NATIONAL INSTITUTE FOR HEALTH SPECIALITIES

NIHS Program Requirements for Specialty Education in Lifestyle Medicine (Emirati Board in Lifestyle Medicine)

The Emirati Board in Lifestyle Medicine is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. The Program must demonstrate substantial compliance with the Common and specialty-specific Program Requirements.

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

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

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

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

Int. B. Definition of lifestyle medicine

Lifestyle medicine is defined as a medical specialty with an evidence-based therapeutic approach to prevent, treat, and reverse lifestyle-related chronic diseases.

Comprehensive lifestyle interventions aim to assess the underlying disease risks, thereby decreasing the illness burden and improving clinical outcomes within value-based medicine.

The practice of lifestyle medicine incorporates six fundamental elements: a whole foods plant-based predominant diet, regular physical activity, adequate restorative sleep, stress management, the avoidance of risky substances, and maintaining positive social relationships.

Upon completion of the training program, the graduates will acquire the knowledge, skills, and competency to practice lifestyle medicine at the consultant level. They will be able to prevent, reverse, and manage lifestyle-related diseases with a comprehensive understanding of the cultural and socio-economic factors involved.

The main differences between conventional medicine and lifestyle medicine are listed below:

Conventional Medicine	Lifestyle medicine
Treats individual risk factors	Treats lifestyle causes with the goal of preventing primary, secondary, and tertiary diseases
Patient is often passive recipient of care (patient is not required to make big changes)	Patient is active partner of care (patient is required to make substantial transitions)
Treatment is short term or long term depends on the nature of the illness	Treatment is often long term and is sustainable
Responsibility falls mostly on the clinicians	Responsibility falls mostly on the patients (emphasis is on motivation and adherence)
Medication is often the "end" treatment. Emphasis is on diagnosis, prescription, and disease management	Medication may be needed, but as an adjunct to lifestyle change.

Int. C. Length of educational program

The educational program in lifestyle medicine 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, consistent 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 fellows. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings.*

I.A.1. The program must be sponsored by one NIHS-accredited Sponsoring Institution. (Core)

I.B. Participating Sites

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

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

I.B.1.a) A Lifestyle medicine fellowship must function as an integral part of an NIHS-accredited program in Public Health, General Preventive Medicine, Internal Medicine or Family Medicine (Core)

I.B.1.b) The Sponsoring Institution must establish the lifestyle medicine fellowship within a department of Public Health, General Preventive Medicine, Internal Medicine or Family Medicine or an administrative unit whose primary mission is the advancement of lifestyle medicine education and patient care. (Core)

I.B.1.c) The Sponsoring Institution must ensure that there is a partnership and close collaboration between the program directors of the parent residency program and fellowship program to ensure compliance with NIHS accreditation requirements. (Core)

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.B.2.a) The PLA must:

I.B.2.a)(1) be renewed at least every 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 fellow education during the assignment; (Core)

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

I.B.2.a)(6) specify the responsibilities for teaching, supervision, and formal evaluation of fellows. (Core)

I.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.B.3.a) At each participating site there must be one faculty member, designated by the program director who is accountable for fellow education at that site, in collaboration with the program director. (Core)

Background and Intent: *While all fellowship programs must be sponsored by a single NIHS-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must 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 fellows, of one-month full time equivalent (FTE) or more through NIHS Accreditation System. (Core)

I.B.5. Fellow assignments away from the Sponsoring Institution should not prevent fellows' regular participation in required didactics. (Core)

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 fellows, residents (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 fellow education. (Core)

I.D.1.a) Lifestyle medicine (LM) interventions are implemented across a wide range of healthcare settings to provide a spectrum of intervention intensity from primary prevention to palliative care based on the health conditions.

The settings include: (Core)

I.D.1.a)(1) outpatient: such as primary care setting/cardiac center/oncology center/diet center; (Core)

I.D.1.a)(2) clinical practices and group therapy sessions;(Core)

I.D.1.a)(3) inpatient rehabilitation/residential/hospital; (Core)

I.D.1.a)(4) telemedicine and virtual clinic. (Core)

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote fellow 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 fellows with proximity appropriate for safe patient care; (Core)

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

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

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

I.D.3. Fellows 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 fellows appointed to the program. (Core)

I.E. Other Learners and Other Care Providers

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

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

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

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 a fellowship, 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 fellowship, and it is this individual's responsibility to communicate with the fellows, 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 fellowship 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 30 percent FTE of non-clinical time to the administration of the program. (Core)

Background and Intent: *Thirty percent FTE is defined as one-and-a-half (1.5) days 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 lifestyle medicine expertise 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 fellowship and subsequently further developed. The time from completion of fellowship to 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 fellowship documented experience in Lifestyle medicine, or with a specialty qualification that are 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 fellows. 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 fellows.*

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for administration and operations; teaching and scholarly activity; fellow recruitment and selection, evaluation, and promotion of fellows, and disciplinary action; supervision of fellows; and fellow 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 fellows in addition to fulfilling the technical aspects of the role. As fellows are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program*

director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

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 fellows 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. Fellowship programs can be highly complex. In a complex organization, the leader typically can 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 fellowship 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 fellowship program education at all sites; (Core)

II.A.4.a)(6) have the authority to remove fellows 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 fellows effectively role model the Core Competencies. Working with a fellow is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.*

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

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 applicants who are offered an interview with information related to the applicant's eligibility for the relevant lifestyle medicine board examination(s); (Core)

II.A.4.a)(9) provide a learning and working environment in which fellows 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)(10) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)

II.A.4.a)(11) 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 a fellow; (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 fellows.*

II.A.4.a)(12) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a)(13) document verification of program completion for all graduating fellows within 30 days; (Core)

II.A.4.a)(14) provide verification of an individual fellow's completion upon the fellow'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 fellows who have previously completed the program. Fellows who leave the program prior to completion also require timely documentation of their summative evaluation.*

II.A.4.a)(15) 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 fellow complement of more than 15, one of the Lifestyle medicine-certified core faculty members must be appointed as associate program director to assist the program director with the administrative and clinical oversight of the program. (Core)

II.A.5.b) Sponsoring institution to provide APD with 0.3 FTE (or 12 hours per week) of protected time for education and program administration, The APD must not work more than 0.7 FTE in a clinical capacity. (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 fellows how to care for patients. Faculty members provide an important bridge allowing fellows 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. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members 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, fellows, 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 fellows and themselves.

Background and Intent: *"Faculty" refers to the entire teaching force responsible for educating fellows. The term "faculty," including "core faculty," does not imply or require an academic appointment 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 fellows at that location. (Core)

II.B.1.a) The ratio of all faculty to fellows must be 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 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 fellows; (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 fellows; (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 fellowship program faculty in the aggregate.*

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 license in lifestyle medicine or other specialty 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 fellowship program education must be approved by the program director. (Core)

***Background and Intent**: The provision of optimal and safe patient care requires a team approach. The education of fellows by non-physician educators enables the fellows to better manage patient care and provides valuable advancement of the fellows' knowledge. If the program director determines that the contribution of a non-physician individual is significant to the education of the fellows, 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 fellows and must devote a significant portion of their entire effort to fellow education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to fellows. (Core)

***Background and Intent**: Core faculty members are critical to the success of fellow education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing fellows' progress toward achievement of competence in the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, 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) The ratio of core faculty to fellows must be 1:2. (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 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 fellows.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer fellows may not require a full-time coordinator; one coordinator may support more than one program.

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. Fellows 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) All required clinical education for entry into NIHS-accredited fellowship programs must be completed in a NIHS-accredited residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or another structured residency program considered acceptable by Central Accreditation Committee. (Core).

III.A.1.b) Prior to appointment in the fellowship, fellows should have completed a residency program in either internal medicine or community medicine or family medicine or preventive medicine or public health medicine that satisfies the requirements in III.A.1.a). (Core)

III.A.1.b)(1) Refer to NIHS criteria included in the Training Bylaw. (Core)

III.A.1.b)(2) In addition to III.A.1.b), the candidates should: (Core)

III.A.1.b)(2)(a) have no fewer than 6 months of experience in specialty clinics; (Core)

III.A.1.b)(2)(b) be a never smoker or a nonsmoker for the last 2 years; (Core)

III.A.1.b)(2)(c) not have a BMI of more than 30. (Core)

III.A.1.c) Fellow Eligibility Exception

The Central Accreditation Committee will allow the following exception to the fellowship eligibility requirements:

III.A.1.c)(1) An NIHS-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1.a), but who does meet all of the following additional qualifications and conditions: (Core)

III.A.1.c)(1)(a) Is eligible for license of specialist in internal medicine or community medicine or family medicine or preventive medicine or public health medicine by UAE Health Authority PQR. (Core)

III.A.1.c)(1)(b) Is evaluated by the program director and fellowship selection committee based on prior training and review of the summative evaluations of training in the core specialty; (Core)

III.A.1.c)(1)(c) The applicant's exceptional qualifications are reviewed and approved of by the GMEC; (Core)

III.A.1.c)(2) Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)

III.A.2. All prerequisite post-graduate clinical education required for initial entry or transfer into NIHS-accredited fellowship programs must be completed in a NIHS-accredited fellowship programs approved by the NIHS. (Core)

III.A.2.a) Prior to appointment in the program, fellows must fulfill the NIHS eligibility criteria. (Core)

III.B. Number of Fellows

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

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

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

III.B.4. The number of available fellow positions in the program must be at least one per year. (Detail)

III.C. Fellows Transfers

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

IV. Educational Program

The NIHS accreditation system is designed to encourage excellence and innovation in 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 are designed to promote progress on a trajectory to autonomous practice which is documented by Milestones evaluation. (Core)

IV.A.2.a) These goals and objectives must be distributed and available to fellows and faculty members. (Core)

IV.A.3. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision in their subspecialty. (Core)

IV.A.4. Structured educational activities beyond direct patient care. (Core)

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

IV.A.5. Advancement of fellows' knowledge of ethical principles foundational to medical professionalism. (Core)

IV.B. Defined Core Competencies

In line with the American College of Preventive Medicine (ACPM), American College of Lifestyle Medicine and other International Lifestyle Medicine Colleges there are five domains which cover 10 core competencies. These address the six pillars of lifestyle medicine which are nutrition, physical activity, sleep health, stress management, avoidance of risky substance uses and positive social connection.

IV.B.1. The following are the core competency goals required for multiple rotations. The competency goal will largely be rotation-specific; therefore, it will be explained separately in each rotation.

The program must integrate the following Core Competencies into the curriculum: (Core)

IV.B.1.a) Professionalism

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

IV.B.1.a)(1) Taking the lead in promoting healthy lifestyle and healthy behaviors. (Core)

IV.B.1.a)(2) Promote healthy behaviors as foundational to prevention, treatment, and reversal of disease. (Core)

IV.B.1.a)(3) Develop leadership culture with emphasis on personal health; practice healthy behaviors; and cultivate school, work, communities, and home environments that support healthy behaviors. (Core)

IV.B.1.a)(4) Use technologies to support LM interventions measurement and monitoring. (Core)

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

IV.B.1.b)(1) Fellows 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)(2) Fellows must be able to take a history and perform a physical examination specific to lifestyle-related health status, including lifestyle "vital signs". (Core)

IV.B.1.b)(3) Fellows must be able to identify and interpret appropriate tests to screen, diagnose, treat, and monitor lifestyle related chronic diseases. (Core)

IV.B.1.b)(3)(a) Utilizing evidence-based clinical practice guidelines to support patients in self-managing their health behaviors and lifestyles. (Core)

IV.B.1.b)(3)(b) Using lifestyle medicine practice guidelines for the prevention, treatment and reversal of some chronic diseases, where available. (Core)

IV.B.1.b)(3)(c) Including lifestyle medicine interventions in treatment plans, and use appropriate informed consent processes before prescribing non–lifestyle medicine modalities for lifestyle medicine–related conditions. (Core)

IV.B.1.b)(3)(d) Collaborating with patients and their families to develop achievable, specific, patient-centered written action plans based on the best current evidence, such as lifestyle prescriptions. (Core)

IV.B.1.c) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social behavioural sciences, as well as the application of this knowledge to patient care. (Core)

IV.B.1.c)(1) Use national guidelines regarding lifestyle prescriptions. (Core)

IV.B.1.c)(1)(a) Demonstrate knowledge of the evidence of specific lifestyle changes that have a positive effect on patients' health outcomes, including reversal of many lifestyle-related diseases. (Core)

IV.B.1.c)(1)(b) Describe ways in which physicians can affect health behavior change. (Core)

IV.B.1.c)(1)(c) Demonstrate knowledge of lifestyle medicine modalities applied for prevention, management, and reversal of chronic disease. (Core)

IV.B.1.c)(1)(d) Demonstrate knowledge of the ways physician engagement with patients and families has a positive effect on patients' health behaviors. (Core)

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

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

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

Fellows 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) Use a team approach and establish effective relationships with patients/caregivers. (Core)

IV.B.1.e)(1)(a) Establishing collaborative relationships with patients and their families to support and sustain behavioral change using evidence-based behavior change methods, tools, and follow-up. (Core)

IV.B.1.e)(1)(b) Working with patients to identify meaningful health behavior changes consistent with their own vision and values. (Core)

IV.B.1.e)(2) Make referrals when appropriate. (Core)

IV.B.1.e)(2)(a) Help patients manage and sustain healthy lifestyle practices, including providing referrals as necessary. (Core)

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

Fellows 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) Have the ability to practice in interdisciplinary and community teams. (Core)

IV.B.1.f)(2) Apply office systems and technologies to support lifestyle medicine. (Core)

IV.B.1.f)(3) Use appropriate community referral resources to support the implementation of healthy lifestyles including smart device apps. (Core)

IV.B.1.f)(4) Analyze processes and outcomes to improve quality/effectiveness of lifestyle interventions in individuals and groups of patients using appropriate evaluation tools. (Core)

IV.C. Curriculum Organization and Fellow Experiences

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

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

IV.C.1.b) Clinical experiences should be structured to facilitate learning in a manner that allows fellows to function as part of an effective interprofessional team that works together towards the shared goals of patient safety and quality improvement. (Core)

IV.C.2. Program Rotations

The following section defines the rotation-specific competency goals that must be met during rotation. All rotations are mandatory. (Core)

IV.C.2.a) Introductory course.

Introduction to lifestyle medicine (4 weeks) (Core)

IV.C.2.a)(1) Training location: academic, lectures in person/online.

Clinical learning will take place in outpatient departments for 3 weeks and inpatient departments for 1 week in the following specialties: lifestyle medicine, family medicine, internal medicine, preventive medicine, cardiology and

endocrinology or the relevant applicable specialty. (Core)

IV.C.2.a)(2) Objectives: (Detail)

- Discuss lifestyle medicine and its unique role in healthcare practice.
- Describe the lifestyle medicine core competencies as identified by a national consensus panel.
- Compare and contrast lifestyle medicine with other fields of health and medicine.
- Summarize the scientific evidence that shows health behaviors are associated with key health outcomes.
- Describe the evidence showing that lifestyle interventions effectively impact disease pathophysiology.
- Describe the priority of lifestyle medicine in the spectrum of treatment algorithms for chronic, lifestyle-related diseases across the lifespan.
- Discuss the prevalence and associated cost burden of lifestyle-related disease, such as hyperlipidemia, cardiovascular disease, prediabetes, diabetes, hypertension, obesity, and cancer.
- Explain the impact of lifestyle choices on planetary health and sustainable living.

IV.C.2.b) The role of the practitioner's personal health and community advocacy (4 weeks). (Core)

IV.C.2.b)(1) Training location: academic, lectures in person/online.

Clinical learning will take place in outpatient departments for 3 weeks and inpatient departments for 1 week in the following specialties: lifestyle medicine, family medicine, internal medicine, preventive medicine, cardiology and endocrinology or the relevant applicable specialty. (Core)

IV.C.2.b)(2) Objectives: (Detail)

- Examine scientific evidence that suggests practitioners who practice healthy lifestyles are more likely to offer counseling, serve as role models, and improve patient outcomes.
- Develop a culture of leadership by modeling personal health behaviors.
- Describe strategies for incorporating personal wellness for practitioners into clinics, medical offices, or other

healthcare settings, including wellness programs.

- Examine essential practitioner characteristics and practices that increase the capacity and impact of the therapeutic alliance.
- Integrate personal readiness assessments and lifestyle action plans into sustainable life patterns for practitioners.
- Explore the role of lifestyle medicine in promoting personal practitioner resiliency and reducing burnout.
- Advocate for lifestyle medicine directly with patients and their families, as well as policy and decision makers within the community.

IV.C.2.c) Nutrition science, assessment, and prescription (8 weeks). (Core)

IV.C.2.c)(1) Training location: didactic learning will take place in academic, lectures in person/online.

Clinical learning will take place in outpatient departments for 6 weeks and inpatient departments for 2 week in the following specialties: lifestyle medicine, family medicine, internal medicine, preventive medicine, cardiology and endocrinology or the relevant applicable specialty. (Core)

IV.C.2.c)(2) Objectives: (Detail)

- Assess food intake patterns and nutrients of deficit and excess.
- Analyze food labels for the health impacts of ingredients.
- Discuss commonalities and key messages of global dietary guidelines.
- Summarize the health impact of prominent dietary patterns, including plant-predominant and non–plant predominant patterns.
- Describe how the level of processing in a food affects health and discuss the evidence base for these effects.
- Describe the practice of culinary medicine and its role in sustainable healthy eating behavior.
- Summarize the major studies of nutrition in the prevention, treatment, and reversal of hyperlipidemia, cardiovascular disease, prediabetes, diabetes, hypertension, obesity, and cancer.
- Apply nutrition prescriptions based on science that shows how nutrition can address the pathophysiology

of most chronic diseases, including inflammation, oxidation, glycosylation, epigenetic expression, and the microbiome.
- Demonstrate the ability to write evidence-based nutrition prescriptions.
- Describe indications for referral to a lifestyle.

IV.C.2.d) Physical activity science, assessment, and prescription (4 weeks). (Core)

IV.C.2.d)(1) Training location: didactic learning will take place in academic, lectures in person/online.

Clinical learning will take place in outpatient departments for 3 weeks and inpatient departments for 1 week in the following specialties: lifestyle medicine, family medicine, internal medicine, preventive medicine, cardiology and endocrinology or the relevant applicable specialty. (Core)

IV.C.2.d)(2) Objectives: (Detail)

- Discuss the aerobic, strength, flexibility, and balance components of physical activity.
- Examine the evidence and pathophysiology between physical activity components and health outcomes.
- Describe the benefits of physical activity in preventing or treating disease in special populations, such as healthy older adults, pregnant women, children and adolescents, persons with obesity or disability, cardiovascular disease, diabetes, cancer, disability, and stroke.
- Summarize the role of physical activity guidelines.
- Integrate key physical activity assessment tools into clinical practice.
- Define fitness terminology relevant to writing exercise prescriptions.
- Integrate evidence from relevant physical activity literature into treatment protocols for management, remission, or reversal in patients with diabetes, cancer, cardiovascular, and cerebrovascular disease.
- Describe indications for referral to health fitness professionals.
- Develop physical activity prescriptions appropriately modified for special populations, such as healthy older adults, pregnant women, children and adolescents, persons with obesity or disability, cardiovascular

disease, diabetes, cancer, disability, and stroke.

IV.C.2.e) Sleep health science and interventions (4 weeks). (Core)

IV.C.2.e)(1) Training location: didactic learning will take place in academic, lectures in person/online.

Clinical learning will take place in outpatient departments for 3 weeks and inpatient departments for 1 week in the following specialties: lifestyle medicine, family medicine, internal medicine, preventive medicine, respiratory medicine or the relevant applicable specialty. (Core)

IV.C.2.e)(2) Objectives: (Detail)

- Describe sleep's role with health and chronic disease pathophysiology.
- Perform sleep assessments to identify patients with insufficient or poor-quality sleep.
- Summarize lifestyle-based interventions that can improve sleep health.
- Assess the risk for common sleep disturbances, such as obstructive sleep apnea, chronic insomnia, and restless legs syndrome, and refer to sleep specialists when applicable.
- Describe the indications for referral to a sleep specialist or for a sleep study to assess for sleep apnea.
- Describe indications for referral to a program or specialist in cognitive behavior therapy for insomnia.

IV.C.2.f) Treating tobacco use disorder and managing other toxic exposures (4 weeks). (Core)

IV.C.2.f)(1) Training location: didactic learning will take place in academic, lectures in person/online. (Core)

Clinical learning will take place in outpatient departments for 3 weeks and inpatient departments for 1 week in the following specialties: lifestyle medicine, family medicine, internal medicine, preventive medicine, and psychiatry/psychology or the relevant applicable specialty. (Core)

IV.C.2.f)(2) Objectives: (Detail)

- Describe the health effects of tobacco, alcohol, and other frequently used substances and the benefits of cessation.

- Apply patient screening tools for substance use.
- Create patient-centered substance use treatment plans using practice guidelines and behavioral interventions.
- Summarize the diagnostic criteria for common substance use disorders.
- Integrate behavior therapy with pharmacotherapy for tobacco and other substance use disorder plans, and refer to a substance use disorder specialist when indicated.
- Apply the National guidelines for patients with tobacco use disorder.

IV.C.2.g) The fundamentals of health behavior change (4 weeks). (Core)

IV.C.2.g)(1) Training location: didactic learning will take place in academic, lectures in person/online.

Clinical learning will take place in outpatient departments for 3 weeks and inpatient departments for 1 week in the following specialties: lifestyle medicine, family medicine, internal medicine, preventive medicine, cardiology, endocrinology and psychiatry/psychology or the relevant applicable specialty. (Core)

IV.C.2.g)(2) Objectives: (Detail)

- Summarize health behavior change theories, such as the health belief model, the social learning theory, and the transtheoretical model (TTM), and their application to lifestyle medicine practice.
- Demonstrate key elements of conducting a patient assessment within the TTM and collaborate to develop stage-matched responses.
- Apply the process of building effective and therapeutic alliances with patients that foster their personal growth.
- Explain how to collaborate with your patients to promote health behavior changes.
- Apply motivational interviewing, cognitive behavioral, health coaching, and positive psychology techniques.
- Summarize the evidence to support the use of behavior change techniques in clinical practice.
- Use the skills of open inquiry, reflections, and empathy to develop and maintain a therapeutic alliance.
- Describe the impact of positive emotions on the success of health behavior change.

- Develop patient- centered, written action plans based on the appropriate stage of change of the TTM.
- Summarize the process of follow-up for ongoing lifestyle change progress, including building patient self-efficacy and relapse prevention.
- Describe the factors that support sustained behavior change.
- Explain the role of family and other support to initiate and maintain health behavior change.
- Manage disruptions to the therapeutic alliance.
- Identify patient resources for sustainable behavior change in relation to the pillars of lifestyle medicine.

IV.C.2.h) Key Clinical processes in lifestyle medicine (4 weeks). (Core)

IV.C.2.h)(1) Training location: didactic learning will take place in academic, lectures in person/online.

Clinical learning will take place in outpatient departments for 3 weeks and inpatient departments for 1 week in the following specialties: lifestyle medicine, family medicine, internal medicine, preventive medicine, cardiology, endocrinology and psychiatry/psychology or the relevant applicable specialty. (Core)

IV.C.3.h)(2) Objectives: (Detail)

- Integrate lifestyle vital signs into components of the patient history and physical exam.
- Analyze and implement evidence-based clinical practice guidelines relevant to lifestyle medicine for prevention, treatment, and reversal of chronic diseases.
- Describe the treatment of disease with the lifestyle medicine pillars as compared with medication.
- Demonstrate how to screen, diagnose, treat, and monitor a lifestyle- related disease and provide lifestyle medicine-focused anticipatory guidance.
- Discuss strategies for a clinical practice to access and implement use of local, national, and global resources.
- Describe the key strategies for leveraging inter-professional teams to enhance health behavior change interventions.
- Examine how group visits and telehealth can optimize lifestyle medicine treatment encounters.
- Create and utilize data from office systems, such as electronic health records with lifestyle medicine

guidance, in clinical decisions and care, including tracking screening frequency, test results, referrals, and recommended follow-up.
- Analyze the evidence for collaborative and chronic care models on improved lifestyle outcomes.
- Discuss successful primary care and office-based models for lifestyle modification.
- Design a quality improvement project for lifestyle medicine clinical practice, using tools, such as Plan-Do-Study-Act (PDSA) cycles.
- Explain the principles of evidence-based medicine and their application to lifestyle medicine.
- Describe methods of assessing the effectiveness of interventions, such as patient activation measures and the therapeutic alliance measures.

IV.C.2.i) Emotional and mental health assessment and interventions (4 weeks). (Core)

IV.C.2.i)(1) Training location: didactic learning will take place in academic, lectures in person/online.

Clinical learning will take place in outpatient departments for 3 weeks and inpatient departments for 1 week in the following specialties: lifestyle medicine, family medicine, internal medicine, preventive medicine and psychiatry/psychology or the relevant applicable specialty. (Core)

IV.C.2.i)(2) Objectives: (Detail)

- Apply screening tools for stress, depression, and anxiety in clinical practice.
- Explain the relationship and pathophysiology between emotional and physical health.
- Summarize the nature of stress, the role of stressors, such as adverse child experiences, and identify manageable elements of pathogenic stress reactions.
- Describe and utilize evidence-based and patient-centered mental and emotional health, including self-management and resilience-building techniques.
- Analyze the clinical relevance and evidence base for mindfulness-based stress reduction (MBSR) and related stress management strategies.
- Manage treatment plans for lifestyle-related mental health diseases, such as depression and anxiety.

- Describe indications for referral to mental health professionals (versus when clinically indicated).
- Apply mindfulness skills to enable presence, clarity, and curiosity in the clinical encounter.

IV.C.2.j) The role of connectedness and positive psychology (4 weeks). (Core)

IV.C.2.j)(2) Training location: didactic learning will take place in academic, lectures in person/online.

Clinical learning will take place in outpatient departments for 3 weeks and inpatient departments for 1 week in the following specialties: lifestyle medicine, family medicine, preventive medicine and psychiatry/psychology or the relevant applicable specialty. (Core)

IV.C.2.j)(2) Objectives: (Detail)

- Apply positive psychology in health behavior change counseling.
- Describe how positive psychology strategies support achieving and sustaining healthy behaviors.
- Compare and contrast eudaimonia and hedonia, and explain their effect on physical health, including longevity.
- Describe how social connectedness and social networks effect emotional well-being, physical health, and longevity.
- Summarize the deleterious and positive effects social media has on emotional well-being and flourishing.
- Explain the relationship among the lifestyle pillars, positive emotions, and flourishing.
- Describe positive psychology activities that can boost emotional well-being and flourishing.

IV.C.3. Adnexa 1 contains the main diseases/conditions in UAE that are presented in health care settings: outpatient and inpatient. The fellow is expected to deal with these conditions during academic teaching, clinical training, and everyday practice. (Core)

IV.C.4. Didactic and clinical activities

IV.C.4.a) Teaching methods of didactic activities:

The Foundations of Lifestyle Medicine Board Review is the trusted American Board of Lifestyle Medicine (ABLM) and International

Board of Lifestyle Medicine exam preparation course. Trainees will undertake this course as part of the didactic activities. (Core)

Trainees will gain the necessary competencies through a variety of learning methods listed below: (Detail)

- Lectures: formal presentations on specific topics by experts in the field.
- Assignments and projects: independent or group tasks that require research, analysis, and application of knowledge.
- Research activities: involvement in research or quality improvement projects to develop analytical and investigative skills.
- Journal clubs: regular meetings where trainees review and discuss recent literature, fostering critical appraisal skills.
- Workshops and seminars: intensive training sessions focused on specific skills or topics, often involving practical exercises.
- Interactive multimedia: use of audio, video conferencing, and online resources to facilitate remote learning and interaction.
- Problem-solving Exercises: activities designed to enhance critical thinking and decision-making skills through practical scenarios.
- Case studies: detailed analysis of specific cases to apply theoretical knowledge to real-world situations.
- Discussion groups: group discussions to encourage peer learning and exchange of ideas.

These formats are typically balanced to provide both formal instruction and experiential learning, ensuring a well-rounded educational experience for fellows.

IV.C.4.b) Formal teaching time:

Formal teaching includes two primary activities: (Detail)

- Structured learning sessions (SLS)
- Adaptive learning activities (ALA)

The didactic components listed in Table 1 below will be delivered via the two formal teaching activities. (Core)

The fellowship will constitute of 2 days ALA or SLS and 3 days clinical across 48 weeks. (Core)

IV.C.4.b)(1) Structured learning sessions (SLS): (Core)

These sessions will be based on the foundations of lifestyle medicine board review course and are specifically designed for trainees who are required to attend them.

Non-compliance may result in disciplinary actions. Attendance and participation in these sessions are part of continuous assessment. The SLS hours should total a minimum of 40 hours per program.

IV.C.4.b)(2) Adaptive learning activities (ALA): (Core)

The SLS hours should total a minimum of 83 hours per program.

IV.C.4.c) Teaching methods of clinical learning activities (CLA): (Core)

IV.C.4.c)(1) Trainees will gain the necessary competencies through a variety of learning methods listed below: (Core)

- Clinical experiences: direct patient care activities, including diagnosis, treatment, and management of cases under supervision.
- Ward rounds: regular visits to patients in a clinical setting with a supervisor, discussing and reviewing cases.
- Multidisciplinary meetings: collaborative sessions with professionals from various disciplines to discuss complex cases and care plans.
- Mentoring and supervision: one-on-one guidance from experienced professionals to support personal and professional development and reflect on clinical experiences and progress.

IV.C.4.c)(2) The fellow can choose two of the following elective rotations to total 4 weeks. These are: (Core)

- Integrative medicine: exposure to complementary therapies (e.g., acupuncture, meditation, yoga) (2 weeks).
- Community health: work with community-based health programs and public health initiatives (2 weeks).
- Occupational health: understanding and applying lifestyle medicine in workplace settings (2 weeks).

IV.C.4.d) Attendance and structure:

IV.C.4.d)(1) Attendance:

All fellows are expected to attend structured learning sessions throughout their fellowship. Absences must be reported to the coordinator, and failure to do so may result in disciplinary action. (Core)

IV.C.4.d)(2) Structure:

The structured learning sessions will cover core topics in lifestyle medicine. (Core)

Table 1. Didactic component

Module number and title	Structured learning sessions	Adaptive learning activities
1) Introduction to lifestyle medicine	3 hours	728 hours*
2) The role of the practitioner's personal health and community advocacy	2 hours	
3) Nutrition science, assessment, and prescription	10 hours	
4) Physical activity science, assessment, and prescription	6 hours	
5) Sleep health science and interventions	3 hours	
6) Treating tobacco use disorder and managing other toxic exposures	3 hours	
7) Fundamentals of health behavior change	4 hours	
8) Key clinical processes in lifestyle medicine	3 hours	
9) Emotional and mental health assessment and interventions	4 hours	
10) The role of connectedness and positive psychology	2 hours	
	40 hours*	
Total	768 hours	

*The total number of hours for the didactic component is 768 hours. However, the minimum number of hours for SLS is 40 hours and for ALA is 83 hours.

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 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 fellow 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 fellow and faculty involvement in scholarly activities. (Core)

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:

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; (Core)

IV.D.3. Fellow Scholarly Activity

IV.D.3.a) While in the program, fellows must engage in at least one of the following scholarly activities: participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor. (Core)

IV.D.3.b) Fellows must participate in scholarly projects. (Core)

IV.D.3.b)(1) Fellows must complete a scholarly project relevant to Lifestyle medicine which was conducted under direct supervision of a faculty member. (Core)

IV.D.3.b)(2) The project shall be prepared in a form which can be used for publication or presentation and submitted for publication in a specialty specific journal or presented in a national or international specialty conference. (Core)

IV.D.3.b)(3) The proof of project submission for publication, or presentation in a medical conference, will be part of the fellow's portfolio and will be documented in the final summative evaluation prior to Board Certification, in accordance with NIHS guidelines. (Core)

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Feedback and Evaluation

Formative and summative evaluation have distinct definitions.

Formative evaluation is monitoring fellow learning and providing ongoing feedback that can be used by fellows to improve their learning.

More specifically, formative evaluations help:

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

Summative evaluation is evaluating a fellow's learning by comparing the fellows against the goals and objectives of the rotation and program, respectively and is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when fellows or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the fellowship program.

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

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

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

V.A.1.a)(2) Assessment of procedural competence should include a formal evaluation process and not be based solely on a minimum number of procedures performed. (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 greater than three months in duration, evaluation must be documented at least every three months. (Core)

V.A.1.b)(2) For block rotations of any duration, a written evaluation must be provided at the end of the rotation. (Core)

V.A.1.b)(3) 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 lifestyle medicine -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 fellow performance and improvement toward unsupervised practice. (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 fellow their documented semi-annual evaluation of performance, including progress and the specialty-specific Milestones (Core)

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

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

V.A.1.d)(3) develop plans for fellows failing to progress, following both the NIHS Emirati Board and institutional policies and procedures. (Core)

V.A.1.e) At least annually, there must be a summative evaluation of each fellow that includes their readiness to progress to the next year of the program, if applicable. (Core)

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

V.A.2. Final Evaluation

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

V.A.2.a)(1) The lifestyle medicine-specific Milestones, and when applicable the specific Case Logs, must be used as tools to document performance and verify that the fellow has demonstrated sufficient competence to be able to engage in autonomous practice upon completion of the program, and once he/she obtain the license to practice in lifestyle medicine. (Core)

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

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

V.A.2.a)(2)(b) verify that the fellow 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 fellow 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 fellows. (Core)

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

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

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

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

V.A.3.b)(3) meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow'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 fellows. (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.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. (Core)

The performance of fellows and faculty members reflects program quality and will use metrics to reflect the program's goals.

The Program Evaluation Committee must present the Annual Program Evaluation Report in a written form to be discussed with all program faculty and fellows as a part of continuous improvement plans.

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 fellow. (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 Emirati Board 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 fellows 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) Fellows and Faculty Surveys; (Core)

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

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

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

V.C.1.c)(6)(b) in-training examination results; (Core)

V.C.1.c)(6)(c) board pass and certification rates; (Core)

V.C.1.c)(6)(d) 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 fellows; (Core)

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

V.C.2. The program will be accredited and reaccredited by the NIHS in accordance with NIHS Accreditation Bylaws.

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

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

V.C.3. The goal of NIHS-accredited education is to train physicians who seek and achieve a board certification. One measure of the effectiveness of the educational program is the ultimate pass rate. (Outcome)

V.C.3.a) Under the guidance of the Program Director all eligible program graduates should take the certifying examination conducted by the NIHS to obtain the Certification. (Outcome)

V.C.3.b) Graduates are eligible to sit for the Certification examination for up to three years from the date of completion of fellowship training. (Outcome)

V.C.4. During the fellowship, the fellows are strongly encouraged to sit for an organized Annual In-Training Examination. (Detail)

VI. The Learning and Working Environment

Fellowship 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 rendered to patients by fellows today
- Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice
- 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 fellows, 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 the quality of patient care. Program must prepare fellows to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by fellows who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Fellows must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating fellows will apply these

skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for fellows and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a)(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety to identify areas for improvement.

VI.A.1.a)(1)(a) The program, its faculty 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)

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) 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) Fellows 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) Fellow 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 fellows to develop and apply.

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

VI.A.1.a)(4)(b) Fellows 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.

Fellows 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.

Fellows 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.

Fellows 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 fellowship medical education provides safe and effective care to patients; ensures each fellow'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 fellows, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a)(1)(b) Fellows 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 some aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the appropriate availability of the supervising faculty member, or senior fellow physician, 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 fellow-delivered care with feedback.

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

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

VI.A.2.c) Levels of Supervision

To promote appropriate fellow supervision while providing for graded authority and responsibility, 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 fellow during the key portions of the patient interaction. (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 fellow 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) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. (Core)

VI.A.2.d)(1) The program director must evaluate each fellow' abilities based on specific criteria, guided by the Milestones. (Core)

VI.A.2.d)(2) Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. (Core)

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

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

Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence. (Outcome)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow 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 fellows 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 fellows 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. Fellows and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; (Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

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 fellows 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 fellows, faculty, and staff. (Core)

VI.B.7. Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows 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 fellowship training.

Fellows and faculty members are at risk of burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of fellow 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 fellows 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 fellow finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

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

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

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

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

The program, in partnership with its Sponsoring Institution, must educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance use disorders, including means to assist those who experience these conditions. Fellows and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

VI.C.1.e)(1) encourage fellows and faculty members to alert the program director or other designated personnel or programs when they are concerned that another fellow, 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 fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for fellows unable to perform their patient care responsibilities. (Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care. (Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the fellow who is or was unable to provide the clinical work. (Core)

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

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

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

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

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

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home. (Core)

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

VI.E.1. Clinical Responsibilities

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

VI.E.2. Teamwork

Fellows must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the Lifestyle medicine 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 fellows are competent in communicating with team members in the hand-over process. (Outcome)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a fellow 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 fellows 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 fellows with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

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

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

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

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

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

VI.F.3.a) Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

VI.F.3.a)(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education. (Core)

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

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

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

VI.F.4.a)(1) to continue to provide care to a single severely ill or unstable patient; (Detail)

VI.F.4.a)(2) humanistic attention to the needs of a patient or family; or, (Detail)

VI.F.4.a)(3) to attend unique educational events. (Detail)

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

VI.F.5. Moonlight

Fellows are not permitted to moonlight. (Core)

*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 fellows at key stages of their graduate medical education.

Adnexa 1

The table below contains the main chronic diseases in the United Arab Emirates that are present in both outpatient and inpatient settings. The fellow is expected to understand the introductory course and manage the conditions listed during academic and clinical training as well as everyday practice.
Common conditions/diseases in UAE, specific topics, and clinical management/ procedures/tools

Topics	Common conditions	Common procedures/tools
Key Processes in Lifestyle Medicine		
• Lifestyle Medicine History and Physical Examination • Fundamentals of Health Behavior Change • The Role of Physician Health and the Physician's Personal Health	• Cardiovascular diseases • Metabolic diseases • Chronic respiratory diseases • Autoimmune disorders • Musculoskeletal disorders • Gastrointestinal disorders • Neurodegenerative disorders • Psychiatric and behavioral health disorders • Cancer, its prevention and management • Renal diseases • Any lifestyle-related disorder in childhood and adolescence (such as overweight, obesity, diabetes, anxiety, depression, irritable bowel syndrome, asthma)	• Lifestyle Medicine vital signs • Risk factor assessment • Physical examination • Lab work and interpretation • Diagnosis and management • De-prescription of medication for common lifestyle-related diseases • Collaborative care and referrals • Chronic care models • Health behavior change theories and health coaching • Patient readiness and stage-matched responses • Motivational interviewing • Cognitive behavioral therapy • Positive psychology • Written action plan development • Effective maintenance and follow-up strategies • Sustainable self-management constructs (relapse planning, digital technology support, community and employee programs, social support

		strategies, cognitive behavioral techniques) • Counselling for overweight and obese patients • Health care service quality improvement using PDSA cycle (Plan-Do-Study-Act) • Strategies for incorporation of Lifestyle Medicine into existing health provider settings • Personal readiness assessment and personal action plan development • Community policy makers and stakeholder's advocacy strategies
Nutrition Science, Assessment and Prescription		
• Diagnosis and management of lifestyle-related diseases • Nutrition Prescriptions for the prevention, treatment and reversal of lifestyle-related disease • Nutritional guidelines • Nutrition assessment • Successful dietary interventions e.g. Diabetes Prevention Program • Nutritional requirements in all stages of life • Dietary patterns • Food patterns and preparation • Macronutrients • Micronutrients and supplements • Phytonutrients and the anti-inflammatory diet • The gut microbiome and its role in health	• Cardiovascular diseases • Metabolic diseases • Chronic respiratory diseases • Autoimmune disorders • Musculoskeletal disorders • Gastrointestinal disorders • Pediatric conditions • Neurodegenerative disorders • Psychiatric and behavioral health • Cancer prevention and management • Renal diseases • Reproductive health • Chronic skin conditions	• Anthropometric measurements • Biochemical and clinical assessment of nutritional status • Interpreting lab tests results for common lifestyle-related diseases • Nutrition prescription • Bioelectrical impedance analysis (BIA) • Dual energy X-ray absorptiometry (DEXA) • Motivational interviewing • Cognitive behavioral therapy

• Impact of diet and nutrition on the gut microbiota • Epigenetics of nutrition and nutrigenomics • Corporate interests and nutrition • Epidemiology, bias, and stigmatization of obesity • Complex etiology and pathophysiology of obesity • Health effects of obesity • Lifestyle interventions in preventing and treating obesity • Treatment guidelines for obesity		
Physical Activity Science and Prescription		

• Definitions and benefits of physical activity for health
• Components of exercise
• Use of exercise as medicine for chronic diseases:
  • Exercise guidelines
  • Fitness assessment
  • Use Metabolic Equivalents of a Task (MET) in assessing fitness
  • Exercise prescriptions for common chronic diseases
  • Exercise requirements in various stages of life
  • Identify resources for sustainable behavior change
	• Sedentary health status
	• Cardiovascular diseases
	• Metabolic diseases
	• Chronic respiratory diseases
	• Autoimmune disorders
	• Musculoskeletal disorders
	• Gastrointestinal disorders
	• Pediatric conditions
	• Neurodegenerative disorders
	• Psychiatric and behavioral health
	• Cancer prevention and management
	• Renal diseases
	• Reproductive health
	• Chronic skin conditions
		• Anthropometric measurements
		• Use key physical activity assessment tools (exercise intensity assessment, functional capacity assessment, five components of fitness testing)
		• Use Metabolic Equivalents of a Task (MET) in assessing fitness
		• Bioelectrical impedance analysis (BIA)
		• Dual energy X-ray absorptiometry (DEXA)
		• Calculation of total daily energy expenditure (TDEE)
		• Use of wearables for physical activity biodata tracking
		• Exercise stress testing (EST)
		• Motivational interviewing
		• Cognitive behavioral therapy

Emotional and Mental Wellbeing, Assessment and Interventions		
• Stress management • Mindfulness and Mindfulness-based stress reduction (MBSR) programs • Positive psychology • Spirituality and health • Emotional distress and poor health • Management of mental health disorders in patients with co-morbidities • Emotional wellness self-management • Positive psychology • Physician empathy	• Stress • Anxiety • Depression • Post-traumatic stress disorder • Obsessive-compulsive disorder • Bipolar disorder • Schizophrenia • Any lifestyle-related disease	• Mental status examination (MSE) • Mini-mental state examination (MMSE) • Perceived Stress Score (PSS) • WHO-5 Wellbeing Index • Validated screening tools for depression and anxiety screening (PHQ9, GAD7) • Cognitive Impairment Testing • Mindfulness and Mindfulness-based stress reduction (MBSR) • Cognitive behavioral therapy • Positive psychology
Sleep Health Science and Interventions		
• Neurobiology of sleep and wakefulness • Sleep and its effect on health and well-being • Circadian rhythms • Sleep hygiene • Sleep rhythms across the lifespan • Classification of sleep disorders • Diagnosis and management of sleep disorders • The management of Jetlag • Pharmacological and nonpharmacological treatments for insomnia • Cognitive behavioral therapy for insomnia	• Circadian rhythm sleep-wake disorders (jet lag, shift work) • Insomnia • Sleep related breathing disorders such as Obstructive sleep apnea • Any lifestyle-related disease	• Polysomnography • Cognitive behavioral therapy for insomnia • Sleep hygiene prescription • Use of wearables for sleep biodata tracking
Treating Tobacco Use Disorder and Managing Other Toxic Exposures		
• Health effects of tobacco and alcohol use • Screening and assessment of tobacco and alcohol	• Alcohol use • Tobacco use including e-cigarettes and vaping • Opioid use	• CO monitoring • Lung function tests • AUDIT-C tool

abuse and other toxic exposures • Behavioral and pharmaceutical treatment of tobacco and alcohol misuse • Regulations and governmental policies • Vulnerabilities and risk factors	• Toxic exposure • Any lifestyle-related disease	• Readiness and confidence scales • Motivational interviewing • Cognitive behavioral therapy • Group therapy

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