NATIONAL INSTITUTE FOR HEALTH SPECIALITIES

NIHS Program Requirements for Medical Internship

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

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Introduction

Int. A. Preamble

Internship is an essential dimension of the transformation of the medical student to residency and the independent practitioner along the continuum of medical education. The journey of internship is physically, emotionally, and intellectually demanding, and requires longitudinally concentrated effort on the part of the individual.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the intern and eventually resident physician to assume personal responsibility for the care of individual patients.

For an intern, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As interns gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept - graded and progressive responsibility - is one of the core tenets of graduate medical education.

Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each intern's development of the skills, knowledge, and attitudes required to enter the residency and eventually unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int. B. Definition of Specialty

The objective of the internship training is to provide a broad-based program of graduate medical education in multiple clinical disciplines designed to facilitate the choice of and preparation for a specific specialty, including specialties requiring a year of fundamental clinical education as a prerequisite. Internship programs also provide clinical education for those medical school graduates planning to serve in public health organizations or in the military as general medical officers, or those who desire one year of fundamental clinical education before entering administrative medicine or research.

Int. C Length of educational program

The Internship educational program must be 12 months in length. (Core)

I. Oversight

I.A. Sponsoring Institution

The Sponsoring Institution is the entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education and prove consistency with the NIHS Institutional Requirements.

The Sponsoring Institution must be the primary clinical defined as the most utilized rotation site of clinical activity for the program.

Background and Intent: *Participating sites will reflect the health care needs of the community and the educational needs of the interns. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings.*

I.A.1. The program must be sponsored by one NIHS-accredited Sponsoring Institution or demonstrate consistency with NIHS Institutional requirements, judged acceptable by Central Accreditation Committee. (Core)

I.B. Participating Sites

A participating site is an entity that provides educational experiences or educational assignments/rotations for interns.

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

I.B.1.a) The sponsoring institution and its participating sites must provide clinical care in all major clinical specialties, including but not limited to family medicine, general surgery, internal medicine, obstetrics and gynecology, emergency medicine, radiology, pediatrics, and psychiatry. (Core)

I.B.1.b) Additional clinical specialties shall be available for elective or optional rotations as needed by personalized educational needs for ach intern. (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 5 years; (Core)

I.B.2.a)(2) be approved by the designated institutional official (DIO); (Core)

I.B.2.a)(3) specify the duration and content of the educational experience; (Core)

I.B.2.a)(4) state the policies and procedures that will govern Intern education during the assignment; (Core)

I.B.2.a)(5) identify the faculty members who will assume educational and supervisory responsibility for interns; (Core)

I.B.2.a)(6) specify the responsibilities for teaching, supervision, and formal evaluation of interns. (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 as the site director, who is accountable for intern education at that site, in collaboration with the program director. (Core)

Background and Intent: *While all internship programs must be sponsored by a single Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must ensure the quality of the educational experience.*

I.B.4. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all interns, of one-month full time equivalent (FTE) or more through NIHS Accreditation System. (Core)

I.B.5. Intern assignments away from the Sponsoring Institution should not prevent interns' regular participation in required didactics.

I.C. Recruitment

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

I.D. Resources

I.D.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for education. (Core)

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote interns' well-being and provide for (Core):

I.D.2.a) access to food while on duty; (Core)

I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and accessible for interns with proximity appropriate for safe patient care; (Core)

Background and Intent: *Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that interns' 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 interns are working. Interns should have access to refrigeration where food may be stored. Food should be available when interns are required to be in the hospital overnight.

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 interns may lactate and store the milk within a refrigerator. These locations should be near clinical responsibilities.*

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

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

I.D.3. Interns must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)

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

I.E. Other Learners and Other Care Providers

The presence of other learners and other care providers, including, but not limited to, students, interns, residents, subspecialty fellows, and advanced practice providers, must enrich the appointed interns' education. (Core)

I.E.1. The program must report circumstances when the presence of other learners has interfered with the interns' education to the DIO and to the graduate medical education committee (GMEC). (Core)

Background and Intent: *The clinical learning environment has become increasingly complex and often includes care providers, students, interns, residents, and fellows from multiple disciplines. The presence of these practitioners and their learners enrich the learning environment. Programs have a responsibility to monitor the learning environment to ensure that interns' education is not compromised by the presence of other providers and learners.*

II. Personnel

II.A. Program Director

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

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

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

Background and Intent: *While the NIHS recognizes the value of input from numerous individuals in the management of an internship, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the internship, and it is this individual's responsibility to communicate with the interns, faculty members, DIO, GMEC, and the NIHS. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Central Accreditation Committee.*

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

Background and Intent*: The success of internship programs is generally enhanced by continuity in the program director position. The professional activities required of a program director are unique and complex and take time to master. All programs are encouraged to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.*

II.A.2. At a minimum, the program director must be provided with the salary support required to devote 25 percent FTE of non-clinical time to the administration of the program. (Core)

II.A.2.a) Additional support must be provided based on program size as follows: (Core)

Number of Approved Interns Positions	Minimum FTE
1-11	0.25
12-19	0.3
20 or more	0.4

Background and Intent: *twenty five percent FTE is defined as 1.25 day per week. "Administrative time" is defined as non-clinical time spent meeting the responsibilities of the program director.*

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

II.A.3.a) must include specialty expertise in a discipline that provides fundamental clinical skills training and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Central Accreditation Committee; (Core)

Background and Intent: *Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.*

The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.

In certain circumstances, the program and Sponsoring Institution may propose and the Central Accreditation Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.

II.A.3.b) must be licensed as consultant and have at least three years post residency documented experience, or with a specialty qualification that is acceptable to the Central Accreditation Committee; (Core)

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

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

***Background and Intent**: A program director is a role model for faculty members and interns. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the Core Competencies for the faculty members and interns.*

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for administration and operations; teaching and scholarly activity; interns' recruitment and selection, evaluation, and promotion of interns, and disciplinary action; supervision of interns; and intern education in the context of patient care. (Core)

II.A.4.a) The program director must:

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

***Background and Intent:** The program director, as the leader of the program, must serve as a role model to interns in addition to fulfilling the technical aspects of the role. As interns are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.*

II.A.4.a)(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)

***Background and Intent:** The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the goal of addressing these needs and health disparities.*

II.A.4.a)(3) administer and maintain a learning environment conducive to educating the interns. in each of the NIHS Competency domains; (Core)

***Background and Intent:** The program director may establish a leadership team to assist in the accomplishment of program goals. Internship programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.*

II.A.4.a)(4) develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the internship program education and at least annually thereafter; (Core)

II.A.4.a)(5) have the authority to approve and/or remove program faculty members for participation in the internship program education at all sites; (Core)

II.A.4.a)(6) have the authority to remove interns from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)

Background and Intent: *The program director has the responsibility to ensure that all who educate interns effectively role model the Core Competencies. Working with an intern 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 interns.

II.A.4.a)(7) submit accurate and complete information required and requested by the DIO, GMEC, and NIHS; (Core)

II.A.4.a)(8) provide a learning and working environment in which interns have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)

II.A.4.a)(9) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)

II.A.4.a)(10) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of an intern; (Core)

Background and Intent: *A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures and will ensure they are followed by the program's leadership, faculty members, support personnel, and interns.*

II.A.4.a)(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a)(12) document verification of program completion for all graduating interns; within 30 days. (Core)

II.A.4.a)(13) provide verification of an individual intern's completion upon the intern's request, within 30 days; (Core)

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 interns who have previously completed the program. Interns who leave the program prior to completion also require timely documentation of their summative evaluation.*

II.A.4.a)(14) obtain review and approval of the Sponsoring Institution's DIO before submitting information, as required in the Institutional Requirements and outlined in the NIHS guidelines to the Common Program Requirements. (Core)

II.A.5. Associate Program Director (APD)

II.A.5.a) For programs with an approved intern complement of more than 15, the sponsoring institution must appoint an Associate Program director to support the PD by actively participating in administrative and educational activities (Core)

II.A.5.b) Sponsoring institution to provide APD with 0.2 FTE of protected time for education and program administration. (Core)

II.A.5.c) APD should assume the role for a duration suitable for ensuring program continuity and stability. (Core)

II.B. Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach interns how to care for patients. Faculty members provide an important bridge allowing interns to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients,

interns, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the interns and themselves.

Background and Intent: *"Faculty" refers to the entire teaching force responsible for educating interns. The term "faculty," including "core faculty," does not imply or require an academic appointment or salary support.*

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

II.B.1.a) The ratio of all faculty to interns is a minimum of 1:1. (Core).

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; (Core)

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

Background and Intent: *Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during internship, residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.*

II.B.2.c) demonstrate a strong interest in the education of interns; (Core)

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

II.B.2.e) administer and maintain an educational environment conducive to educating interns; (Core)

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

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

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 internship program faculty in the aggregate.

II.B.2.g)(1) as educators; (Core)

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

II.B.2.g)(3) in fostering their own and their interns' well-being; (Core)

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

***Background and Intent**: Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's practice and review of the literature, one can make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for interns in practice-based learning.*

II.B.2.h) provide equivalent teaching and supervision for interns as that provided to residents in all participating sites. (Core)

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) Physician faculty members must:

II.B.3.b)(1) have current specialty license as required, or possess qualifications judged acceptable to the Central Accreditation Committee. (Core)

II.B.3.c) Any non-physician faculty members who participate in internship 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 interns by non-physician educators enables the intern to better manage patient care and provides valuable advancement of the interns' knowledge. Furthermore, other individuals contribute to the education of the intern in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the interns, the program director may designate the individual as a program faculty member or a program core faculty member.*

II.B.4. Core Faculty

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

***Background and Intent**: Core faculty members are critical to the success of intern education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing interns' progress toward achievement of competencies. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual NIHS Faculty annual survey.*

II.B.4.a) Core faculty members must be designated by the program director. (Core)

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

II.B.4.c) There must be a minimum of three core faculty members, including at least one member from each sponsoring program. (Core)

II.B.4.d) There must be at least one additional core faculty member for every four interns over 12 interns. (Core)

II.C. Program Coordinator

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

II.C.2. At a minimum, the program coordinator must be provided with adequate time for the administration of the program. (Core)

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

The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the NIHS and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of interns.

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

II.D. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)

Background and Intent: *Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.*

III. Intern Appointments

III.A. Eligibility Requirements

III.A.1. An applicant must meet the following qualifications to be eligible for appointment to a NIHS-accredited program: (Core)

III.A.1.a) Refer to NIHS criteria included in the Training Bylaw.

III.B. Number of Interns

III.B.1. The program director must not appoint more interns than approved by the Central Accreditation Committee. (Core)

III.B.2. All changes in intern complement must be approved by the NIHS Central Accreditation Committee. (Core)

III.B.3. The number of interns appointed to the program must not exceed the program's educational and clinical resources. (Core)

III.B.4. There must be at least four interns appointed to the program each year. (Core)

III.C. Intern's Transfers

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

IV. Educational Program

The NIHS 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.

IV.A. Curriculum Components

The Educational Curriculum must contain the following educational components: (Core)

IV.A.1. A set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates. (Core)

IV.A.2. Competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice which is documented by Milestones evaluation. (Core)

IV.A.3. These goals and objectives must be distributed and available to interns and faculty members. (Core)

IV.A.4. Delineation of intern responsibilities for patient care, progressive responsibility for patient management, and graded supervision. (Core)

IV.A.4.a) These responsibilities are described for each rotation and specified in Milestones progress as determined by the Clinical Competency Committee (CCC).

IV.A.5. A broad range of structured didactic activities: (Core)

IV.A.4.a) Interns must be provided with protected time to participate in structured core didactic activities. (Core)

IV.A.4.b) Didactic activities include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, case discussions, grand rounds, didactic teaching, journal clubs, and education in critical appraisal of medical evidence. (Detail)

IV.A.6. Advancement of interns' knowledge of ethical principles essential to medical professionalism. (Core)

IV.A.7. Advancement in the interns' knowledge of the basic principles of scientific inquiry, including how to design, conduct, and evaluate clinical research, explanation of it to patients, and applied to patient care. (Core)

IV.B. Defined Core Competencies

IV.B.1. The program must integrate the following Core Competencies into the curriculum: (Core)

IV.B.1.a) Professionalism

Interns must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

IV.B.1.a)(1) Interns must demonstrate competence in:

IV.B.1.a)(1)(a) compassion, integrity, and respect for others; (Core)

IV.B.1.a)(1)(b) responsiveness to patient needs that supersedes self-interest; (Core)

IV.B.1.a)(1)(c) respect for patient privacy and autonomy; (Core)

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

IV.B.1.a)(1)(e) respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)

IV.B.1.a)(1)(f) ability to recognize and develop a plan for one's own professional wellbeing; (Core)

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

IV.B.1.b) Patient Care and Procedural Skills

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

IV.B.1.b)(1)(a) Interns must demonstrate competence in:

IV.B.1.b)(1)(a)(i) obtaining a comprehensive medical history; (Core)

IV.B.1.b)(1)(a)(ii) performing a comprehensive physical examination; (Core)

IV.B.1.b)(1)(a)(iii) assessing a patient's problems and/or chief complaint; (Core)

IV.B.1.b)(1)(a)(iv) appropriately using diagnostic studies and tests; (Core)

IV.B.1.b)(1)(a)(v) integrating information to develop a differential diagnosis; (Core)

IV.B.1.b)(1)(a)(vi) developing and implementing a treatment plan. (Core)

IV.B.1.b)(2) Interns must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)

IV.B.1.c) Medical Knowledge

Interns 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)

IV.B.1.c)(1) Interns must take EMREE exam prior to or at the completion of the internship program in order to be eligible for residency program selection. (Outcome)

IV.B.1.c)(1)(a) Results of interns' examination success should be evaluated as part of the program's Annual Program Evaluation process. (Detail)

IV.B.1.d) Practice-based Learning and Improvement

Interns must demonstrate the ability to investigate and evaluate their care of patients, applying scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)

IV.B.1.d)(1) Interns must demonstrate competence in:

IV.B.1.d)(1)(a) identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)

IV.B.1.d)(1)(b) setting learning and improvement goals; (Core)

IV.B.1.d)(1)(c) identifying and performing appropriate learning activities; (Core)

IV.B.1.d)(1)(d) systematically analyzing practice using quality improvement methods and implementing changes with the goal of practice improvement; (Core)

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

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

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

IV.B.1.e) Interpersonal and Communication Skills

Interns must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)

IV.B.1.e)(1) Interns must demonstrate competence in:

IV.B.1.e)(1)(a) communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Core)

IV.B.1.e)(1)(b) communicating effectively with physicians, other health professionals and health-related agencies; (Core)

IV.B.1.e)(1)(c) working effectively as a member of a health care team or other professional group; (Core)

IV.B.1.e)(1)(d) educating patients, families, students, and other health professionals; (Core)

IV.B.1.e)(1)(e) acting in a consultative role to other physicians and health professionals; (Core)

IV.B.1.e)(1)(f) maintaining comprehensive, timely, and legible medical records, if applicable. (Core)

IV.B.1.f) Systems-based Practice

Interns must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

IV.B.1.f)(1) Interns must demonstrate competence in:

IV.B.1.f)(1)(a) working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)

IV.B.1.f)(1)(b) coordinating patient care within the health care system as relevant to their role; (Core)

IV.B.1.f)(1)(c) advocating for quality patient care and optimal patient care systems; (Core)

IV.B.1.f)(1)(d) working in interprofessional teams to enhance patient safety and improve patient care quality;(Core)

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

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

IV.C. Curriculum Organization and Intern Experiences

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

IV.C.1.a) Assignment of rotations must be structured with sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, relationships with faculty members, and high-quality assessment and feedback. (Core)

IV.C.1.a) Each rotation assignment must be no less than two weeks. (Core)

IV.C.1.b) Clinical experiences should be structured to facilitate learning in a manner that allows interns to function as part of an effective interprofessional team. (Core)

IV.C.2. The program must provide instruction and experience in pain management if applicable in specialty, including recognition of the signs of addiction. (Core)

IV.C.3. There must be fundamental clinical skills (FCS) rotations in the specialties of emergency medicine, family medicine, general surgery, internal medicine, obstetrics and gynecology, pediatrics and psychiatry

including primary clinical care experiences (medical, surgical, or pediatric). (Core)

Each rotation must be no shorter than four weeks for emergency medicine, family medicine, general surgery, obstetrics and gynecology, and psychiatry and no shorter than eight weeks for internal medicine and pediatrics. (Core)

IV.C.3.a) These rotations shall occur in units where residents from other programs regularly rotate. (Core)

IV.C.3.a)(1) Intern's clinical and educational responsibilities must be equivalent to first-year residents from other programs. (Core)

IV.C.3.b) On these rotations, the intern must be actively involved in the medical care of patients. (Core)

IV.C.3.b)(1) This should include participating in decision-making and in direct care for all active issues on their patients. (Detail)

IV.C.3.b)(2) This should include planning care and writing orders, progress notes, and relevant records. (Detail)

IV.C.3.c) During the rotation in obstetrics and gynecology the clinical experience shall be focused on the care for low risk and high-risk pregnancy including interdisciplinary medical management of such cases. (Core)

IV.C.3.d) During the four weeks rotation in emergency medicine:

IV.C.3.d)(1) Interns must participate in the evaluation and management of the care of all types and acuity levels of patients who present to an institution's emergency department, and must have first-contact responsibility for those patients. (Core)

IV.C.3.d)(2) This experience must be a continuous four-week block. (Core)

IV.C.3.e) During the four weeks of documented experience in ambulatory care in family medicine:

IV.C.3.e)(1) The experience must be scheduled in no shorter than half day sessions. (Detail)

IV.C.3.e)(2) Ambulatory clinic sessions should not be interrupted by duties with inpatient services. (Core)

Specialty Background and Intent*: FCS rotations provide interns with broad exposure to hands-on patient care in various health care settings, with patients or diseases that they are likely to encounter in their subsequent careers. It is important that interns receive robust clinical experience with appropriate supervision from qualified faculty members, as would be expected of an intern intending to practice the specialty that hosts the rotation.*

IV.C.4. Interns must have at least three blocks (of four weeks each) of elective rotations. (Core)

IV.C.4.a) Elective rotations must be determined by the educational needs of the individual intern. (Core)

IV.C.4.b) Elective options must include medical, surgical, and hospital-based specialties. (Core)

IV.C.4.b)(1) Interns should have access to elective rotations in specialties important to their future career tracks, such as but not limited to anesthesiology, dermatology, neurology, ophthalmology, physical medicine and rehabilitation, radiology, and radiation oncology. (Detail)

Specialty Background and Intent: *Elective rotations allow interns to gain specialized clinical skills or interact with patients and faculty members they would not routinely encounter during their FCS rotations. Exposure to future specialty rotations while in the internship program enables interns to have insight into delivery of specialty-specific care within the context of the larger health care system.*

IV.C.5. Rotations taken away from the Sponsoring Institution and its participating sites must have educational justification and meet the following requirements: (Core)

IV.C.5.a) Outside rotations should be limited to no longer than a total of eight weeks of the internship program. (Core)

IV.C.5.b) The program must develop a curriculum, including objectives, intern's responsibilities, and faculty member(s) assigned for supervision. (Core)

IV.C.6. The program must ensure that interns seeking acceptance into a residency program with specified curricular components have a curriculum which conforms to the respective specialty requirements. (Core)

IV.C.7. The program must counsel and assist interns not accepted into a residency program or without a defined career path. (Core)

IV.C.8. Didactic sessions should correspond to an intern's clinical rotations and complement and enhance the clinical experience. (Detail)

IV.C.9. Didactic sessions should include:

IV.C.9.a) multidisciplinary conferences; (Detail)

IV.C.9.b) morbidity and mortality conferences; (Detail)

IV.C.9.c) journal or evidence-based reviews; (Detail)

IV.C.9.d) case-based planned didactic experiences; (Detail)

IV.C.9.e) seminars and workshops to meet specific competencies; (Detail)

IV.C.9.f) computer-aided instruction; (Detail)

IV.C.9.g) grand rounds; (Detail)

IV.C.9.h) quality improvement and safety; (Detail)

IV.C.9.i) one-on-one instruction. (Detail)

IV.C.10. To ensure interns' participation in didactic experiences, interns' attendance should be monitored. (Detail)

IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through intern participation in scholarly activities. Scholarly activities must include discovery, integration, application and teaching.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate intern and faculty involvement in scholarly activities. (Core)

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

Background and Intent: *Elements of a scholarly approach to patient care include:*

- *Asking meaningful questions to stimulate interns to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan*

- *Challenging the evidence that the interns use to reach their medical decisions so that they understand the benefits and limits of the medical literature*
- *When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)*
- *Improving intern learning by encouraging them to teach using a scholarly approach*

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 journal publications, case-presentation publications
- 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 scholarly activity by the following methods: (Core)

IV.D.2.b)(1) faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, 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;

IV.D.2.b)(2) peer-reviewed publication including case-discussion and letters to the editor.

IV.D.3. Interns' Scholarly Activity

IV.D.3.a) Interns must participate in scholarship. (Core)

IV.D.3.a)(1) Participation must include each intern's presentation of a case report or a presentation to colleagues on a subject of interest, and/or development of a research or quality improvement project. (Core)

IV.D.3.a)(2) Basic science and clinical investigation must be included in the didactic curriculum for interns. (Core)

V. Evaluation

V.A. Intern's Evaluation

V.A.1. Feedback and Evaluation

Formative and summative evaluation have distinct definitions.

Formative evaluation is monitoring intern's learning and providing ongoing feedback that can be used by interns to improve their learning.

More specifically, formative evaluations help:

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

Summative evaluation is evaluating an intern's learning by comparing the interns against the goals and objectives of the rotation and program, respectively and is utilized to make decisions about program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components.

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

V.A.1.a)(1) This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for interns who have deficiencies that may result in a poor final rotation evaluation. (Detail)

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

V.A.1.b)(1) For block rotations of any duration, a written evaluation must be provided at the end of the rotation. (Core)

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

V.A.1.c) The program must provide an objective performance evaluation based on the competencies and the specialty-specific Milestones, and must: (Core)

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

V.A.1.c)(2) provide that information to the Clinical Competency Committee for its synthesis of progressive intern performance and improvement. (Core)

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

V.A.1.d)(1) Meet with and review with each intern their documented semi-annual evaluation of performance, including progress and the specialty-specific Milestones (Core)

V.A.1.d)(1)(a) Review of intern Case-Logs must be a part of the semi-annual review. (Detail)

V.A.1.d)(2) Assist interns in developing individualized learning plans to capitalize on their strengths and identify areas for growth. (Core)

V.A.1.d)(3) Develop plans for interns failing to progress, following NIHS policies and procedures. (Core)

Interns who are experiencing difficulties with achieving progress in 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 intern, will take a variety of forms based on the specific learning needs of the intern. However, the NIHS recognizes that there are situations which require more significant intervention that may alter the time course of intern progression. To ensure due process, it is essential that the program director follow NIHS and institutional policies and procedures.

V.A.1.e) At least at the completion of program, there must be a summative evaluation of each intern that includes their readiness to graduate the program. (Core)

V.A.1.f) The evaluations of an intern's performance must be accessible for review by the intern. (Core)

V.A.1.g) The program must provide performance evaluations of those interns accepted into a residency (following completion of the internship) to the specialty program director (Core)

V.A.2. Final Evaluation

V.A.2.a) The program director must provide a final evaluation for each intern upon completion of the program. (Core)

V.A.2.a)(1) The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure interns are able to engage in selected autonomous practice upon completion of the program and after obtaining a medical license. (Core)

V.A.2.a)(2) The final evaluation must:

V.A.2.a)(2)(a) become part of the intern's permanent record maintained by the institution, and must be accessible for review by the intern in accordance with institutional policy; (Core)

V.A.2.a)(2)(b) verify that the intern has demonstrated the knowledge, skills, and behaviours necessary to enter autonomous practice; (Core)

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

V.A.2.a)(2)(d) be shared with the intern upon completion of the program. (Core)

V.A.3. A Clinical Competency Committee must be appointed by the program director. (Core)

V.A.3.a) The Clinical Competency Committee must include at least three members of the program faculty, at least one of whom is a core faculty member. (Core)

V.A.3.a)(1) Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's interns. (Core)

V.A.3.a)(2) The Program Director has final responsibility for intern evaluation and promotion decisions. (Core)

V.A.3.b) The Clinical Competency Committee must:

V.A.3.b)(1) review all interns evaluation at least semi-annually; (Core)

V.A.3.b)(2) determine each intern's progress on achievement of the specialty-specific Milestones; (Core)

V.A.3.b)(3) meet prior to the interns' semi-annual evaluations and advise the program director regarding each intern's progress. (Core)

V.B. Faculty Evaluation

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, review of patient outcomes, professionalism, research, and scholarly activities. (Core)

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the interns. (Core)

V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

V.B.3.a) The program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. Therefore, the annual review of the program's faculty members is mandatory and can be used as input into the Annual Program Evaluation. (Core)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. The Program Evaluation Committee must present the Annual Program Evaluation Report in a written form to be discussed with all program faculty and interns as a part of continuous improvement plans. (Core)

The performance of interns and faculty members is a reflection of program quality and will use metrics to reflect the program's goals.

V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one intern. (Core)

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

V.C.1.b)(1) acting as an advisor to the program director, through program oversight; (Core)

V.C.1.b)(2) review of the program's requirements, both NIHS required and program self-determined goals, and the progress toward meeting them; (Core)

V.C.1.b)(3) guiding ongoing program improvement, including developing new goals based upon outcomes; (Core)

V.C.1.b)(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats related to the program's mission and aims. (Core)

V.C.1.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:

V.C.1.c)(1) program curriculum; (Core)

V.C.1.c)(2) outcomes from prior Annual Program Evaluation(s); (Core)

V.C.1.c)(3) NIHS letters of notification including citations, areas for improvement, and comments; (Core)

V.C.1.c)(4) the quality and safety of patient care; (Core)

V.C.1.c)(5) Aggregate interns and the faculty:

V.C.1.c)(5)(a) well-being; (Core)

V.C.1.c)(5)(b) recruitment and retention following institutional policies; (Core)

V.C.1.c)(5)(c) workforce diversity following institutional policies; (Core)

V.C.1.c)(5)(d) engagement in quality improvement and patient safety; (Core)

V.C.1.c)(5)(e) scholarly activity; (Core)

V.C.1.c)(5)(f) interns and Faculty Surveys; (Core)

V.C.1.c)(5)(g) written evaluations of the program (see above). (Core)

V.C.1.c)(6) Aggregate intern:

V.C.1.c)(6)(a) achievement of the Milestones; (Core)

V.C.1.c)(6)(b) certification rates; (Core)

V.C.1.c)(6)(c) graduates' performance. (Core)

V.C.1.c)(7) Aggregate faculty:

V.C.1.c)(7)(a) faculty evaluation; (Core)

V.C.1.c)(7)(b) professional development. (Core)

V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

V.C.1.e) The Annual Program Evaluation review, including the action plan, must:

V.C.1.e)(1) be distributed to and discussed with the members of the teaching faculty and the interns; (Core)

V.C.1.e)(2) be submitted to the DIO. (Core)

V.C.2. The program will be accredited and re-accredited by the NIHS in accordance with NIHS Accreditation Bylaws. (Core)

V.C.2.a) The program must complete a Self-Study before its reaccreditation site visit. (Core)

V.C.2.a)(1) The Self-Study is an objective, comprehensive evaluation of the internship program with the aim to improve it. (Detail)

V.C.3. Under the guidance of the Program Director all eligible program graduates should aim and obtain enrolment in a NIHS residency program. (Detail)

VI. The Learning and Working Environment

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

- Excellence in the safety and quality of care
- Excellence in professionalism through faculty modeling of:

- the effacement of self-interest in a humanistic environment that supports the professional development of physicians
- the joy of curiosity, problem-solving, intellectual rigor, and discovery

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

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare interns 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 interns 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.

Interns 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.

It is necessary for interns 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, interns, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

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

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

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

Background and Intent: *Optimal patient safety occurs in the setting of a coordinated inter-professional learning and working environment.*

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

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a)(3)(a) Interns, residents, fellows, faculty members, and other clinical staff members must:

- know their responsibilities in reporting patient safety events at the clinical site; (Core)
- know how to report patient safety events, including near misses, at the clinical site; (Core)
- be provided with summary information of their institution's patient safety reports. (Core)

VI.A.1.a)(3)(b) Interns must participate as team members in real and/or simulated inter-professional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a)(4) Interns Education and Experience in Disclosure of Adverse Events

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

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

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

VI.A.1.b) Quality Improvement

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

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

Interns must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

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

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

Interns and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

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

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care. Interns must have the opportunity to participate in inter-professional quality improvement activities. (Core)

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each intern's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a)(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician who is responsible and accountable for the patient's care. (Core)

VI.A.2.a)(1)(a) This information must be available to interns, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a)(1)(b) Interns and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a resident or fellow. Other portions of care provided by the intern can be adequately supervised by the appropriate availability of the supervising faculty member, resident physician or fellow, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of intern-delivered care with feedback.

VI.A.2.b)(1) The program must demonstrate that the appropriate level of supervision in place for all interns is based on each intern's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

VI.A.2.b)(2) The program must define when physical presence of a supervising physician is required. (Core)

VI.A.2.c) Levels of Supervision

To promote appropriate intern supervision, the program must use the following classification of supervision: (Core)

VI.A.2.c)(1) Direct Supervision: the supervising physician is physically present with the intern during the key portions of the patient interaction. (Core)

VI.A.2.c)(1)(a) The program must have clear guidelines that delineate which competencies must be demonstrated to determine when an intern can progress to indirect supervision. (Core)

VI.A.2.c)(1)(b) The program director must ensure that clear expectations exist and are communicated to the interns, and that these expectations outline specific situations in which an intern would still require direct supervision. (Core)

VI.A.2.c)(1)(c) Interns must be initially supervised directly. (Core)

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 intern for guidance and is available to provide appropriate direct supervision. (Core)

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

VI.A.2.d) Programs must set guidelines for circumstances and events in which interns must communicate with the supervising faculty member(s). (Core)

VI.A.2.d)(1) Each intern must know the limits of their scope of authority, and the circumstances under which the intern is permitted to act without direct supervision. (Outcome)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each intern and to delegate to the intern the appropriate level of patient care authority and responsibility. (Core)

VI.B. Professionalism

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

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

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

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

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

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. Interns 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 intern.*

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

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

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

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

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

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

VI.B.5. All interns and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)

VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, interns, residents, faculty, and staff. (Core)

VI.B.7. Programs, in partnership with their Sponsoring Institutions, should have a process for education of interns and faculty regarding

unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of internship training.

Interns and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of intern competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture, in a clinical learning environment, models constructive behaviors and prepares interns with the skills and attitudes needed to thrive throughout their careers.

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 intern finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, and enhancing professional relationships; (Core)

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

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

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

VI.C.1.e) attention to intern and faculty member burnout, depression, and substance use disorders.

The program, in partnership with its Sponsoring Institution, must educate faculty members and interns in identification of the symptoms of burnout, depression, and substance use disorders,

including means to assist those who experience these conditions. Interns and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

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

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

VI.C.1.e)(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

VI.C.2. There are circumstances in which interns 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 interns 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 intern who is or was unable to provide the clinical work. (Core)

Background and Intent: *Interns 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.*

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

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

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

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if an intern may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each intern must be based on patient safety, intern ability, severity and complexity of patient illness/condition, and available support services. (Core)

VI.E.2. Teamwork

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

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Programs must ensure that interns are competent in communicating with team members in the hand-over process. (Outcome)

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

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide interns with

educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home. (Core)

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

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

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

There may be circumstances when interns choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)

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

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

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

VI.F.3.a) Clinical and educational work periods for interns 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 intern education. (Core)

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

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

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, an intern, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a)(1) humanistic attention to the needs of a patient or family; or, (Detail)

VI.F.4.a)(2) to attend unique educational events. (Detail)

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

VI.F.5. Moonlight

Interns are not permitted to moonlight. (Core)

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one- day-off-in-seven requirements. (Core)

VI.F.6.a) Interns must not be scheduled for more than four consecutive weeks of night float. (Core)

VI.F.6.b) Scheduled night float must not exceed a total of eight weeks during the 12-month program. (Core)

VI.F.7. Maximum In-House On-Call Frequency

Interns must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by interns on at-home call must count toward the 80-hour maximum weekly limit. (Core)

VI.F.8.b) Interns 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)

*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

†Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

‡Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of interns, residents or fellows at key stages of their graduate medical education.


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