, the program should incorporate approximately 50 percent of the time in general internal medicine; however such general medicine services may comprise no fewer than eight (8) months and no more than 16 months of the second and third years of the residency.
 - ii. Subspecialty medicine. A minimum of one month experience with each of the following subspecialties must also be provided: endocrinology; gastroenterology; hematology/oncology (combined or separate); infectious disease; nephrology; rheumatology; neurology. The subspecialty experiences may be in either an inpatient or an outpatient setting. If the ICU requirement has not been met as a one month rotation during the specialty track intern year, then it must continue to be integrated throughout the second and third years of the residency.
 - iii. Continuity ambulatory care. The program must provide ambulatory continuity experience as described in Standard IV.H. for residents in both the primary care and traditional tracks. The hallmark of the primary care track is to provide progressively increasing exposure to continuity ambulatory care with two half-days per week required in the ambulatory continuity clinic. The program must provide one half-day per week of an ambulatory continuity experience for residents in the traditional track.

- iv. Other ambulatory care. The primary care track requires that a minimum of 50 percent and a maximum of 65 percent of the program be spent in ambulatory rotations, including the continuity ambulatory experience. The traditional track requires that a minimum of 20 percent and a maximum of 40 percent of the program be spent in ambulatory rotations, including the continuity ambulatory experience. Examples of acceptable ambulatory rotations for either track are as follows: office gynecology; ambulatory surgical subspecialties, such as orthopedics, ENT, urology and ophthalmology; psychiatry; adolescent medicine; substance abuse; disease prevention/wellness; geriatric medicine; community/epidemiology/public health; emergency medicine; allergy; dermatology; any medicine subspecialty in an ambulatory site; physical medicine; vascular medicine.
- v. For residents who are using the traditional track as preparation for practice as a hospitalist, structured educational programs in the following areas must be provided: utilization review/quality management; mortality and morbidity reporting; managed-care aspects of the hospitalized patient; infection control.

2. Thirty-six (36) Month Program Following Other AOA Internships.

- a. A 36-month internal medicine residency program may be offered to residents who have completed an AOA internship other than the internal medicine specialty track. In such cases, the resident must select the primary care track or the traditional (hospitalist) track before beginning the 36-month program.
 - i. General Internal Medicine. Regardless of the track selected, the program should incorporate approximately 50 percent of the time in general internal medicine; however such general medicine services may comprise no fewer than 12 months and no more than 24 months of the 36 month residency program.
 - ii. Subspecialty medicine. A minimum of one month experience with each of the following subspecialties must also be provided: cardiology; pulmonary; endocrinology; gastroenterology; hematology/oncology (combined or separate); infectious disease; nephrology; rheumatology; neurology. Cardiology and pulmonary

must be offered during the first-year. The subspecialty experiences may be in either an inpatient or an outpatient setting. At least one month of critical care (ICU/CCU) is required and may be offered as block time or integrated diffusely throughout the entire program.

- iii. Continuity ambulatory care. The program must provide ambulatory continuity experience as described in Standard IV.H. for residents in both the primary care and traditional tracks. The hallmark of the primary care track is to provide progressively increasing exposure to continuity ambulatory care with two half-days per week required in the ambulatory continuity clinic. The program must provide one half-day per week of an ambulatory continuity experience for residents in the traditional track.
 - iv. Other ambulatory care. The primary care track requires that a minimum of 50 percent and a maximum of 65 percent of the program be spent in ambulatory rotations, including the continuity ambulatory experience. The traditional track requires that a minimum of 20 percent and a maximum of 40 percent of the program be spent in ambulatory rotations, including the continuity ambulatory experience. Examples of acceptable ambulatory rotations for either track are as follows: office gynecology; ambulatory surgical subspecialties, such as orthopedics, ENT, urology and ophthalmology; psychiatry; adolescent medicine; substance abuse; disease prevention/wellness; geriatric medicine; community/epidemiology/public health; emergency medicine; allergy; dermatology; any medicine subspecialty in an ambulatory site; physical medicine; vascular medicine.
 - v. For residents who are using the traditional track as preparation for practice as a Hospitalist, structured educational programs in the following areas must be provided: utilization review/quality management; mortality and morbidity reporting; managed-care aspects of the hospitalized patient; infection control.
3. Sample primary care and traditional track programs are provided on the ACOI web site at www.acoi.org.

STANDARD V- FACULTY AND ADMINISTRATION

- A. Director of Medical Education
 - 1. The director of medical education shall have the qualifications and responsibilities described in the *AOA Basic Documents for Postdoctoral Training*.
 - 2. The internal medicine specialty track internship shall be under the direction of the director of medical education in conjunction with the internal medicine residency program director of the sponsoring institution.
- B. Program Director
 - 1. The program director of a residency program shall possess the following qualifications:
 - a. be certified in internal medicine by the AOA through the American Osteopathic Board of Internal Medicine.
 - b. have practiced in internal medicine or a medical subspecialty for a minimum of three (3) years;
 - c. be a practicing specialist in internal medicine or a medical subspecialty;
 - d. be educationally and attitudinally suited to conduct a training program;
 - e. be an Active member of the ACOI and meet the continuing medical education requirements of the AOA and the ACOI;
 - f. understand and fulfill the basic requirements of the AOA and ACOI.
 - 2. The appointment of the program director must be approved by the AOA, upon recommendation by the ACOI Council on Education and Evaluation, following the submission of a curriculum vitae. Appointments shall be reviewed every three (3) years with re-approval contingent upon compliance with individual program requirements.
 - 3. The program director's authority in directing the residency training program must be defined in the program documents of the institution.
 - 4. The program director shall be directly responsible to the director of medical education to verify that each resident is meeting or exceeding the minimum standards of the program.

5. The program director shall evaluate the program, the residents and the faculty as described in Standard VII- Evaluation.
6. The program director shall arrange rotations necessary to meet the program goals and inform the base institution of these arrangements so that affiliation agreements can be made.
7. The program director shall, in cooperation with the AOA Department of Education, prepare required materials for on-site program review. The ACOI/AOA Program Review Workbook must be completed and provided to the on-site reviewer in the agreed upon time period prior to the on-site review. Review materials that are not provided in a timely manner will result in the program being recommended for a one-year probationary status without the ability to recruit new residents.
8. The program director shall provide the resident with all documents pertaining to the training program and shall also provide to the resident the requirements for satisfactory completion of the program.
9. The program director must submit to the ACOI and the director of medical education, annual reports for all residents, including internal medicine specialty track interns. Annual reports to the ACOI shall be submitted on-line by July 31 of each calendar year. Final reports for residents who complete the program in months other than June must be submitted within 30 days of training completion. A copy of each resident's annual schedule must be kept on file and available during the on-site review.
10. The program director shall approve and arrange supervision of the resident's preparation of required medical research.
11. The program must be represented each year at the annual ACOI Congress on Medical Education for Resident Trainers. The program director should represent the program at this meeting, but may designate another trainer to attend. Attendance by the program director, however, shall occur no less often than every other year and must also occur during the first year of appointment. It is recommended that any physician anticipating appointment to the position of program director of an internal medicine program should attend the Congress prior to assuming the position.
12. The program director must notify the ACOI of the resident's entry into the training program by submitting a resident list annually on a form furnished by ACOI.
13. The program director shall be responsible for coordinating all schedules, including lectures and educational sessions, allocating

appropriate time for resident participation. The program director must provide a method to document resident attendance at these meetings.

14. The program director shall schedule completion of the required Resident Patient Evaluation for all residents prior to the end of the second training year.
15. The program director must maintain an e-mail address and provide it to the ACOI.
16. The program director shall ensure that the program description as described in Standard III.D. is accurate, complete and updated annually.
17. The program director shall be required to comply with the following actions and procedures of the Council on Education and Evaluation (CEE): to undergo a site visit in the required time period; to follow directives associated with an approval action; to supply the CEE with requested information. A program director who does not comply with these actions or procedures shall be deemed unqualified to continue in that position. In order to maintain program approval, the CEE will require that the institution replace the director with a qualified physician who will institute those actions needed for full compliance with the CEE's decisions.

C. Faculty Qualifications and Responsibilities

1. There must be at least two faculty members participating in the training program, including the program director. Faculty must be either AOA or ABIM certified or a candidate in the process of being certified. Faculty must be recertified within the period specified by the certifying body.
2. The faculty of the training program must be selected based on their commitment to teaching and the quality of the teaching provided. They must participate in faculty development training in accordance with OPTI requirements as described in the *Program to Accredite Osteopathic Postdoctoral Training Institutions*. Faculty credentials, including CVs must be on file and available for inspection at the time of the AOA on-site program review.
3. Faculty must make available sufficient non-clinical time to provide instruction to residents. Faculty must participate in the academic educational programs such as formal lectures, case conferences, journal clubs, book clubs, and board review.
4. Osteopathic faculty must teach the application of osteopathic principles and practice in internal medicine.

5. Assigned attending faculty must provide at all times adequate supervision and back-up for all patient care provided by residents. Supervision provided by the faculty shall be progressive and adjusted to the training level and performance of each individual resident.
6. The supervising faculty must complete and review with the resident a performance evaluation at the end of each rotation. When requested, faculty must also assist the program director in determining the progress of each resident and whether a resident can advance to the next training year.
7. Faculty must participate in an annual evaluation of program goals and curriculum.
8. The faculty must function in an ethical, professional manner.

STANDARD VI - RESIDENT REQUIREMENTS

- A. Applicants for residency training in internal medicine must:
 1. Have graduated from an AOA-accredited college of osteopathic medicine.
 2. Have completed a one (1) year AOA-approved internship.
 3. Be, and remain, a member of the AOA during residency training.
 4. Be appropriately licensed in the state in which the training is conducted.
- B. During the training program, all residents, including internal medicine specialty track interns, must:
 1. Submit a resident annual report online to the ACOI by July 31 of each calendar year. Final reports of residents who complete the program in months other than June must be submitted within thirty (30) days of completion of the training year. Failure to submit the annual report to the ACOI:
 - within sixty (60) days of the required date will result in the assessment of a \$100 late fee for review of the training year;
 - within one (1) year of the required date will result in the assessment of a \$500 late fee for review of the training year; and

- there will be a \$250 late fee for review of each additional residency year that is delinquent for one or more years. If, by completion of the program, all of the annual reports are incomplete, the ACOI Council on Education and Evaluation may require that the resident repeat training.
2. Attend a minimum of 70% of all meetings as directed by the program director and participate in major committee meetings such as Tumor Committee, Mortality Review Committee and clinical pathologic conferences, in addition to participation in institution intern/student education programs.
 3. Participate each year in the annual Resident In-Service Examination sponsored by the ACOI.
 4. Participate in, and satisfactorily complete, the Resident Patient Evaluation once during the residency, before the completion of the second year. The Resident Patient Evaluation must be submitted on the required forms as provided in Appendix B.
 5. Participate in a research component as indicated in Standard IV, Section G.
 6. Complete a service evaluation after each rotational assignment.
 7. Complete the procedures log book by the end of the second year of residency and submit it to the ACOI. Although not required by the ACOI, it is strongly recommended that, in addition to the procedures log book, each resident maintain a permanent copy of all logs and annual reports for use in future privilege requests.
 8. Participate in an annual evaluation of program goals and curriculum.
 9. Maintain ambulatory continuity logs.
 10. Maintain a current e-mail address and provide it to the ACOI upon entering the program.
 11. Function in an ethical and professional manner.

STANDARD VII- EVALUATION

- A. The curriculum will be evaluated annually by faculty and residents to make certain it is meeting the current goals of the program.
- B. The program director, with faculty input, will complete semiannual written evaluations of each resident's performance. At the end of each training year,

the program director, again with faculty input, will determine whether each resident has the necessary qualifications to progress to the next training year.

- C. The ambulatory clinic director must also complete semiannual written evaluations of the resident's performance.
- D. Completed evaluations must be shared with the resident to foster continuous improvement. Monthly rotational evaluations must be signed by the supervising faculty; semiannual reports must be signed by the program director, and residents must sign all evaluations to document that review has occurred.
- E. The program director must document that residents needing remediation as a result of evaluations are given it in a timely manner. There must be documentation of follow-up evaluations of these residents.
- F. Residents must complete a monthly service evaluation of each rotation. The information provided on these evaluations must be included as part of the assessment of faculty performance.
- G. Faculty performance must be reviewed on an annual basis by the program director.
- H. Multiple measures should be used for program evaluation to obtain a comprehensive view of program quality. Recommended methods include:
 - 1. Performance on the ACOI annual Resident In-Service Examination.
 - 2. Pass rates on the AOBIM certification examination.
 - 3. Resident retention rates in the program.
 - 4. Percent of graduates completing the program on time.
 - 5. Placement of graduates.
 - 6. Professional accomplishments of graduates.
- I. Evaluation tools for measuring performance in achieving the seven core competencies of the osteopathic profession are available on the ACOI website, www.acoi.org.

