ACGME-I
INTERNATIONAL ADVANCED SPECIALTY
PROGRAM REQUIREMENTS
SUMMARY OF REVISIONS AND RATIONALE

Advanced Specialty Requirements for: **Pulmonary Critical Care**
Proposed Effective Date of revised requirements: **1 July 2025**

Comments are currently being solicited on revisions to the International Advanced Specialty Program Requirements for the subspecialty listed above. To aid those providing comment, the following table summarizes and provides a rationale for the major revisions in the requirements.

The comments provided will be considered by the Review Committee-International as it determines the final revision of these Requirements, which will be posted on the ACGME-I website following approval.

REQUIREMENTS DELETED

Requirement Number	Line Number	Rationale
I.A.2. The primary clinical site should have at least three ACGME-I-accredited internal medicine subspecialty programs from the following disciplines: cardiovascular disease; gastroenterology; infectious diseases; nephrology; or pulmonary disease.	37-40	This requirement was removed to eliminate redundancy. Required faculty members from these subspecialties are identified in II.B.2. and II.B.3.
I.A.3. The Sponsoring Institution must: a) establish the fellowship within a department of internal medicine or an administrative unit whose primary mission is the advancement of internal medicine subspecialty education and patient care; and, b) provide the program director with adequate support for the administrative activities of the fellowship.	42-52	This requirement was removed to eliminate redundancy with I.A.1.
II.A.1. The program director must: a) monitor fellow stress, including mental or emotional conditions inhibiting performance or learning, and drug- or alcohol related dysfunction; b) provide access to timely confidential counseling and psychological support services to fellows; c) evaluate and modify situations that demand excessive	61-78	This requirement was removed to eliminate redundancy with Foundational Requirements IV.D.2., VI.A.2., and VI.F.1.

service or consistently produce undesirable stress on fellows; d) ensure that fellows' service responsibilities are limited to patients for whom the teaching service has diagnostic and therapeutic responsibility; and,e) participate in academic societies and educational programs designed to enhance educational and administrative skills.		
II.B.2. Core faculty members must be active clinicians with knowledge of, experience in, and commitment to pulmonary disease and/or critical care medicine as a specialty. **II.B.3.** Core faculty members must assist the program director in planning, implementing, monitoring, and evaluating fellows' clinical and research education. a) At least one core faculty member must be knowledgeable in evaluation and assessment of the ACGME-I Competencies and devote significant time to evaluating fellows, including through direct observation.	88-90 91-98	These requirement was removed to eliminate redundancy with Foundational Requirement II.B.4.
IV.A.1.b).(2).(a).(iv).(a) Each fellow must perform a minimum of 100 flexible fiber-optic bronchoscopy procedures	360-361	Flexible fiber-optic bronchoscopy remains as a patient care competency. There is no number established to ensure achievement of competence.
IV.B.4. Fellows must participate in clinical case conferences, journal clubs, research conferences, and morbidity and mortality or quality improvement conferences	536-538	This requirement was removed to eliminate redundancy with Foundational Requirement IV.B.
IV.C.14.a).(2) Each fellow should be responsible, on average, for four to eight patients during each half day session	624-625	The specific number of patients seen by fellows during ambulatory care experiences was removed to allow programs flexibility. Programs should continue to monitor fellows' ambulatory clinic load to maximize learning opportunities over service needs.

REQUIREMENTS ADDED

Requirement Number	Line Number	Rationale
II.D.1. The following must be available	122-129	The addition of imaging equipment at

at the primary clinical site: a) timely bedside imaging services, including portable chest x- ray (CXR), bedside ultrasound, and echocardiogram for patients in the critical care units; and b) computed tomography (CT) imaging, including CT angiography		the primary clinical site provides opportunities for fellows to develop competence in use of these diagnostic tools and supports the requirement for patient care competence in IV.A.1.b).(3).(a).(viii).
II.D.5.g) Support services must be available including equipment, expertise and personnel to provide both continuous and intermittent renal replacement therapy in the critical care units.	188-189	The addition of renal replacement therapy provides opportunities for fellows to develop competence in use of these treatments.
IV.A.1.b).(1) Fellows must demonstrate competence in managing care of patients a) in a variety of health care settings, including inpatient and ambulatory settings. b) using critical thinking and evidence-based tools; c) using population-based data; and d) with whom they have limited or no physical contact, through the use of telemedicine.	237-246	The additions to competencies in patient care and procedural skills include the new and emerging area of telemedicine, the importance of training fellows to deliver care in the ambulatory setting, and the increasing importance of data-driven clinical decision-making.
IV.A.1.b).(3).(a).(viii) Fellows must perform diagnostic and therapeutic procedures relevant to their specific career path, including those skills essential to critical care ultrasound, including image acquisition, image interpretation at the point of care, and use of ultrasound to place intravascular and intracavitary tubes and catheters	372-379	The requirement for competence in critical care ultrasound was added and previous language was revised to ensure educational experiences and appropriate care for a wide variety of pulmonary critical care patients.
IV.C.1. 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	541-545	Education and patient safety are impacted by the length of clinical rotations. Programs must consider the length of a rotation when planning educational experiences.
IV.C.2. Rotations must be structured to allow fellows to function as a part of an effective interprofessional team that works together toward the shared goals of patient safety and quality improvement.	546-548	Clinical rotations must be planned to enhance opportunities for fellows to actively engage with an interprofessional team. These experiences should allow for interaction between team members to both teach fellows and provide patient

		care.
IV.C.12. The education program must provide fellows with elective experiences relevant to their future practice or to further still/competence development.	617-618	Providing educational experiences that are individualized to each fellow's learning needs and individual interests is an important component of the fellowship.
IV.D.1.a) While in the program all fellows must complete 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.	644-650	All fellows must engage in scholarly work during the fellowship. Scholarly work is broadly interpreted to include a variety of professional activities.