PHILADELPHIA COURT OF COMMON PLEAS
PETITION/MOTION COVER SHEET

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ASSIGNED TO JUDGE:	ANSWER/RESPONSE DATE:
Do not send Judge courtesy copy of Petition/Motion/Answer/Response. Status may be obtained online at http://courts.phila.gov	

CONTROL NUMBER:

067569

(RESPONDING PARTIES MUST INCLUDE THIS NUMBER ON ALL FILINGS)

June Term, 2019
Month *Year*

No. 6771

DREXEL UNIVERSITY VS AMERICAN ACADEMIC HEALTH SYSTEM, LLC ET AL.

Name of Filing Party:
DREXEL UNIVERSITY -PLF

INDICATE NATURE OF DOCUMENT FILED:
☒ Petition *(Attach Rule to Show Cause)* ☐ Motion
☐ Answer to Petition ☐ Response to Motion

Has another petition/motion been decided in this case? ☐ Yes ☒ No
Is another petition/motion pending? ☐ Yes ☒ No
If the answer to either question is yes, you must identify the judge(s):

TYPE OF PETITION/MOTION (see list on reverse side)	PETITION/MOTION CODE (see list on reverse side)
PRELIMINARY INJUNCTION	PRINJ

ANSWER / RESPONSE FILED TO (Please insert the title of the corresponding petition/motion to which you are responding):

I. CASE PROGRAM

COMMERCE PROGRAM

Name of Judicial Team Leader:
Applicable Petition/Motion Deadline: 06/26/2019
Has deadline been previously extended by the Court: NO

II. PARTIES *(required for proof of service)*
(Name, address and **telephone number** of all counsel of record and unrepresented parties. Attach a stamped addressed envelope for each attorney of record and unrepresented party.)

STEPHEN A. COZEN
COZEN O'CONNOR ONE LIBERTY PLACE 1650 MARKET STREET SUITE 2800 , PHILADELPHIA PA 19103

AMERICAN ACADEMIC HEALTH SYSTEM, LLC
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PHILADELPHIA ACEDEMIC HEALTH SYSTEM, LLC
222 NORTH SEPULVEDA BOULEVARD SUITE 900 , EL SEGUNDO CA 90245

PHILADELPHIA ACEDEMIC HEALTH SYSTEM, LLC
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III. OTHER

By filing this document and signing below, the moving party certifies that this motion, petition, answer or response along with all documents filed, will be served upon all counsel and unrepresented parties as required by rules of Court (see PA. R.C.P. 206.6, Note to 208.2(a), and 440). Furthermore, moving party verifies that the answers made herein are true and correct and understands that sanctions may be imposed for inaccurate or incomplete answers.

(Attorney Signature/Unrepresented Party)	June 21, 2019 *(Date)*	Stephen A. Cozen *(Print Name)*	03492 *(Attorney I.D. No.)*

The Petition, Motion and Answer or Response, if any, will be forwarded to the Court after the Answer/Response Date.
No extension of the Answer/Response Date will be granted even if the parties so stipulate.

30-1061B E-File# 1901073265
31-JAN-19 16:37:25

DREXEL UNIVERSITY, Plaintiff, v. AMERICAN ACADEMIC HEALTH SYSTEM, LLC, PHILADELPHIA ACADEMIC HEALTH HOLDINGS, LLC, PHILADELPHIA ACADEMIC HEALTH SYSTEM, LLC and JOEL FREEDMAN, Defendants.	:	COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY, PA COMMERCE COURT NO. 190606171 JURY TRIAL DEMANDED 067569

ORDER

AND NOW, this _____ day of _____, 2019, upon consideration of the Petition of Plaintiff Drexel University's ("Drexel") for *Ex Parte* Preliminary Injunction, it is hereby **ORDERED** that Drexel's Petition is **GRANTED**. It is further **ORDERED** that:

1. Defendants American Academic Health System, LLC ("AAHS"), Philadelphia Academic Health Holdings, LLC ("PAHH"), Philadelphia Academic Health System, LLC ("PAHS") and Joel Freedman are hereby **PRELIMINARILY ENJOINED** from closing Hahnemann University Hospital ("Hahnemann") or taking any other action that would disrupt the provision of medical services or academic or training programs at Hahnemann;

2. AAHS, PAHH, PAHS and Freedman are also **PRELIMINARILY ENJOINED** from announcing the closure of Hahnemann or their intention to close Hahnemann during the term of this Preliminary Injunction;

3. This Preliminary Injunction shall be in effect until June ___, 2019 at 12 p.m., unless the Court terminates, shortens or extends the Preliminary Injunction;

4. A hearing, which shall include the presentation of testimony, evidence and arguments from counsel for the parties, shall be held on June ___, 2019 at 10 a.m. in Courtroom _____ to determine whether the Preliminary Injunction should be terminated or extended beyond its current expiration time;

5. Drexel shall promptly serve a copy of this Order on counsel for Defendants American Academic Health System, LLC, Philadelphia Academic Health Holdings, LLC, Philadelphia Academic Health System, LLC and Joel Freedman; and

6. The counsel for the parties shall promptly notify the Court and opposing counsel if there are any issues with the timing of the hearing on this Preliminary Injunction.

BY THE COURT:

_____

J.

DREXEL UNIVERSITY, Plaintiff, v. AMERICAN ACADEMIC HEALTH SYSTEM, LLC, PHILADELPHIA ACADEMIC HEALTH HOLDINGS, LLC, PHILADELPHIA ACADEMIC HEALTH SYSTEM, LLC and JOEL FREEDMAN, Defendants.	:	COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY, PA COMMERCE COURT NO. _____ JURY TRIAL DEMANDED

ORDER

AND NOW, this _____ day of _____, 2019, upon consideration of the evidence and arguments presented at the hearing before the Court on June ___, 2019, it is hereby **ORDERED** that Plaintiff Drexel University's ("Drexel") Petition for Preliminary Injunction is **GRANTED**. It is further **ORDERED** that:

1. Defendants American Academic Health System, LLC ("AAHS"), Philadelphia Academic Health Holdings, LLC ("PAHH"), Philadelphia Academic Health System, LLC ("PAHS") and Joel Freedman are hereby **PRELIMINARILY ENJOINED** from closing Hahnemann University Hospital ("Hahnemann") or taking any other action that would disrupt the provision of medical services or academic or training programs at Hahnemann;

2. AAHS, PAHH, PAHS and Freedman are also **PRELIMINARILY ENJOINED** from announcing the closure of Hahnemann or their intention to close Hahnemann during the term of this Preliminary Injunction; and

3. This Preliminary Injunction shall remain in effect until it is terminated by the Court after its ruling as to the parties' rights and obligations under Counts I and II of Drexel's Complaint in this action.

BY THE COURT:

_____

J.

Stephen A. Cozen (PA ID # 03492)
F. Warren Jacoby (PA ID # 10012)
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DREXEL UNIVERSITY, Plaintiff, v. AMERICAN ACADEMIC HEALTH SYSTEM, LLC, PHILADELPHIA ACADEMIC HEALTH HOLDINGS, LLC, PHILADELPHIA ACADEMIC HEALTH SYSTEM, LLC, and JOEL FREEDMAN, Defendants.	COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY, PA COMMERCE COURT NO. _____ JURY TRIAL DEMANDED

PETITION FOR *EX PARTE* PRELIMINARY INJUNCTION AND PRELIMINARY INJUNCTION

Plaintiff, Drexel University ("Drexel"), by and through its undersigned counsel, hereby petitions the Court for an Ex Parte Preliminary Injunction and, thereafter, a Preliminary Injunction against Defendants American Academic Health System, LLC ("AAHS"), Philadelphia Academic Health Holdings, LLC

("PAHH"), Philadelphia Academic Health System, LLC ("PAHS") and Joel Freedman ("Freedman"). In support thereof, Drexel states:

I. INTRODUCTION

1. This case arises out of the repeated threats by AAHS and Freedman, its founder, principal shareholder, chairman and Chief Executive Officer, to abruptly and, without authority and contrary to law, close Hahnemann University Hospital in Philadelphia ("Hahnemann").

2. This would be in direct violation of multiple provisions of an Academic Affiliation Agreement between AAHS and Drexel (the "AAA"), would violate the provisions of applicable federal, state and local laws, and would greatly disrupt the health and medical community in Philadelphia.

3. To prevent this from happening, Drexel filed a Complaint in this action seeking Declaratory Relief against AAHS, PAHH, PAHS and Freedman related to their actual and threatened violations of the Academic Affiliation Agreement (the "AAA") between Drexel and AAHS, and applicable law. A copy of Drexel's Complaint is attached hereto and made a part hereof as Exhibit 1.

4. The urgency of the relief Drexel seeks cannot be understated. If Freedman, through AAHS, PAHH and PAHS, abruptly and otherwise without authority closes Hahnemann, there would be potentially catastrophic consequences for patients, Drexel, the hospital's residents, Drexel University College of Medicine ("DUCOM") students and faculty, and the community at large.

5. Drexel therefore brings this Petition for an Ex Parte Preliminary Injunction and a Preliminary Injunction. The factual allegations in support of

Drexel's prayer for relief are discussed at length in Drexel's Complaint, and incorporated by reference herein.

II. LEGAL ARGUMENT

A. Standard of Review

6. Under Pennsylvania law, there are six "essential prerequisites" that a party must establish to obtain a preliminary injunction.

7. The petitioning party must show:

a. The injunction is necessary to prevent immediate and irreparable harm that cannot be compensated adequately by damages;

b. Greater injury would result from refusing the injunction than from granting it and, concomitantly, the issuance of an injunction will not substantially harm other interested parties in the proceedings;

c. The preliminary injunction will properly restore the parties to their status as it existed immediately prior to the alleged wrongful conduct;

d. The party seeking injunctive relief has a clear right to relief and is likely to prevail on the merits;

e. The injunction is reasonably suited to abate the offending activity; and

f. The preliminary injunction will not adversely affect the public interest.

SEIU Healthcare Pa. v. Commonwealth, 104 A.3d 495, 502 (Pa. 2014).

8. Further, Pennsylvania Rule of Civil Procedure 1531 provides that "[if] it appears to the satisfaction of the court that immediate and irreparable injury will be sustained before notice can be given or a hearing held, . . . the court may issue a preliminary or special injunction without a hearing or without notice." Pa. R. Civ. P. 1531(a).

9. As set forth below, Drexel satisfies each of these perquisites and therefore is entitled to injunctive relief.

B. <u>An Injunction Is Necessary to Prevent Immediate and Irreparable Harm to Drexel and the Public at Large</u>

10. AAHS's, PAHH's, PAHS's and Freedman's threatened, anticipated and publicized breaches of the AAA by closing Hahnemann and eliminating the Residency Programs have caused and will continue to cause DUCOM to suffer substantial and irreparable harm that cannot be compensated for by money damages.

11. This harm includes the potential loss of accreditation of DUCOM and the Residency Programs, severe reputational damage, and the loss of countless future residents, as well as the impact on other medical personnel and the public at large.

12. Hahnemann's patients (both present and future) would see their medical care thrown into great uncertainty if the hospital is closed or the Residency Programs terminated. The risk to public health is substantial. *See Allegheny Anesthesiology Assocs. v. Allegheny Gen. Hosp.*, 826 A.2d 886, 893 (Pa. 2003) (Threat of death, enhanced by injury or serious disruption to ongoing medical care is of "paramount importance" in determining immediate and irreparable harm).

13. The threatened closure of Hahnemann and termination of the Residency Programs would also immediately disrupt the education of DUCOM's medical students, displace DUCOM's residents, and interrupt the careers of the DUCOM-affiliated physicians who practice at Hahnemann

14. The closure may also result in a reduction of medical students and medical faculty in the Philadelphia area, depriving the City now and in the future of potentially hundreds of doctors.

15. Furthermore, a decrease in the number of healthcare practitioners could ultimately limit the availability and affordability of healthcare for the low-income population that Hahnemann currently serves. *See New Castle Orthopedic Assocs. v. Burns*, 392 A.2d 1383, 1387 (1978) (considering the effect of an injunction on the availability and rising cost of medical services).

16. Therefore, this Court should grant the requested injunctive relief to prevent immediate and irreparable harm.

C. The Balance of Harms Weigh Heavily in Favor of Issuing the Injunction

17. Drexel satisfies the second element of a preliminary injunction because greater injury would result if the Court denied Drexel's petition than if it issued the injunction.

18. As discussed above, the harm from refusing the injunction is substantial to both Drexel and the public at large.

19. The harm to AAHS, PAHH, PAHS and Freedman, meanwhile, is substantially less.

20. A preliminary injunction would keep Hahnemann operating in the same manner it has operated since 1998.

21. Whatever financial loss, if any, that AAHS, PAHH, PAHS and Freedman would allegedly suffer is far outweighed by the catastrophic harm that would result to Drexel and the public if this pillar of the Philadelphia medical community is abruptly shuttered, whether directly or as the result of the modification or elimination of vital medical programs.

D. A Preliminary Injunction Would Maintain the Status Quo

22. The third element for a preliminary injunction – that the injunction restore the parties to their prior status – is easily obtained.

23. This is exactly the relief that Drexel seeks through this Petition.

24. Drexel requests only that the Court enjoin AAHS, PAHH, PAHS and Freedman from taking a drastic action – either closing Hahnemann or eliminating the Residency Programs – until the parties can negotiate a solution with the help of the Court to provide for an orderly closure of the hospital.

25. The Court should therefore hold that this element weighs in favor of an injunction.

E. Drexel Is Likely to Prevail on Its Claims Against AAHS, PAHH, PAHS and Freedman

26. Drexel also satisfies the fourth element of obtaining a preliminary injunction because it is likely to prevail on the merits of its claims.

27. Under Section 2.4 of the AAA, the parties recognized that "material modifications in the size, scope and location of the Residency Programs will

require a measured and cooperative approach of the parties[,]" which has not occurred.

28. The threatened closure of Hahnemann and termination of the Residency Programs therefore violate Section 2.4 of the AAA.

29. Section 2.4.3 of the AAA further provides that "[u]nless otherwise agreed by the parties, the number of Residents shall be proportional to the Tenet GME residents cap for each of Hahnemann University, MCP and Warminster Hospitals."

30. The threatened closure of Hahnemann and termination of the Residency Programs therefore violate Section 2.4.3 of the AAA.

31. Section 2.8 of the AAA provides that AAHS shall not close the Clinical Programs at Hahnemann without Drexel's written consent unless it provides Drexel with either substitute programs or adequate financial support for replacement programs.

32. Drexel has not given written consent to the closure of the Clinical Programs.

33. The threatened closure of Hahnemann and termination of the Residency Programs therefore violate Section 2.8 of the AAA.

34. Section 4.2 of the AAA provides that AAHS "agrees that [Drexel] University shall have the right to provide certain hospital-based services at [Hahnemann] on an exclusive basis, subject to the terms and conditions described on Schedule 4.2.(4)."

35. Schedule 4.2.(4) provides that Emergency Medicine at Hahnemann is one such hospital-based service that DUCOM has the exclusive right to provide,

pending an agreement between the parties on the reimbursement and assignment of responsibilities.

36. The threatened closure of Hahnemann and the termination of the Residency Programs therefore violate Section 4.2 and Schedule 4.2.(4) of the AAA.

37. The threatened closure of Hahnemann would also violate a regulation promulgated by the Philadelphia Board of Health, which prohibits the closure of facilities that provide emergency care without the consent of the Philadelphia Health Commissioner. Regulation of the Philadelphia Board of Health, as reapproved October 1, 1969.

38. Moreover, an abrupt closure would violate state law and federal law, which require notice to be provided to regulators and effected employees no less than 90 and 60 days, respectively, prior to the closing. 28 Pa. Code § 101.196; 29 U.S.C. 2102.

39. The Court should therefore find that Drexel is likely to prevail on the merits of its claims.

F. The Preliminary Injunction Would Reasonably Abate AAHS's, PAHH's, PAHS's and Freedman's Breaches of the AAA

40. The preliminary injunction sought by Drexel is suited to halt AAHS's and Freedman's offending conduct.

41. Drexel is asking that the Court require AAHS, PAHH, PAHS and Freedman to adhere to their contractual duties, and comply with applicable law, before taking any drastic actions that affect Drexel's rights under the AAA and adversely and irreparably impact the public at large.

42. Pennsylvania courts have held that an injunction like the one Drexel seeks is appropriate to abate conduct similar to what AAHS and Freedman have threatened.

43. In *SEIU Healthcare Pennsylvania,* the Supreme Court of Pennsylvania considered a request for a preliminary injunction to prevent and reverse the closure of twenty-six health centers and the furloughing of dozens of nurse consultants in the state. 104 A.3d at 498.

44. The Supreme Court held that the injunction sought was "reasonably suited to abate the offending activity," because it instructed the defendant to stop reducing the number of health centers and health services in the state, and to restore the level of services that existed prior to the offending conduct. *SEIU Healthcare Pa.*, 104 A.3d at 509.

45. DUCOM's request for a preliminary injunction is equally appropriate to address AAHS's, PAHH's, PAHS's and Freedman's offending activity.

G. <u>The Injunction Would Serve the Public Interest</u>

46. AAHS's, PAHH's, PAHS's and Freedman's threatened closure of Hahnemann would be disastrous for the City of Philadelphia and its citizens.

47. As noted above, the closure of Hahnemann would create a substantial void in the provision of medical services in the City and other hospitals would likely be overwhelmed by the newfound influx of patients who would otherwise have gone to Hahnemann.

48. A substantial number of citizens of Philadelphia would also lose their jobs.

49. The closure of Hahnemann would also disrupt critical public services such as the SANE program, EMS training, and the Healing Hurt program.

50. Local, state and federal law all also prohibit the abrupt closure of Hahnemann that AAHS, PAHH, PAHS and Freedman have threatened.

51. The Philadelphia Board of Health has promulgated a regulation prohibiting the closure of the facilities of a hospital in the City providing emergency care without the written consent of the Health Commissioner.

52. The Pennsylvania Department of Health has promulgated a regulation that prohibits a closure of a hospital without 90 days' notice to the Department.

53. The Federal WARN Act requires 60 days' notice to employees before an employer of 100 or more closes a site of employment, which, upon information and belief, AAHS and Freedman have not provided.

54. The Court should therefore find that the public will not be adversely affected by the preliminary injunction.

WHEREFORE, for the foregoing reasons, Plaintiff Drexel University respectfully requests that the Court issue an Ex Parte Preliminary Injunction and, thereafter, a Preliminary Injunction in accordance with the proposed Orders attached hereto.

Respectfully submitted,

COZEN O'CONNOR

Dated: June 21, 2019

By: _____

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EXHIBIT 1

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DREXEL UNIVERSITY, Plaintiff, v. AMERICAN ACADEMIC HEALTH SYSTEM, LLC, PHILADELPHIA ACADEMIC HEALTH HOLDINGS, LLC, PHILADELPHIA ACADEMIC HEALTH SYSTEM, LLC, and JOEL FREEDMAN, Defendants.	COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY, PA COMMERCE COURT JUNE 2019 NO. 006771 JURY TRIAL DEMANDED

NOTICE TO DEFEND

NOTICE TO DEFEND AND CLAIM RIGHTS	ADVERTENCIA SOBRE COMO DEFENDERSE Y RECLAMAR DERECHOS
You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within (20) days after this	Usted ha sido demandado en corte. Si usted deser defender el reclamo puesto en contra suya en las

complaint and notice are served, by entering a written appearance personally or by attorney and filing in writing with the court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so, the case may proceed without you and a judgment may be entered against you by the court without further notice for any money claimed in the complaint or for any other claim or relief requested by the plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER OR CANNOT AFFORD ONE, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP.

Philadelphia Bar Association
Lawyer Referral and Information
Philadelphia, Pennsylvania
One Reading Center
(215) 238-1701

siguientes paginas, tiene que tomar accion inmediatamente. Se la advierte que si falla en hacerlo, el caso puede ser procesado sin su de usted por la corte. Un juicio tambien puede ser registrado en contra de usted por la corte. Un juicio tambien puede ser registrado en su contra por cualquier otro reclamo o peticion requerida en estos papeles por el querellante. Usted puede perder dinero, propiedad otros derechos importantes para usted.

USTED DEBE LLEVAR ESTE PAPEL A SU ABOGADO INMEDIATAMENTE. SI USTED NO TIENE UN ABOGADO O NO PUEDE PAGAR POR LOS SERVICIOS DE UNO, VAYA O LLAME A LA OFICINA INDICADA, PARA AVERIGUAR DONDE PUEDA OBTENER ASISTENCIA LEGAL.

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DREXEL UNIVERSITY, Plaintiff, v. AMERICAN ACADEMIC HEALTH SYSTEM, LLC, PHILADELPHIA ACADEMIC HEALTH HOLDINGS, LLC, PHILADELPHIA ACADEMIC HEALTH SYSTEM, LLC, and JOEL FREEDMAN, Defendants.	COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY, PA COMMERCE COURT NO. _____ JURY TRIAL DEMANDED

COMPLAINT FOR DECLARATORY JUDGMENT AND DAMAGES

Plaintiff, Drexel University ("Drexel"), asserts the following claims and seeks the following relief from and against Defendants, American Academic Health System, LLC ("AAHS"), Philadelphia Academic Health Holdings, LLC ("PAHH"), Philadelphia Academic Health System, LLC ("PAHS"), and Joel Freedman ("Freedman"). In support thereof, Drexel states:

I. THE PARTIES

1. Plaintiff Drexel University is a Pennsylvania non-profit educational institution with a principal place of business at 3141 Chestnut Street, Philadelphia, PA 19104. Drexel University College of Medicine ("DUCOM") is one of the schools within Drexel University.

2. Defendant American Academic Health System, LLC, an affiliate of Paladin Healthcare, is, upon information and belief, a Delaware limited liability company with a principal place of business at 222 North Sepulveda Boulevard, Suite 900, El Segundo, CA 90245. Upon information and belief, AAHS is the managing member of Philadelphia Academic Health Holdings, LLC ("PAHH").

3. Defendant Philadelphia Academic Health System, LLC is, upon information and belief, a Delaware limited liability company with a principal place of business at 222 North Sepulveda Boulevard, Suite 900, El Segundo, CA 90245. Upon information and belief, PAHH is the Managing Member of PAHS.

4. Defendant Philadelphia Academic Health System, LLC is, upon information and belief, a Delaware limited liability company with a principal place of business at 222 North Sepulveda Boulevard, Suite 900, El Segundo, CA 90245.

5. Defendant Joel Freedman, upon information and belief, is a resident of Philadelphia, Pennsylvania. Freedman is the founder, principal shareholder, chairman of the Board of Directors and chief executive officer of AAHS.

II. JURISDICTION AND VENUE

6. This Court has subject matter jurisdiction over this dispute pursuant to 42 Pa. C.S. § 931(a) and 42 Pa. C.S. § 7532.

7. This Court has personal jurisdiction over AAHS, PAHH, PAHS and Freedman because they conduct continuous and systematic business in the Commonwealth of Pennsylvania. In addition, a substantial number of the transactions and occurrences giving rise to this litigation and the claims asserted by Drexel University herein occurred in Pennsylvania.

8. Venue is appropriate in this county pursuant to Pennsylvania Rule of Civil Procedure 2179 because the actions described herein took place in Philadelphia County, Drexel University's causes of action arose in Philadelphia County, and AAHS, PAHH, PAHS and Freedman regularly conduct business in Philadelphia County.

III. FACTUAL BACKGROUND

A. The Academic Affiliation Agreement

9. Hahnemann University Hospital ("Hahnemann") is located at the southwest corner of Broad and Vine Streets in Center City Philadelphia, and has been in operation since 1885. Hahnemann is a 496-bed academic medical center that, as discussed below, has been affiliated with DUCOM since 1998. Hahnemann provides the community with a full complement of services including emergency care, neonatal care, obstetrics, general medicine and gynecology, as well as various branches of surgery and psychiatry. It is an important medical education center for Drexel, and is a critical public health resource for the City of Philadelphia and its citizens. A number of City health programs are based at Hahnemann, including sexual assault services, emergency medical services training, and behavioral health care. The Hahnemann emergency department had over 56,000 patient visits last year alone, the majority of which were low-income

patients. Hahnemann also operates one of only six maternity units and hospitals open in Philadelphia today and handled 1,700 deliveries of newborns in 2018. Hahnemann employs 2700 physicians, nurses, administrators and other staff, including 570 medical residents.

10. DUCOM is one of the largest medical schools in the country. It educates 1 in every 83 medical students in the nation and has more than 1,000 medical students. DUCOM is the academic partner in the education of more than 570 medical residents and fellows. DUCOM has more than 700 clinical and basic science faculty, and more than 1,700 affiliate and volunteer faculty.

11. DUCOM has long-standing academic medicine partnerships with several affiliate clinical training sites, including Hahnemann. These affiliated hospitals and health systems expose students to diverse patient populations and a variety of health conditions, and provide medical care for the citizens of Philadelphia.

12. In 1998, as part of the bankruptcy of the Allegheny Health Education & Research Foundation ("AHERF"), Hahnemann, along with six other hospitals in Southeastern Pennsylvania owned by AHERF, was sold to Tenet Healthsystem Philadelphia, Inc. ("Tenet"). The assets of AHERF's College of Medicine, part of the Allegheny University of Health Sciences ("AUHS"), were transferred by Tenet to an independent nonprofit corporation known as Philadelphia Health and Education Corporation ("PHEC"), and Drexel University then entered into a management agreement with PHEC to operate the college of medicine.

13. In 2002, Drexel exercised an option it had in the management agreement to assume ownership and control of PHEC and, as part of that

transaction, Tenet and Drexel entered into an amended and restated academic affiliation agreement dated April 25, 2002 (the "AAA"), which provides for an academic affiliation between DUCOM and Tenet's hospitals in the Philadelphia area through June 30, 2022; other terms and conditions relating to the undergraduate and graduate medical education programs and clinical services to be provided by DUCOM faculty physicians at Tenet's hospitals; and the funding and mission support payment arrangements related to the hospitals' academic affiliation with DUCOM. A copy of the AAA is not attached hereto, but is by reference thereto made a part hereof as Exhibit A.[1]

14. In January 2018, Tenet sold its two remaining Philadelphia acute care hospitals – Hahnemann and St. Christopher's Hospital for Children ("St. Christopher's") – for $170 million to AAHS, an affiliate of California-based Paladin Healthcare.

15. By virtue of this transaction with Tenet, AAHS assumed and became obligated under and bound by terms and conditions of all of Tenet's contracts with DUCOM, including the AAA. To the extent that AAHS has assigned the AAA to an affiliates, such assignment does not relieve AAHS of its obligations under the AAA. (AAA, § 16.5.1)

16. The parties to the AAA expressly agreed therein that the purpose of the Agreement was, inter alia, "to provide, through a program of classroom and clinical education that meets high academic standards, an environment conducive

[1] The AAA is governed by a confidentiality clause in which each party agreed to keep the AAA confidential. Each of the parties to this litigation have copies of the AAA, and Drexel will provide a copy of the AAA in camera to the judge assigned to this action. Drexel has disclosed certain terms of the AAA in this Complaint in order to protect its rights and enforce the AAA as the result of the conduct of the Defendants for which Drexel seeks relief. Drexel did not seek the consent of AAHS to disclose those terms in this Complaint because of Defendants' conduct as alleged herein.

to the training of future physicians (e.g. medical students, interns, residents and post-doctoral fellows), research scientists and other health professionals and for the continuing education of those engaged in the provision of health care services." (AAA, Article I.)

17. Since 2002, and as required by the AAA, DUCOM has maintained Hahnemann as its primary hospital affiliate for the clinical education of its medical students. DUCOM's faculty physicians are responsible for and have provided a substantial part of Hahnemann's clinical department leadership, certain hospital-based physician services on an exclusive basis, the administration, teaching and supervision required for the training of the hospital's substantial graduate medical education programs and represent a major of the medical staff practicing at Hahnemann.

18. The AAA is central to DUCOM's academic mission and its role as the academic component of the Hahnemann Academic Medical Center (the "AMC"), and sets forth the respective rights and obligations of both DUCOM and AAHS with regard to funding and operational matters relating to the AMC that foster the coordination of the parties' "respective missions and operations..., [which] are...in large measure interdependent." (AAA, Recital E.)

B. <u>The DUCOM Residency Programs</u>

19. Article 2 of the AAA sets forth the scope and terms of the affiliation between DUCOM and Hahnemann and describes, among other things, the parties' rights and obligations with respect to the graduate medical education residency programs (the "Residency Programs") that DUCOM administers, supervises and teaches at Hahnemann.

20. All of the Residency Programs are governed by Section 2.4 of the AAA, which provides:

> 2.4 Operation of Residency Programs. **The Hospitals have historically operated certain graduate medical education programs sponsored by the University ("Residency Programs") for the training of interns, residents and clinical fellows (collectively, "Residents") and it is Tenet's intent to continue to do so.** The specific number and size of residency programs, the mix of specialties, and the allocation among the Hospitals is subject to a variety of internal and external factors, including, but not limited to, state legislative actions, federal funding for graduate medical education, evolving relationships of primary care physicians to specialists in the health care delivery system, and local, regional and national demands. **The parties also recognize that the University sponsors the Residency Programs at Hahnemann University, MCP, St. Christopher's and Warminster Hospitals, is actively engaged in the operation of the Residency Programs, and that material modifications in the size, scope and location of those Residency Programs will require a measured and cooperative approach of the parties.** All Residents shall be employed by Tenet or Hospitals and, as between the parties, Tenet and Hospitals shall be entitled to any and all state and federal graduate medical education reimbursement and funding. **The parties shall cooperate with each other and act in good faith to maintain accreditation of those Residency Programs by the Accreditation Council on Graduate Medical Education ("ACGME") and the Liaison Committee on Medical Education ("LCME"). The parties agree to cooperate in the recruitment, administration and supervision of the Residency Programs in this section.**

AAA, § 2.4 (emphases added).[2]

[2] "MCP" stands for the Medical College of Pennsylvania, which has merged into Hahnemann since the execution of the AAA.

21. Section 2.4.3 of the AAA specifically addresses the size of the Residency Programs, and provides:

> 2.4.3. Size of Residency Program. The number of Residents to be recruited and employed annually and the annual budget for the Residency Programs shall be developed jointly by the GME Physician Director and the Regional Senior Vice President of Tenet. Unless otherwise agreed by the parties, **the number of Residents shall be proportional to the Tenet GME residents cap for each of Hahnemann University, MCP and Warminster Hospitals**. If such cap should increase or decrease by action of the federal government, the parties agree that the number of University Residents shall change proportionately.

AAA, § 2.4.3 (emphasis added).

22. The "residents cap" referenced in Section 2.4.3 above is the number of residency positions that the Centers for Medicare and Medicaid Services ("CMS") establishes for each eligible hospital for which CMS will compensate the hospital's costs pursuant to Section 1886 of the Social Security Act (42 U.S.C. § 1395ww). (Affidavit of Jill Tillman, attached hereto and made a part hereof as Exhibit B, ¶¶ 8-9.)

23. The cap for Hahnemann set by CMS has not materially changed since caps therefor were established in 1997, and remains at approximately 570 residents annually. In other words, Hahnemann is eligible to receive compensation from CMS for the cost of approximately 570 residency positions. Throughout the term of the AAA, the number of DUCOM-administered residency positions occupied at Hahnemann has been at or near the 570 cap number. (Tillman Aff., Ex. A, ¶ 10.)

24. CMS reimburses Hahnemann approximately $100,000 per year for the salary and fringe benefits for each resident it employs.

25. As the Section 2.4.3 language quoted in paragraph 18 above makes clear, there are only two methods by which the number of residency positions at Hahnemann can change: (a) by mutual agreement of the parties, or (b) by a change in the cap by the Federal government through CMS.

26. The residents at Hahnemann are employees of AAHS but, pursuant to the AAA, DUCOM is responsible for the administration, supervision and teaching of the majority of the participants in the Residency Programs and fellowship programs at Hahnemann, and has done so since 1998. (Tillman Aff., Ex. A, ¶ 6.)

27. The medical residents and fellows provide critically needed medical services to patients at Hahnemann, in addition to being educated and trained to potentially work at other medical institutions and provide other medical services in the Greater Philadelphia area in the future.

28. Thus, the residents at Hahnemann are integrated into every aspect of inpatient and outpatient services at Hahnemann and are the backbone of how Hahnemann functions. (Tillman Aff., Ex. A, ¶ 12.)

29. For example, there are residents working around the clock in the emergency room at Hahnemann. Without these residents, physicians would be unable to handle the volume, the emergency room would be overwhelmed and patients who use their services from throughout the City would not receive the urgent care that they need. (Tillman Aff., Ex. A, ¶ 13.)

30. The residents are also essential to the teaching of DUCOM medical students. (Tillman Aff., Ex. A, ¶ 14.)

31. Each year, the Residency Programs train and employ hundreds of medical residents and fellows under the direction and supervision of qualified

teaching physicians with DUCOM faculty appointments. (Tillman Aff., Ex. A, ¶ 7.)

32. These medical residents and fellows, in turn, help to teach the medical students at DUCOM. (Tillman Aff., Ex. A, ¶ 7.)

33. Moreover, the Residency Programs at Hahnemann are critical to DUCOM's accreditation with the official accrediting body for medical schools, the Liaison Committee on Medical Education (the "LCME").

34. Indeed, the essential role of medical residents at Hahnemann is one of the central reasons why Hahnemann is a party to an Academic Affiliation Agreement, and why it is able to hold itself out to the public as a "University" hospital by virtue of its standing as an ***academic*** medical center.

35. The LCME's "Standards for Accreditation of Medical Education Programs Leading to the MD Degree" for the 2018-19 academic year (the "LCME Standards") requires that medical schools operate or have access to residency programs in order to retain their accreditation. A copy of the LCME Standards is attached hereto and made a part hereof as Exhibit C.

36. For example, LCME Standard 3.1 states, "[e]ach medical student in a medical education program participates in one or more required clinical experiences conducted in a health care setting <u>in which he or she works with resident physicians</u> currently enrolled in an accredited program of graduate medical education." (Ex. B, ¶ 3.1 (emphasis added).)

37. The Residency Programs themselves are accredited by the Accreditation Council on Graduate Medical Education (the "ACGME").

38. The ACGME's "Common Program Requirements" require that there "be a program letter of agreement (PLA) between the program and each participating site providing a required assignment." (ACGME's Common Program Requirements, attached hereto and made a part hereof as Exhibit D, ¶ I.B.1.)

C. Clinical Programs at Hahnemann

39. Section 2.8 of the AAA addresses those clinical programs that "are required for accreditation for the School of Medicine[,]" and sets certain restrictions on the ability of AAHS to close such programs.

40. Medical school typically lasts for four years. At DUCOM, as in most medical schools, students spend most of their first two years of school in classes and most of their last two years of school in clinical rotations. (Tillman Aff., Ex. A, ¶ 15.)

41. Medical students must be exposed to a variety of Clinical Programs to fulfill their academic requirements and develop into effective doctors. The majority of DUCOM students go through their Clinical Programs at either Hahnemann or St. Christopher's. (Tillman Aff., Ex. A, ¶ 16.)

42. The Clinical Programs are governed by Section 2.8 of the AAA, and are listed in Schedule 2.8 and include Obstetrics/Gynecology, Pediatrics, and Psychiatry.

43. Section 2.8(b) of the AAA states that AAHS "agrees that it shall not close a Section 2.8 Programs [sic] at an AMC Hospital without the written consent of [Drexel] University, which consent shall not be withheld unreasonably by University if [AAHS] provides University with either (a) a substitute program reasonably acceptable to the University for a minimum term of two years to

replace any clinical clerkships associated with the Section 2.8 Programs for all School of Medicine third and fourth year students at then-current levels or (b) adequate financial support so that the School of Medicine can start or arrange for a replacement program of its own to meet any accreditation requirements associated with the Section 2.8 Programs."

44. An "AMC Hospital" is defined in Section 2.3.4 of the AAA to be either Hahnemann, MCP, or St. Christopher's.

D. <u>The Emergency Department at Hahnemann</u>

45. Under Section 4.2 of the AAA, AAHS "agrees that [Drexel] University shall have the right to provide certain hospital-based services at [Hahnemann] on an exclusive basis, subject to the terms and conditions described on Schedule 4.2.(4)." (Tillman Aff., Ex. A, ¶ 19.)

46. Schedule 4.2.(4) of the AAA provides that Emergency Medicine at Hahnemann is one such hospital-based service that DUCOM has the exclusive right to provide. (Tillman Aff., Ex. A, ¶ 20.)

47. The Emergency Department at Hahnemann, as overseen by DUCOM for the last two decades, is a nationally-recognized leader in emergency services and education. In fact, Drexel University College of Medicine offered the first emergency medical residency in the United States. (Tillman Aff., Ex. A, ¶ 21.)

48. Schedule 4.2.(4) further provides that AAHS can only contract with a third party for the provision of Emergency Medicine at Hahnemann if it cannot first reach an agreement with DUCOM for those services. (Tillman Aff., Ex. A, ¶ 22.)

49. The Emergency Department at Hahnemann is critical to the provision of medical care to the Greater Philadelphia area. (Tillman Aff., Ex. A, ¶ 24.)

50. The emergency room at Hahnemann provides medical care for approximately 56,000 patients each year. (Tillman Aff., Ex. A, ¶ 25.)

51. There are also a number of public services and community programs administered by DUCOM through the Emergency Department at Hahnemann. (Tillman Aff., Ex. A, ¶ 26.)

52. For example, DUCOM administers the Sexual Assault Nurse Examiner (SANE) program (which is funded by a grant from the City of Philadelphia and provides care for victims of rape and sexual assault), EMS training to current and future emergency medical technicians, ambulance drivers, and paramedics, and the Healing Hurt program (which provides care for victims of crime and their families). (Tillman Aff., Ex. A, ¶ 27.)

53. The SANE program is exclusive to DUCOM and covers victims across the entire City, including those who are on Medicaid or are indigent. There is no other medical school or organization in Philadelphia that provides this critical treatment and care for the victims of rape and sexual assault. (Tillman Aff., Ex. A, ¶ 28.)

E. Freedman's Complete Control over AAHS and His Management of Hahnemann

54. Freedman is not merely AAHS's founder, chairman and CEO; he controls all aspects of the company's operations either directly or through his complete control of PAHH and PAHS.

55. Upon information and belief, 90% of the equity in AAHS is owned by a Trust that Freedman established for the sole benefit of himself and his family.

56. Upon information and belief, Freedman has greatly undercapitalized AAHS in an attempt to benefit himself and his family personally.

57. Upon information and belief, AAHS has not paid dividends to any of its Members.

58. Upon information and belief, other officers and directors of AAHS have essentially no power or authority within the company regarding its operations or finances. Even if such individuals with apparent authority to make a statement, decision or agreement on behalf of AAHS do so, Freedman has shown no hesitancy to contradict, overrule or renege on them, apparently ignoring corporate formalities.

59. In fact, Freedman has complete control over the day-to-day operations of Hahnemann and St. Christopher's and, for all intents and purposes, continuously ignores and overrules the roles, duties and authority of the officers and management personnel of those hospitals. There are no checks on his decision making and actions regarding the management of AAHS and the Hospitals whatsoever.

60. Drexel has also been seeking financial and other records from Freedman and AAHS for months in an effort to understand AAHS's purported financial troubles. However, little reliable information has been produced despite numerous requests.

61. To the extent that these financial and other corporate records exist at all, Freedman has stated that they are not reliable.

62. The failure and inability of other officers to perform their duties and the lack of reliable corporate records are evidence that AAHS does not observe corporate formalities because of Freedman's complete domination of the company.

63. As AAHS has fallen further and further behind in its financial obligations to Drexel, Freedman has been inconsistent and seemingly capricious in his statements and actions in response to the apparent crisis that he contends exists at Hahnemann.

64. Freedman has turned the executive offices at AAHS into a "revolving door." In the last year alone, Freedman has fired at least 17 people with substantial responsibility in running the day-to-day operations of Hahnemann, including three Chief Executive Officers (Anthony Rajkumar, David Small, and Suzanne Richards), the Chief Medical Officer (Troy Siebert), the Regional Chief Nursing Officer (Dr. Evers Manley), the Chief Restructuring Officer (Manny Sacapano), the interim Chief Financial Officer (Robert Amon), the Chief Information Officer (Pam Saechow), the Director of Security (Frank Bonilla), and the Directors of Perioperative Services, Emergency Department, Plant Operations, Communications, Radiation Oncology, and Tenet Physician Practices. Freedman has also fired all of Hahnemann's primary care physicians, both cardiologists, and their respective staffs. (Tillman Aff., Ex. A, ¶ 30.)

65. What has remained constant at AAHS is instability and a lack of any reasonable or consistent direction or plans, due in large measure to Freedman's failure to provide the stable and informed leadership necessary for AAHS to work through the many operational and other problems that it has acknowledged exist.

His behavior and leadership style have put not only Hahnemann at risk, but DUCOM and the public as well.

66. Freedman's conduct at the Hahnemann Medical Executive Committee (the "MEC") meetings provides a telling example. This Committee, comprised of both representatives from Hahnemann and DUCOM, makes key leadership decisions related to medical staff policies, procedures, and rules, with an emphasis on quality control and quality improvement initiatives. It is also responsible for adopting and implementing medical staff policies and procedures, and creating medical staff appointment and reappointment criteria. The meetings of the MEC are, by their nature, highly sensitive and confidential. Regretfully, Freedman has turned them into a circus.

67. Freedman -- who has also privately conceded to DUCOM that he is acting out of "panic" and "emotion" -- has used the MEC meetings to engage in tirades against DUCOM, which he falsely blames for Hahnemann's apparent financial distress rather than acknowledging his own failures.

68. By way of example, he has falsely stated that DUCOM had consented to permit AAHS to replace DUCOM at Hahnemann's Emergency Department with a company named CEP America, LLC (better known as "Vituity") as of June 30, 2019, which was not the case, as DUCOM had advised Freedman.

69. In all, Freedman's reckless comments have spread and continue to spread throughout the Hahnemann and DUCOM community, have fueled uncertainty and harmful rumors, and are having a deleterious effect on recruitment, retention, morale and productivity at Hahnemann and DUCOM and the provision of medical services by the hospital, to the detriment of the public at large.

F. AAHS and Freedman Threaten to Take Drastic Action in Violation of the AAA

70. On April 16, 2019, Freedman told Jill Tillman, the CEO of Drexel University Physicians, and Tony Esposito, Drexel's Interim Co-CFO and Associate Dean for Financial Affairs at DUCOM, that AAHS was planning to publicly announce on or around April 30, 2019 that it was closing Hahnemann in its entirety as of July 30, 2019. (Tillman Aff., Ex. A, ¶ 32.)

71. In that same conversation, however, Freedman stated that although AAHS was going to announce the closure of Hahnemann -- which would have a materially harmful, if not calamitous, effect on the hospital and its provision of medical services to the public, as well as other programs affiliated with Hahnemann -- AAHS may instead decide to re-organize Hahnemann into a "community hospital" in which, among other things, the Residency Programs would no longer be operated at Hahnemann, which would likewise substantially disrupt the operations of Hahnemann. (Tillman Aff., Ex. A, ¶ 33.)

72. Even though Freedman has not yet announced the closure of Hahnemann or the Residency Programs, he has made these threats in his interactions with Drexel at least three other times since then.

73. Freedman's multiple and repeated threats to close Hahnemann and/or the Residency Programs are consistent with his behavior and other statements over the last several months and have the foreseeable effect of severely damaging DUCOM's reputation as well as its efforts to find solutions to salvage Hahnemann and the public trust, and severely disrupt the current educational and clinical programs and DUCOM's ability to provide training and education to residents who

are currently matriculated in the programs, either on a current basis or as planned for the immediate future.

74. Freedman, who has acknowledged in private moments with senior DUCOM personnel that he "sometimes speaks without thinking of the ramifications," has also previously threatened at MEC sessions to close the hospital entirely, and to begin transferring patients to other institutions as early as June 2019.

75. At other times in the past, he has threatened to try to keep the hospital open but at the same time to end the Residency Programs, without the input of DUCOM, contrary to the AAA.

76. Most importantly, there is no functional difference between these alternative threats. Closing Hahnemann in its entirety would necessarily eliminate the Residency Programs at Hahnemann, while closing the Residency Programs at Hahnemann would necessarily lead to the closure of Hahnemann in its entirety given the substantial reliance that Hahnemann has on the residents for the basic, day-to-day operations of the hospital. (Tillman Aff., Ex. A, ¶ 36.)

77. Moreover, either action would be a material modification in the size, scope and location of the Residency Programs, which requires a measured and cooperative approach between AAHS and Drexel under Section 2.4 of the AAA before any changes are implemented.

78. AAHS's potential actions would also be in violation of the explicit language of Section 2.4.3 of the AAA, which requires that the number of residents shall be proportional to the residency cap established by CMS unless the parties

agree otherwise. Throughout the term of the AAA, "proportional" has meant that the number of residents was at or around the cap number.

79. DUCOM has not agreed to the closure of the Residency Programs as threatened by AAHS.

80. The closure of Hahnemann in its entirety would also violate Section 2.8 of the AAA, which prohibits AAHS from closing the Clinical Programs at Hahnemann without the written consent of Drexel, unless AAHS provides substitute programs or adequate financial support for DUCOM to start replacement programs.

81. DUCOM has not consented to close the Clinical Programs at Hahnemann as threatened by AAHS.

82. The threatened closure of Hahnemann in its entirety and the termination of the Residency Programs would also have a devastating impact on the community, which would be deprived of 496 hospital beds and scores of doctors in the heart of Philadelphia. (Tillman Aff., Ex. A, ¶ 39.)

83. The closure of Hahnemann in its entirety and the termination of the Residency Programs would necessarily also lead to the closure of the Emergency Department at Hahnemann, which is critical to the provision of medical care in Philadelphia.

84. The emergency room at Hahnemann provides medical care for approximately 56,000 patients each year, who would immediately flood the other emergency rooms in other hospitals in the City.

85. Upon information and belief, the other hospitals in Philadelphia, such as Temple University Hospital, Thomas Jefferson University Hospital, and the

Hospital of the University of Pennsylvania, would not be able to effectively absorb and treat the patients who would otherwise go to Hahnemann for emergency medical care. (Tillman Aff., Ex. A, ¶ 44.)

86. Moreover, the public service programs that DUCOM administers at the Emergency Department at Hahnemann, such as the SANE program and other services to the indigent and those on Medicaid, would no longer be provided to the citizens of Philadelphia. (Tillman Aff., Ex. A, ¶ 45.)

87. Hahnemann is also one of the largest employers in Philadelphia, with thousands of employees. The closure of Hahnemann in its entirety and the termination of the Residency Programs therefore would present an alarming reduction of employment to many citizens of the City.

88. Under the terms of the AAA, AAHS cannot close Hahnemann without the consent of Drexel. Drexel has not consented to the closure of Hahnemann. (AAA, Section 16.5.2)

89. Pursuant to regulations promulgated by the Philadelphia Board of Health,

> [n]o hospital in the City of Philadelphia which has provided emergency care and has conducted, maintained or operated any facilities for such care at any time during the 12-month period immediately preceding the date of this regulation shall discontinue such care or facilities, in whole or in part, unless and until it shall be authorized so to do in writing by the Health Commissioner of the City of Philadelphia or his designee.

Regulation of the Board of Health of the City of Philadelphia Governing the Conduct, Operation and Maintenance of Emergency Care and Facilities in Hospitals, as reapproved October 1, 1969.

90. The Hahnemann has operated an Emergency Department at its facility for many years prior to 1969 and is subject to the Board of Health regulation. Upon information and belief, AAHS has not obtained the written consent of the City's Health Commissioner to discontinue such care or facilities at Hahnemann, which would make any closure of Hahnemann or the Residency Programs a violation of this Board of Health regulation.

91. The Pennsylvania Department of Health has also promulgated regulations governing the closure of hospitals, which require a hospital to "give written notice of an intent to close to the Department, not later than 90 days prior to the anticipated date of closing." 28 Pa. Code § 101.196.

92. Upon information and belief, AAHS has failed to give such notice as of the date of this Complaint.

93. The Worker Adjustment and Retraining Notification (WARN) Act, 29 U.S.C. 2101 *et seq.*, requires employers of 100 or more employees to provide notice to employees of the closure of the site of employment.

94. Upon information and belief, AAHS has failed to give such notice as of the date of this Complaint.

95. If any part of Hahnemann were to be closed as threatened, the residents, who chose to come to Philadelphia to live and complete their medical training and provide medical services to the citizens of Philadelphia, would be immediately displaced. (Tillman Aff., Ex. A, ¶ 40.)

96. DUCOM would face major hurdles in recruiting and retaining faculty at the school, which would inflict substantial harm to DUCOM.

97. DUCOM-employed physicians who practice at Hahnemann would have to relocate on short notice, which would be greatly disruptive to their provision of medical care to patients and their medical practices in general, in addition to the impact on their patients and the citizens of Philadelphia.

98. If the Residency Programs are terminated at Hahnemann, approximately 570 residents would be displaced. It would be the largest orphaning of medical residents in the history of the United States. (Tillman Aff., Ex. A, ¶ 41.)

99. In such an event, the ACGME would be forced to rapidly relocate all of the residents to other hospitals and many would likely be lost to the Greater Philadelphia area. (Tillman Aff., Ex. A, ¶ 43.)

100. The closure of Hahnemann would also have a devastating impact on the Greater Philadelphia community, which would suddenly be deprived of an untold number of doctors and medical personnel in the heart of Center City Philadelphia.

101. Any one of these consequences would cause irreparable damage to DUCOM's reputation in the medical community and its academic medicine programs. Moreover, the disruption to the practices of the DUCOM faculty physicians, and the care of their patients, will greatly impair the provision of medical services to the Philadelphia community.

102. The abrupt termination of the Residency Programs in the manner that AAHS is threatening would be totally unprecedented in the United States and thus it is impossible to know exactly how disastrous the effect would be to DUCOM and the Greater Philadelphia area.

103. DUCOM would also face the substantial risk that current students and faculty would leave the school and potentially leave the Philadelphia area altogether, depriving the City and region now and in the future of potentially hundreds of doctors in addition to the hundreds of jobs that would be lost as well.

104. Contrary to the terms, conditions, and principles of the AAA, neither Freedman nor anyone else associated with AAHS has engaged in a measured and cooperative approach with anyone at DUCOM while threatening the closure of Hahnemann, even though it is undoubtedly a material modification in the size, scope and location of the Residency Programs, and would irreparably impact DUCOM, its students, residents, faculty, staff, patients, the medical community and the citizens of the City of Philadelphia.

COUNT I
DECLARATORY JUDGMENT PURSUANT TO 42 Pa. C.S. §§ 7531 *et seq.*
(Breach of AAA Sections 2.4.3, 2.4, 2.8, and 4.2 – Closure of Hahnemann University Hospital and Elimination of Residency Programs, Clinical Programs and Emergency Department, and Violation of Federal, State and Local Law)
Drexel University vs. American Academic Health System, LLC

105. Drexel incorporates the foregoing as though the same were set forth at length herein.

106. On April 16, 2019, Freedman, AAHS's founder, chairman and CEO, told Jill Tillman, the CEO of Drexel University Physicians, and Tony Esposito, Drexel's Interim Co-CFO and Associate Dean for Financial Affairs at DUCOM, that AAHS was planning to publicly announce on or around April 30, 2019 that it was closing Hahnemann in its entirety as of July 30, 2019 without the input, consent or cooperation of DUCOM.

107. Freedman also stated that, notwithstanding the public announcement of the closure of Hahnemann in its entirety, AAHS may ultimately decide to eliminate the Residency Programs at Hahnemann but otherwise attempt to keep the hospital open.

108. Although these specific threats to close Hahnemann and/or the Residency Programs did not come to pass, Freedman has threatened on at least three occasions since then that he and AAHS are going to close Hahnemann within the next few weeks.

109. As discussed above, either threatened action leads to the same result: the closure of Hahnemann in its entirety and the elimination of the Residency Programs.

110. Under Section 2.4 of the AAA, the parties recognized and agreed that "material modifications in the size, scope and location of the Residency Programs will require a measured and cooperative approach of the parties[,]" which has not occurred.

111. The threatened closure of Hahnemann and termination of the Residency Programs therefore violate Section 2.4 of the AAA.

112. Section 2.4.3 of the AAA further provides that "[u]nless otherwise agreed by the parties, the number of Residents shall be proportional to the Tenet GME residents cap for each of Hahnemann University, MCP and Warminster Hospitals."

113. The threatened closure of Hahnemann and termination of the Residency Programs therefore violate Section 2.4.3 of the AAA.

114. Section 2.8 of the AAA provides that AAHS shall not close the Clinical Programs at Hahnemann without Drexel's written consent unless it provides Drexel with either substitute programs or adequate financial support for replacement programs.

115. Drexel has not given written consent to the closure of the Clinical Programs.

116. The threatened closure of Hahnemann and termination of the Residency Programs therefore violate Section 2.8 of the AAA.

117. Section 4.2 of the AAA provides that AAHS "agrees that [Drexel] University shall have the right to provide certain hospital-based services at [Hahnemann] on an exclusive basis, subject to the terms and conditions described on Schedule 4.2.(4)."

118. Schedule 4.2.(4) provides that Emergency Medicine at Hahnemann is one such hospital-based service that DUCOM has the exclusive right to provide, pending an agreement between the parties on the reimbursement and assignment of responsibilities.

119. The threatened closure of Hahnemann and the termination of the Residency Programs therefore violate Section 4.2 and Schedule 4.2.(4) of the AAA.

120. Section 16.5.2 and Schedule 16.5.2 of the AAA provide that AAHS shall not close Hahnemann without the consent of Drexel.

121. The threatened closure of Hahnemann and resultant termination of the AAA, without the consent of Drexel, therefore violate Section 16.5.2 and Schedule 16.5.2 of the AAA.

122. In fact, the threatened closure of Hahnemann and termination of the Residency Programs would violate the Philadelphia Board of Health Regulation prohibiting the closure of the facilities of a hospital in the City providing emergency care without the written consent of the Health Commissioner. Philadelphia Board of Health Regulation, as reapproved October 1, 1969.

123. An abrupt closure of Hahnemann would also violate both state law, which requires 90 days' notice to the Department of Health before any hospital closure, and Federal law, which requires 60 days' notice to employees before an employer of 100 or more closes a site of employment. *See* 28 Pa. Code § 101.196; 29 U.S.C. § 2102.

WHEREFORE, Drexel University demands judgment in its favor and respectfully requests that the Court:

a. Declare that American Academic Health System, LLC is in violation of Sections 2.4, 2.4.3, 2.8, 4.2, and 16.5.2 and Schedules 4.2.(4) and 16.5.2 of the AAA;

b. Declare that American Academic Health System, LLC may not close Hahnemann University Hospital in its entirety or in part, and/or terminate or modify the Residency Programs, Clinical Programs, and Emergency Department at Hahnemann University Hospital without engaging in a measured and cooperative approach with Drexel University in accordance with the AAA, and obtaining Drexel University's written consent;

c. Declare that American Academic Health System, LLC may not close Hahnemann University Hospital in its entirety without (i) obtaining

the consent of the Philadelphia Health Commissioner pursuant to the Board of Health Regulation, (ii) providing the requisite notice to the Pennsylvania Department of Health pursuant to 28 Pa. Code § 101.196 and the employees of Hahnemann pursuant to the WARN Act, 29 U.S.C. § 2102; and (iii) obtaining the consent of Drexel under Section 16.5.2 of the AAA, and

d. Issue such other and further relief as this Court deems just and proper.

COUNT II
DECLARATORY JUDGMENT FOR BREACH OF COVENANT OF GOOD FAITH AND FAIR DEALING PURSUANT TO 42 Pa. C.S. §§ 7531 *et seq.*
Drexel University vs. American Academic Health Services, LLC

124. Drexel incorporates the foregoing as though the same were set forth at length herein

125. Under Pennsylvania law, there is an implied covenant of good faith and fair dealing in every contract.

126. This implied covenant is vital to the workings of the AAA, which requires that AAHS and Drexel work together cooperatively in many different areas so that the hospitals covered by the AAA, and DUCOM in general, can function properly and smoothly.

127. AAHS, through Freedman, has breached this covenant of good faith and fair dealing through his above-described behavior over the last several months.

128. Among other things, Freedman has falsely blamed DUCOM for Hahnemann's alleged financial problems and made other defamatory statements about DUCOM.

129. Freedman has also vacillated between alternative threats to either close Hahnemann or eliminate the Residency Programs, which has caused significant anxiety among DUCOM employees, bred a substantial level of distrust between the parties, and caused apprehension to the public at large.

130. Freedman has also caused substantial upheaval in upper management at Hahnemann and St. Christopher's by firing numerous key personnel, including ***five*** Chief Executive Officers in the last year alone between the two hospitals.

131. These actions have made the measured and cooperative approach between the parties required by the AAA nearly impossible and amount to a breach of the implied covenant of good faith and fair dealing.

132. As a direct and proximate result of Freedman's actions, acting in the name of AAHS, PAHH and PAHS, DUCOM has suffered and continues to suffer irreparable harm.

WHEREFORE, Drexel University demands judgment in its favor and respectfully requests that the Court:

a. Declare that the actions and inactions of American Academic Health System, LLC constitute a breach of the implied covenant of good faith and fair dealing in the AAA;

b. Declare that American Academic Health System, LLC may not close Hahnemann University Hospital in its entirety or in part, and/or terminate or modify the Residency Programs, Clinical Programs, and Emergency Department at Hahnemann University Hospital without fulfilling the implied covenant of good faith and fair dealing by engaging in a measured and cooperative approach with Drexel

University in accordance with the AAA and obtaining Drexel University's written consent; and

c. Issue such other and further relief as this Court deems just and proper.

COUNT III
BREACH OF CONTRACT
(Failure to Make Required Payments Under the AAA)
Drexel University vs. American Academic Health System, LLC

133. Drexel incorporates the foregoing as though the same were set forth at length herein.

134. Article 4 of the AAA sets forth the services that Drexel is obligated to provide at the covered hospitals and for which AAHS is obligated to pay.

135. Section 4.1 of the AAA requires Drexel to provide certain services to support medical education and the Residency Programs at the covered hospitals.

136. The services are defined in Section 4.1 as Administrative, Supervisory and Teaching Services ("AS&T Services"), as well as medical directorship services ("Directorship Services").

137. The AS&T Services are "required to meet any accreditation or reimbursement requirements" (AAA, § 4.1), and to provide Program Services in accordance with Schedule 4.2.

138. Article 4 of the AAA sets forth the "Services Furnished Between the Parties", which include the services that Drexel is obligated to provide to AAHS and for which it is entitled to payment based upon payment schedules that are part of the AAA.

139. Section 4.1 further states that AAHS "shall compensate [Drexel] for documented AS&T Services and Directorship Services reasonably required at the

Hospitals, in an amount consistent with the payment methodologies set forth on Schedules 4.1.1 and 4.1.2 [of the AAA], respectively . . . ."

140. Schedule 4.1.1 provides the payment methodology for AS&T Services. Specifically, Schedule 4.1.1(2) states that "[b]eginning in Academic Year 2005 and thereafter, [AAHS] shall pay [Drexel] the Base Year Amount ($13,785,744) for providing the AS&T Services, subject to adjustments no more frequently than annually to reflect increases or decreases of more than 5% (the '5% Threshold') in [AAHS's] Base DME Funding", and provides a formula for determining Base DME Funding.[3]

141. Schedule 4.1.2 further provides the payment methodology for Directorship Services. Specifically, Exhibit A to Schedule 4.1.2 determines the amount owed to Drexel.

142. Drexel has performed AS&T Services, Directorship Services, and Program Services at Hahnemann, as well as all of the other conditions, covenants and promises required on its part to be performed in accordance with the terms and conditions of the AAA.

143. Drexel has properly invoiced AAHS under the AAA for such AS&T Services, Directorship Services and Program Services.

144. AAHS has breached the AAA by failing to timely pay Drexel for the AS&T Services, Directorship Services, and Program Services that DUCOM has performed.

145. In addition, AAHS has received substantial global payments from insurance companies which cover both hospital services as well as physician

[3] The Base Year Amount has been reduced from $13,785,744 to $11,410,538 since 2006.

services performed by Drexel and for which Drexel is entitled to payment from the proceeds of such payments, but AAHS has failed to remit those payments to Drexel.

146. Instead, AAHS has kept the entirety of those global payments for itself, without any justification.

147. As a direct and proximate result of AAHS's breach as set forth above, Drexel has incurred damages as of June 18, 2019 in excess of $12,953,610, which amount is increasing daily.

WHEREFORE, Drexel University demands judgment in its favor and against Defendant American Academic Health System, LLC and prays that this Court enter an Order granting the following relief:

a. Compensatory damages of in excess of $12,953,610;

b. Expectation damages and consequential damages to be determined at trial;

c. Reasonable court costs; and

d. Such other and further relief that the Court deems appropriate.

COUNT IV
PEIRCING THE CORPORATE VEIL
Drexel University vs. Philadelphia Academic Health Holdings, LLC, Philadelphia Academic Health System, LLC and Joel Freedman

148. Drexel incorporates the foregoing as though the same were set forth at length herein.

149. Freedman exercises complete control over AAHS either directly as the company's founder, chairman, CEO and controlling shareholder or through his complete control of PAHH and PAHS.

150. Upon information and belief, 90% of the equity in AAHS is owned by a Trust that Freedman established for the sole benefit of himself and his family.

151. Upon information and belief, Freedman has greatly undercapitalized AAHS in an attempt to benefit himself and his family personally.

152. Upon information and belief, AAHS has not paid dividends to any of its Members. Freedman regularly ignores corporate formalities by making unilateral decisions and statements on behalf of AAHS, even if those decisions or statements overrule or contradict the decisions and statements of other AAHS officers and directors.

153. In other words, the other officers and directors of AAHS, PAHH and PAHS have basically no power or authority within the companies.

154. In fact, Freedman has complete control over the day-to-day operations of Hahnemann and St. Christopher's and, for all intents and purposes, continuously ignores and overrules the roles, duties and authority of the officers and management personnel of those hospitals. There are no checks on his decision making whatsoever.

155. Freedman, AAHS, PAHH and PAHS have also failed to produce financial and other corporate records that Drexel has been seeking for months.

156. To the extent that these financial and other corporate records exist at all, Freedman has stated that they are not reliable.

157. The failure and inability of other officers to perform their duties and the lack of reliable corporate records are evidence that AAHS does not observe corporate formalities because of Freedman's complete domination of the company.

158. Moreover, the AAA provides that "certain obligations of [AAHS] hereunder shall be performed by one or more of the [AAHS] LLCs and [AAHS] shall cause the [AAHS] LLCs, where applicable, to satisfy such obligations. (AAA, § 16.12.) This demonstrates that PAHH and PAHS is totally controlled by Freedman and AAHS.

WHEREFORE, Drexel University demands judgment in its favor and respectfully requests that the Court:

a. Declare that Philadelphia Academic Health Holdings, LLC, Philadelphia Academic Health System, LLC and Joel Freedman are the alter egos of American Academic Health System, LLC;
b. Hold PAHH, PAHS and Freedman personally liable, jointly and severally, with AAHS for the violations by AAHS of the AAA to the same extent determined for AAHS in Counts I and II;
c. Hold PAHH, PAHS and Freedman personally liable, jointly and severally, with AAHS for any and all damages awarded to Drexel against AAHS for Drexel's breach of contract claim in Count III; and
d. Issue such other and further relief as this Court deems just and proper.

Respectfully submitted,

COZEN O'CONNOR

Dated: June 21, 2019

By: _____

Stephen A. Cozen (PA ID # 03492)
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One Liberty Place
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Attorneys for Plaintiff

VERIFICATION

I, Jill Tillman, am the Chief Executive Officer of Drexel University Physicians. I hereby state that I am authorized to make this Verification on behalf of Drexel University and that the statements set forth in the foregoing Complaint are true and correct to the best of my knowledge, information and belief, and based upon the information provided to me by others and the documents I have reviewed. I further state pursuant to Pennsylvania Rule of Civil Procedure 1024(b) that, upon reasonable investigation, I have been unable to determine which of the inconsistent facts which are pleaded in the alternative are true, but have sufficient knowledge or information to reasonably believe that one set of the inconsistent facts are true. I make this Verification subject to the penalties of 18 Pa. C.S. § 4904, relating to unsworn falsification to authorities.

Dated: June 20, 2019

Jill Tillman Jill Tillman
NAME

CEO, Drexel University Physicians
TITLE Associate Dean, Clinical Practices

EXHIBIT A

TO BE SUBMITTED IN CAMERA

EXHIBIT B

DREXEL UNIVERSITY, Plaintiff, v. AMERICAN ACADEMIC HEALTH SYSTEMS, LLC, PHILADELPHIA ACADEMIC HEALTH HOLDINGS, LLC, PHILADELPHIA ACADEMIC HEALTH SYSTEM, LLC, and JOEL FREEDMAN, Defendants.	:	COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY, PA COMMERCE COURT NO. _____

AFFIDAVIT OF JILL TILLMAN

COMMONWEALTH OF PENNSYLVANIA :
: ss:
COUNTY OF PHILADELPHIA :

I, Jill Tillman, having been duly sworn on oath, depose and state as follows:

1. I am of sound mind and over the age of eighteen, and I make this Affidavit based upon my personal knowledge.

2. I am currently the Chief Executive Officer of Drexel University Physicians, and I am very knowledgeable of the operations of Drexel University College of Medicine ("DUCOM") at Hahnemann University Hospital, Philadelphia, PA ("Hahnemann").

3. DUCOM's operations and provision of services at Hahnemann are governed by the Amended and Restated Academic Affiliation Agreement (the "AAA") executed by DUCOM and the former owner of Hahnemann's, Tenet Healthsystem Philadelphia, Inc. ("Tenet"), in 2002.

4. American Academic Health Systems, LLC ("AAHS") purchased Hahnemann and St. Christopher's Hospital for Children ("St. Christopher's") from Tenet in or around January 11, 2018. Pursuant to this transaction, AAHS assumed Tenet's obligations and responsibilities under the AAA.

5. Under the AAA, DUCOM provides many medically related services and programs at Hahnemann. These include administration, supervision and teaching of the majority of the graduate medical education programs (the "Residency Programs"), certain specified clinical programs (the "Clinical Programs"), Medical Directorships, certain contracted services including the provision of physician's clinical care in the Emergency Department (the "ED") and the provision of certain Laboratory Services and Anatomic Pathology.

The Residency Programs

6. The residents at Hahnemann are employees of AAHS, but DUCOM is responsible for the administration, supervision and teaching for the majority of the Residency and fellowship Programs at Hahnemann and has done so since November 1998.

7. Each year, the Residency Programs train and employ hundreds of medical residents, and fellows under the direction and supervision of qualified teaching physicians with DUCOM faculty appointments. These residents and fellows, in turn, provide medical services to patients at Hahnemann.

8. The Centers for Medicare and Medicaid Services ("CMS") compensates hospitals across the country for the costs of approved graduate medical education programs, such as the Residency Programs at Hahnemann.

9. However, CMS establishes an annual cap for each hospital on the number of resident slots for which it will reimburse costs.

10. The annual cap at Hahnemann has historically been approximately 570 resident slots and has not materially changed since caps were established in 1997.

11. Hahnemann has historically filled every eligible resident slot at Hahnemann. In other words, the Residency Programs at Hahnemann have consistently had about 570 residents each year.

12. Residents at Hahnemann are integrated into every aspect of inpatient and outpatient services and are the backbone of how the hospital functions.

13. For example, there are residents working around the clock in the emergency room at Hahnemann. Without those residents, physicians would be unable to handle the volume, the emergency room would be overwhelmed and patients who use their services from throughout the City would not receive the urgent care that they need.

14. The residents are also essential to the teaching of DUCOM students. All of the Residency Programs are governed by Section 2.4 of the AAA. Under Section 2.4, the parties acknowledge and recognize that "material modifications in the size, scope and location of those Residency Programs will require a measured and cooperative approach of the parties." [emphasis added]

The Clinical Programs

15. Medical school education typically lasts for four years. At DUCOM, as in most medical schools, students spend most of their first two years of school in classes and most of their last two years of school in clinical rotations.

16. The majority of DUCOM students go through their Clinical Programs at both Hahnemann (for adult rotations) and St. Christopher's (for pediatric rotations).

17. The Clinical Programs are governed by Section 2.8 of the AAA, and are listed in Schedule 2.8 and include Obstetrics/Gynecology, Pediatrics, and Psychiatry.

18. Section 2.8(b) of the AAA states that AAHS "agrees that it shall not close a Section 2.8 Programs [sic] at [Hahnemann] without the written consent of [Drexel] University, which consent shall not be withheld unreasonably by University if [AAHS] provides University with either (a) a substitute program reasonably acceptable to the University for a minimum term of two years to replace any clinical clerkships associated with the Section 2.8 Programs for all School of Medicine third and fourth year students at then-current levels or (b) adequate financial support so that the School of Medicine can start or arrange for a replacement program of its own to meet any accreditation requirements associated with the Section 2.8 Programs."

The Emergency Department at Hahnemann

19. Under Section 4.2 of the AAA, AAHS "agrees that [Drexel] University shall have the right to provide certain hospital-based services at [Hahnemann] on an exclusive basis, subject to the terms and conditions described on Schedule 4.2.(4)."

20. Schedule 4.2.(4) provides that Emergency Medicine at Hahnemann is one such hospital-based service that DUCOM has the exclusive right to provide.

21. The Emergency Department at Hahnemann, as overseen by DUCOM for the last two decades, is a nationally-recognized leader in emergency services and education. In fact, Drexel University College of Medicine offered the first emergency medical residency in the United States.

22. Schedule 4.2.(4) further provides that AAHS can only contract with a third party for the provision of Emergency Medicine at Hahnemann if it cannot first reach an agreement with DUCOM for those services.

23. On November 5, 2018, AAHS and DUCOM signed an extension of our Emergency Department Coverage agreement through June 30, 2019. This provides for physician coverage of the Emergency Department at Hahnemann.

24. The Emergency Department at Hahnemann is critical to the provision of medical care to the Greater Philadelphia area.

25. The emergency room at Hahnemann provides medical care for approximately 56,000 patients each year.

26. There are a number of public services and community programs administered by DUCOM through the Emergency Department at Hahnemann.

27. For example, DUCOM administers the Sexual Assault Nurse Examiner (SANE) program (which is funded by a grant from the City of Philadelphia and provides care for victims of rape and sexual assault), EMS training to current and future emergency medical technicians, ambulance drivers, and paramedics, and the Healing Hurt program (which provides care for victims of crime and their families).

28. The SANE program is exclusive to DUCOM and covers victims across the entire city, including those who are on Medicaid or are indigent. There

is no other medical school or organization in Philadelphia that provides this critical treatment and care for the victims of rape and sexual assault.

Freedman Has Terminated Many Key Personnel at Hahnemann and St. Christopher's Since AAHS Bought the Hospitals

29. In the two-plus years since AAHS bought Hahnemann and St. Christopher's from Tenet, Freedman has fired many employees in vital positions at the hospitals.

30. At Hahnemann, Freedman has fired at least 17 people with substantial responsibility in running the day-to-day operations of Hahnemann, including three Chief Executive Officers (Anthony Rajkumar, David Small, and Suzanne Richards), the Chief Medical Officer (Troy Siebert), the Regional Chief Nursing Officer (Dr. Evers Manley), the Chief Restructuring Officer (Manny Sacapano), the interim Chief Financial Officer (Robert Amon), the Chief Information Officer (Pam Saechow), the Director of Security (Frank Bonilla), and the Directors of Perioperative Services, Emergency Department, Plant Operations, Communications, Radiation Oncology, and Tenet Physician Practices. Freedman has also fired all of Hahnemann's primary care physicians, both cardiologists, and their respective staffs.

31. At St. Christopher's, at least six people with substantial responsibility in running the day-to-day operations of the hospitals have been fired, including two Chief Executive Officers (James Burke and George Rizutto), the Chief Executive Officer of the Physician Practice Plan (Michele Szkolnicki), the Chief Operating Officer (Tom Runkle), and the Chief Nursing Officer (Joanna Horst).

Freedman and AAHS Threaten to Close Hahnemann

32. On April 16, 2019, Freedman told Tony Esposito, the Interim Co-CFO and Associate Dean for Financial Affairs at DUCOM, and me that he was running out of cash and he/AAHS would likely have to publicly announce on or around April 30, 2019 that it was closing Hahnemann in its entirety as of July 30, 2019.

33. In that conversation, Freedman stated both (a) that AAHS would likely announce the closure of Hahnemann by the end of the month although they may not actually close it, and (b) that he was exploring multiple opportunities for the hospitals, including placing pediatrics at Hahnemann, re-organizing Hahnemann into a "community hospital", moving all Obstetric services to another Philadelphia hospital, and decreasing or eliminating residency programs/slots that executives from other hospitals were interested in assuming.

34. Although Freedman and AAHS did not follow through on these specific threats, Freedman has repeated them at least three times in May 2019.

35. On April 18, 2019, Freedman again told Tony Esposito and me that he was running out of cash and had tasked consultants from EisnerAmper to do a closure/liquidation analysis as their number one priority rather than looking at opportunities to restructure.

36. There is no functional difference between these alternative threats. Closing Hahnemann in its entirety would necessarily eliminate the Residency Programs at Hahnemann, while closing the Residency Programs at Hahnemann, absent a significant restructuring of workflow, would necessarily lead to the closure of Hahnemann in its entirety given the substantial reliance that Hahnemann has on the residents for the basic, day-to-day operations of the hospital.

37. AAHS and Freedman did not engage in a measured and cooperative approach with Drexel before considering the reduction or elimination of the Residency Programs and having discussions with executives from other hospitals about these plans, as is required by Section 2.4 of the AAA.

38. AAHS and Freedman have not sought to obtain the written consent of Drexel before deciding to reduce the number of residents in the Residency Programs at Hahnemann as compared to the cap established by CMS, as required by Section 2.4.3 of the AAA.

39. Simply stated, the closure of Hahnemann would be greatly disruptive to DUCOM, its students, faculty, and staff, and the citizens of Philadelphia.

40. If any part of Hahnemann were to be closed as threatened, many – if not all – of the residents, who chose to come to Philadelphia to live and complete their medical training and provide medical services to the citizens of Philadelphia, would be immediately displaced.

41. If the Residency Programs are terminated at Hahnemann, approximately 570 residents would be "orphaned". It would be the largest orphaning of medical residents in the history of the United States.

42. The abrupt termination of the Residency Programs in the manner that AAHS is threatening would be totally unprecedented in the United States. Thus, it is impossible to know exactly how disastrous the resultant consequences would be to Hahnemann, DUCOM, and the Greater Philadelphia area.

43. DUCOM-employed physicians who practice at Hahnemann may be forced to relocate on short notice, which would be detrimental to their provision of medical care to patients and their medical practices in general, in addition to the impact on their patients and the citizens of Philadelphia.

44. Upon information and belief, the other hospitals in Philadelphia, such as Temple University Hospital, Einstein Medical Center, Thomas Jefferson University Hospital, and the Hospital of the University of Pennsylvania, absent an organized and thoughtful plan, would not be able to effectively absorb and treat the approximately 56,000 patients who would otherwise go to Hahnemann for emergency medical care annually.

45. Moreover, the public services administered by DUCOM at Hahnemann's Emergency Department, such as the SANE Program, the EMS training and the Healing Hurt Program would also be placed at risk if Hahnemann closes in its entirety.

46. The facts set forth in this Affidavit are true and correct to the best of my knowledge, information, and belief.

Jill Tillman

Jill Tillman

Sworn to before me this 20 day of June, 2019.

Notary Public

Commonwealth of Pennsylvania - Notary Seal
PATRICIA A. BUCK, Notary Public
Philadelphia County
My Commission Expires June 22, 2023
Commission Number 1019561

EXHIBIT C

LCME®

LIAISON COMMITTEE ON
MEDICAL EDUCATION

FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL

Standards for Accreditation of
Medical Education Programs Leading to the MD Degree

Published March 2017
For surveys in the 2018-19 academic year
Standards and Elements Effective July 1, 2018

LCME® *Functions and Structure of a Medical School*
Standards for Accreditation of Medical Education
Programs Leading to the MD Degree

TABLE OF CONTENTS

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INTRODUCTION

Accreditation is a voluntary, peer-review process designed to attest to the educational quality of new and established educational programs. The Liaison Committee on Medical Education (LCME) accredits complete and independent medical education programs leading to the MD degree in which medical students are geographically located in the United States or Canada for their education and which are operated by universities or medical schools chartered in the United States or Canada. Accreditation of Canadian medical education programs are undertaken in cooperation with the Committee on Accreditation of Canadian Medical Schools (CACMS). By judging the compliance of medical education programs with nationally accepted standards of educational quality, the LCME serves the interests of the general public and of the medical students enrolled in those programs.

To achieve and maintain accreditation, a medical education program leading to the MD degree in the U.S. must meet the standards and elements contained in this document. The accreditation process requires a medical education program to provide assurances that its graduates exhibit general professional competencies that are appropriate for entry to the next stage of their training and that serve as the foundation for lifelong learning and proficient medical care. While recognizing the existence and appropriateness of diverse institutional missions and educational objectives, local circumstances do not justify accreditation of a substandard program of medical education leading to the MD degree.

The LCME regularly reviews the content of the standards and elements, and seeks feedback on their validity, importance, and clarity from members of the medical education community, including its sponsoring organizations. Changes to existing standards and elements that impose new or additional compliance requirements are reviewed by LCME's stakeholders and are considered at a public hearing before being adopted. Once approved, new or revised standards are published in the *Functions and Structure of a Medical School* (F&S) and in the relevant version of the *Data Collection Instrument* (DCI), which will indicate when the changes become effective. Such periodic review may result in the creation or elimination of a specific standard and/or element, or a substantial reorganization of the *Functions and Structure of a Medical School* document.

The *Functions and Structure of a Medical School* is organized according to 12 accreditation standards, each with an accompanying set of elements. The language of each of the 12 LCME accreditation standards is a concise statement of the expectations of that standard. The elements of a standard specify the components that collectively constitute the standard; they are statements that identify the variables that need to be examined in evaluating a medical education program's compliance with the standard. The LCME will consider performance in all the elements associated with a specific standard in the determination of the program's compliance with that standard.

The *Glossary of Terms for LCME Accreditation Standards and Elements* has been incorporated into the *Functions and Structure of a Medical School* for the reader's convenience. The glossary provides the LCME's definitions of terms used in the *Functions and Structure of a Medical School*.

As you read this document, please note the following:

- The 12 standards are organized to flow from the level of the institution to the level of the student.
- As a background reference, tables at the end of this document provide a mapping of the standards as formatted for academic year 2014-15 to the standards and elements format in place for academic year 2018-19.

STANDARD 1: MISSION, PLANNING, ORGANIZATION, AND INTEGRITY

A medical school has a written statement of mission and goals for the medical education program, conducts ongoing planning, and has written bylaws that describe an effective organizational structure and governance processes. In the conduct of all internal and external activities, the medical school demonstrates integrity through its consistent and documented adherence to fair, impartial, and effective processes, policies, and practices.

1.1 Strategic Planning and Continuous Quality Improvement

A medical school engages in ongoing planning and continuous quality improvement processes that establish short and long-term programmatic goals, result in the achievement of measurable outcomes that are used to improve programmatic quality, and ensure effective monitoring of the medical education program's compliance with accreditation standards.

1.2 Conflict of Interest Policies

A medical school has in place and follows effective policies and procedures applicable to board members, faculty members, and any other individuals who participate in decision-making affecting the medical education program to avoid the impact of conflicts of interest in the operation of the medical education program, its associated clinical facilities, and any related enterprises.

1.3 Mechanisms for Faculty Participation

A medical school ensures that there are effective mechanisms in place for direct faculty participation in decision-making related to the medical education program, including opportunities for faculty participation in discussions about, and the establishment of, policies and procedures for the program, as appropriate.

1.4 Affiliation Agreements

In the relationship between a medical school and its clinical affiliates, the educational program for all medical students remains under the control of the medical school's faculty, as specified in written affiliation agreements that define the responsibilities of each party related to the medical education program. Written agreements are necessary with clinical affiliates that are used regularly for required clinical experiences; such agreements may also be warranted with other clinical facilities that have a significant role in the clinical education program. Such agreements provide for, at a minimum the following:

- The assurance of medical student and faculty access to appropriate resources for medical student education
- The primacy of the medical education program's authority over academic affairs and the education/assessment of medical students
- The role of the medical school in the appointment and assignment of faculty members with responsibility for medical student teaching
- Specification of the responsibility for treatment and follow-up when a medical student is exposed to an infectious or environmental hazard or other occupational injury
- The shared responsibility of the clinical affiliate and the medical school for creating and maintaining an appropriate learning environment

1.5 Bylaws

A medical school promulgates bylaws or similar policy documents that describe the responsibilities and privileges of its administrative officers, faculty, medical students, and committees.

1.6 Eligibility Requirements

A medical school ensures that its medical education program meets all eligibility requirements of the LCME for initial and continuing accreditation, including receipt of degree-granting authority and accreditation by a regional accrediting body by either the medical school or its parent institution.

STANDARD 2: LEADERSHIP AND ADMINISTRATION

A medical school has a sufficient number of faculty in leadership roles and of senior administrative staff with the skills, time, and administrative support necessary to achieve the goals of the medical education program and to ensure the functional integration of all programmatic components.

2.1 Administrative Officer and Faculty Appointments

The senior administrative staff and faculty of a medical school are appointed by, or on the authority of, the governing board of the institution.

2.2 Dean's Qualifications

The dean of a medical school is qualified by education, training, and experience to provide effective leadership in medical education, scholarly activity, patient care, and other missions of the medical school.

2.3 Access and Authority of the Dean

The dean of a medical school has sufficient access to the university president or other institutional official charged with final responsibility for the medical education program and to other institutional officials in order to fulfill his or her responsibilities; there is a clear definition of the dean's authority and responsibility for the medical education program.

2.4 Sufficiency of Administrative Staff

A medical school has in place a sufficient number of associate or assistant deans, leaders of organizational units, and senior administrative staff who are able to commit the time necessary to accomplish the missions of the medical school.

2.5 Responsibility of and to the Dean

The dean of a medical school with one or more regional campuses is administratively responsible for the conduct and quality of the medical education program and for ensuring the adequacy of faculty at each campus. The principal academic officer at each campus is administratively responsible to the dean.

2.6 Functional Integration of the Faculty

At a medical school with one or more regional campuses, the faculty at the departmental and medical school levels at each campus are functionally integrated by appropriate administrative mechanisms (e.g., regular meetings and/or communication, periodic visits, participation in shared governance, and data sharing).

STANDARD 3: ACADEMIC AND LEARNING ENVIRONMENTS

A medical school ensures that its medical education program occurs in professional, respectful, and intellectually stimulating academic and clinical environments, recognizes the benefits of diversity, and promotes students' attainment of competencies required of future physicians.

3.1 Resident Participation in Medical Student Education

Each medical student in a medical education program participates in one or more required clinical experiences conducted in a health care setting in which he or she works with resident physicians currently enrolled in an accredited program of graduate medical education.

3.2 Community of Scholars/Research Opportunities

A medical education program is conducted in an environment that fosters the intellectual challenge and spirit of inquiry appropriate to a community of scholars and provides sufficient opportunities, encouragement, and support for medical student participation in the research and other scholarly activities of its faculty.

3.3 Diversity/Pipeline Programs and Partnerships

A medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.

3.4 Anti-Discrimination Policy

A medical school does not discriminate on the basis of age, creed, gender identity, national origin, race, sex, or sexual orientation.

3.5 Learning Environment/Professionalism

A medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations and is one in which all individuals are treated with respect. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, develop and conduct appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.

3.6 Student Mistreatment

A medical education program defines and publicizes its code of professional conduct for the relationships between medical students, including visiting medical students, and those individuals with whom students interact during the medical education program. A medical school develops effective written policies that address violations of the code, has effective mechanisms in place for a prompt response to any complaints, and supports educational activities aimed at preventing inappropriate behavior. Mechanisms for reporting violations of the code of professional conduct are understood by medical students, including visiting medical students, and ensure that any violations can be registered and investigated without fear of retaliation.

STANDARD 4: FACULTY PREPARATION, PRODUCTIVITY, PARTICIPATION, AND POLICIES

The faculty members of a medical school are qualified through their education, training, experience, and continuing professional development and provide the leadership and support necessary to attain the institution's educational, research, and service goals.

4.1 Sufficiency of Faculty

A medical school has in place a sufficient cohort of faculty members with the qualifications and time required to deliver the medical curriculum and to meet the other needs and fulfill the other missions of the institution.

4.2 Scholarly Productivity

The faculty of a medical school demonstrate a commitment to continuing scholarly productivity that is characteristic of an institution of higher learning.

4.3 Faculty Appointment Policies

A medical school has clear policies and procedures in place for faculty appointment, renewal of appointment, promotion, granting of tenure, remediation, and dismissal that involve the faculty, the appropriate department heads, and the dean and provides each faculty member with written information about his or her term of appointment, responsibilities, lines of communication, privileges and benefits, performance evaluation and remediation, terms of dismissal, and, if relevant, the policy on practice earnings.

4.4 Feedback to Faculty

A medical school faculty member receives regularly scheduled and timely feedback from departmental and/or other programmatic or institutional leaders on his or her academic performance and progress toward promotion and, when applicable, tenure.

4.5 Faculty Professional Development

A medical school and/or its sponsoring institution provides opportunities for professional development to each faculty member in the areas of discipline content, curricular design, program evaluation, student assessment methods, instructional methodology, and research to enhance his or her skills and leadership abilities in these areas.

4.6 Responsibility for Educational Program Policies

At a medical school, the dean and a committee of the faculty determine the governance and policymaking processes of the program.

STANDARD 5: EDUCATIONAL RESOURCES AND INFRASTRUCTURE

A medical school has sufficient personnel, financial resources, physical facilities, equipment, and clinical, instructional, informational, technological, and other resources readily available and accessible across all locations to meet its needs and to achieve its goals.

5.1 Adequacy of Financial Resources

The present and anticipated financial resources of a medical school are derived from diverse sources and are adequate to sustain a sound program of medical education and to accomplish other programmatic and institutional goals.

5.2 Dean's Authority/Resources

The dean of a medical school has sufficient resources and budgetary authority to fulfill his or her responsibility for the management and evaluation of the medical curriculum.

5.3 Pressures for Self-Financing

A medical school admits only as many qualified applicants as its total resources can accommodate and does not permit financial or other influences to compromise the school's educational mission.

5.4 Sufficiency of Buildings and Equipment

A medical school has, or is assured the use of, buildings and equipment sufficient to achieve its educational, clinical, and research missions.

5.5 Resources for Clinical Instruction

A medical school has, or is assured the use of, appropriate resources for the clinical instruction of its medical students in ambulatory and inpatient settings and has adequate numbers and types of patients (e.g., acuity, case mix, age, gender).

5.6 Clinical Instructional Facilities/Information Resources

Each hospital or other clinical facility affiliated with a medical school that serves as a major location for required clinical learning experiences has sufficient information resources and instructional facilities for medical student education.

5.7 Security, Student Safety, and Disaster Preparedness

A medical school ensures that adequate security systems are in place at all locations and publishes policies and procedures to ensure student safety and to address emergency and disaster preparedness.

5.8 Library Resources/Staff

A medical school provides ready access to well-maintained library resources sufficient in breadth of holdings and technology to support its educational and other missions. Library services are supervised by a professional staff that is familiar with regional and national information resources and data systems and is responsive to the needs of the medical students, faculty members, and others associated with the institution.

5.9 Information Technology Resources/Staff

A medical school provides access to well-maintained information technology resources sufficient in scope to support its educational and other missions. The information technology staff serving a medical education program has sufficient expertise to fulfill its responsibilities and is responsive to the needs of the medical students, faculty members, and others associated with the institution.

5.10 Resources Used by Transfer/Visiting Students

The resources used by a medical school to accommodate any visiting and transfer medical students in its medical education program do not significantly diminish the resources available to already enrolled medical students.

5.11 Study/Lounge/Storage Space/Call Rooms

A medical school ensures that its medical students have, at each campus and affiliated clinical site, adequate study space, lounge areas, personal lockers or other secure storage facilities, and secure call rooms if students are required to participate in late night or overnight clinical learning experiences.

5.12 Required Notifications to the LCME

A medical school notifies the LCME of any substantial change in the number of enrolled medical students; of any decrease in the resources available to the institution for its medical education program, including faculty, physical facilities, or finances; of its plans for any major modification of its medical curriculum; and/or of anticipated changes in the affiliation status of the program's clinical facilities. The program also provides prior notification to the LCME if it plans to increase entering medical student enrollment on the main campus and/or in one or more existing regional campuses above the threshold of 10 percent, or 15 medical students in one year or 20 percent in three years; or to start a new or to expand an existing regional campus; or to initiate a new parallel curriculum (track).

STANDARD 6: COMPETENCIES, CURRICULAR OBJECTIVES, AND CURRICULAR DESIGN

The faculty of a medical school define the competencies to be achieved by its medical students through medical education program objectives and is responsible for the detailed design and implementation of the components of a medical curriculum that enable its medical students to achieve those competencies and objectives. Medical education program objectives are statements of the knowledge, skills, behaviors, and attitudes that medical students are expected to exhibit as evidence of their achievement by completion of the program.

6.1 Program and Learning Objectives

The faculty of a medical school define its medical education program objectives in outcome-based terms that allow the assessment of medical students' progress in developing the competencies that the profession and the public expect of a physician. The medical school makes these medical education program objectives known to all medical students and faculty. In addition, the medical school ensures that the learning objectives for each required learning experience (e.g., course, clerkship) are made known to all medical students and those faculty, residents, and others with teaching and assessment responsibilities in those required experiences.

6.2 Required Clinical Experiences

The faculty of a medical school define the types of patients and clinical conditions that medical students are required to encounter, the skills to be performed by medical students, the appropriate clinical settings for these experiences, and the expected levels of medical student responsibility.

6.3 Self-Directed and Life-Long Learning

The faculty of a medical school ensure that the medical curriculum includes self-directed learning experiences and time for independent study to allow medical students to develop the skills of lifelong learning. Self-directed learning involves medical students' self-assessment of learning needs; independent identification, analysis, and synthesis of relevant information; and appraisal of the credibility of information sources.

6.4 Inpatient/Outpatient Experiences

The faculty of a medical school ensure that the medical curriculum includes clinical experiences in both outpatient and inpatient settings.

6.5 Elective Opportunities

The faculty of a medical school ensure that the medical curriculum includes elective opportunities that supplement required learning experiences and that permit medical students to gain exposure to and deepen their understanding of medical specialties reflecting their career interests and to pursue their individual academic interests.

6.6 Service-Learning

The faculty of a medical school ensure that the medical education program provides sufficient opportunities for, encourages, and supports medical student participation in service-learning and community service activities.

6.7 Academic Environments

The faculty of a medical school ensure that medical students have opportunities to learn in academic environments that permit interaction with students enrolled in other health professions, graduate and professional degree programs, and in clinical environments that provide opportunities for interaction with physicians in graduate medical education programs and in continuing medical education programs.

6.8 Education Program Duration

A medical education program includes at least 130 weeks of instruction.

STANDARD 7: CURRICULAR CONTENT

The faculty of a medical school ensure that the medical curriculum provides content of sufficient breadth and depth to prepare medical students for entry into any residency program and for the subsequent contemporary practice of medicine.

7.1 Biomedical, Behavioral, Social Sciences

The faculty of a medical school ensure that the medical curriculum includes content from the biomedical, behavioral, and socioeconomic sciences to support medical students' mastery of contemporary scientific knowledge and concepts and the methods fundamental to applying them to the health of individuals and populations.

7.2 Organ Systems/Life Cycle/Primary Care/Prevention/Wellness/Symptoms/Signs/Differential Diagnosis, Treatment Planning, Impact of Behavioral and Social Factors

The faculty of a medical school ensure that the medical curriculum includes content and clinical experiences related to each organ system; each phase of the human life cycle; continuity of care; and preventive, acute, chronic, rehabilitative, end-of-life, and primary care in order to prepare students to:

- Recognize wellness, determinants of health, and opportunities for health promotion and disease prevention
- Recognize and interpret symptoms and signs of disease
- Develop differential diagnoses and treatment plans
- Recognize the potential health-related impact on patients of behavioral and socioeconomic factors
- Assist patients in addressing health-related issues involving all organ systems

7.3 Scientific Method/Clinical/Translational Research

The faculty of a medical school ensure that the medical curriculum includes instruction in the scientific method (including hands-on or simulated exercises in which medical students collect or use data to test and/or verify hypotheses or address questions about biomedical phenomena) and in the basic scientific and ethical principles of clinical and translational research (including the ways in which such research is conducted, evaluated, explained to patients, and applied to patient care).

7.4 Critical Judgment/Problem-Solving Skills

The faculty of a medical school ensure that the medical curriculum incorporates the fundamental principles of medicine, provides opportunities for medical students to acquire skills of critical judgment based on evidence and experience, and develops medical students' ability to use those principles and skills effectively in solving problems of health and disease.

7.5 Societal Problems

The faculty of a medical school ensure that the medical curriculum includes instruction in the diagnosis, prevention, appropriate reporting, and treatment of the medical consequences of common societal problems.

7.6 Cultural Competence and Health Care Disparities

The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process. The medical curriculum includes instruction regarding the following:

- The manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments
- The basic principles of culturally competent health care
- The recognition and development of solutions for health care disparities
- The importance of meeting the health care needs of medically underserved populations
- The development of core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensional and diverse society

7.7 Medical Ethics

The faculty of a medical school ensure that the medical curriculum includes instruction for medical students in medical ethics and human values both prior to and during their participation in patient care activities and requires its medical students to behave ethically in caring for patients and in relating to patients' families and others involved in patient care.

7.8 Communication Skills

The faculty of a medical school ensure that the medical curriculum includes specific instruction in communication skills as they relate to communication with patients and their families, colleagues, and other health professionals.

7.9 Interprofessional Collaborative Skills

The faculty of a medical school ensure that the core curriculum of the medical education program prepares medical students to function collaboratively on health care teams that include health professionals from other disciplines as they provide coordinated services to patients. These curricular experiences include practitioners and/or students from the other health professions.

STANDARD 8: CURRICULAR MANAGEMENT, EVALUATION, AND ENHANCEMENT

The faculty of a medical school engage in curricular revision and program evaluation activities to ensure that medical education program quality is maintained and enhanced and that medical students achieve all medical education program objectives and participate in required clinical experiences and settings.

8.1 Curricular Management

A medical school has in place an institutional body (e.g., a faculty committee) that oversees the medical education program as a whole and has responsibility for the overall design, management, integration, evaluation, and enhancement of a coherent and coordinated medical curriculum.

8.2 Use of Medical Educational Program Objectives

The faculty of a medical school, through the faculty committee responsible for the medical curriculum, ensure that the medical curriculum uses formally adopted medical education program objectives to guide the selection of curriculum content, review and revise the curriculum, and establish the basis for evaluating programmatic effectiveness. The faculty leadership responsible for each required course and clerkship link the learning objectives of that course or clerkship to the medical education program objectives.

8.3 Curricular Design, Review, Revision/Content Monitoring

The faculty of a medical school are responsible for the detailed development, design, and implementation of all components of the medical education program, including the medical education program objectives, the learning objectives for each required curricular segment, instructional and assessment methods appropriate for the achievement of those objectives, content and content sequencing, ongoing review and updating of content, and evaluation of course, clerkship, and teacher quality. These medical education program objectives, learning objectives, content, and instructional and assessment methods are subject to ongoing monitoring, review, and revision by the faculty to ensure that the curriculum functions effectively as a whole to achieve medical education program objectives.

8.4 Program Evaluation

A medical school collects and uses a variety of outcome data, including national norms of accomplishment, to demonstrate the extent to which medical students are achieving medical education program objectives and to enhance medical education program quality. These data are collected during program enrollment and after program completion.

8.5 Medical Student Feedback

In evaluating medical education program quality, a medical school has formal processes in place to collect and consider medical student evaluations of their courses, clerkships, and teachers, and other relevant information.

8.6 Monitoring of Completion of Required Clinical Experiences

A medical school has in place a system with central oversight that monitors and ensures completion by all medical students of required clinical experiences in the medical education program and remedies any identified gaps.

8.7 Comparability of Education/Assessment

A medical school ensures that the medical curriculum includes comparable educational experiences and equivalent methods of assessment across all locations within a given course and clerkship to ensure that all medical students achieve the same medical education program objectives.

8.8 Monitoring Student Time

The medical school faculty committee responsible for the medical curriculum and the program's administration and leadership ensure the development and implementation of effective policies and procedures regarding the amount of time medical students spend in required activities, including the total number of hours medical students are required to spend in clinical and educational activities during clerkships.

STANDARD 9: TEACHING, SUPERVISION, ASSESSMENT, AND STUDENT AND PATIENT SAFETY

A medical school ensures that its medical education program includes a comprehensive, fair, and uniform system of formative and summative medical student assessment and protects medical students' and patients' safety by ensuring that all persons who teach, supervise, and/or assess medical students are adequately prepared for those responsibilities.

9.1 Preparation of Resident and Non-Faculty Instructors

In a medical school, residents, graduate students, postdoctoral fellows, and other non-faculty instructors in the medical education program who supervise or teach medical students are familiar with the learning objectives of the course or clerkship and are prepared for their roles in teaching and assessment. The medical school provides resources to enhance residents' and non-faculty instructors' teaching and assessment skills, and provides central monitoring of their participation in those opportunities.

9.2 Faculty Appointments

A medical school ensures that supervision of medical student learning experiences is provided throughout required clerkships by members of the school's faculty.

9.3 Clinical Supervision of Medical Students

A medical school ensures that medical students in clinical learning situations involving patient care are appropriately supervised at all times in order to ensure patient and student safety, that the level of responsibility delegated to the student is appropriate to his or her level of training, and that the activities supervised are within the scope of practice of the supervising health professional.

9.4 Assessment System

A medical school ensures that, throughout its medical education program, there is a centralized system in place that employs a variety of measures (including direct observation) for the assessment of student achievement, including students' acquisition of the knowledge, core clinical skills (e.g., medical history-taking, physical examination), behaviors, and attitudes specified in medical education program objectives, and that ensures that all medical students achieve the same medical education program objectives.

9.5 Narrative Assessment

A medical school ensures that a narrative description of a medical student's performance, including his or her non-cognitive achievement, is included as a component of the assessment in each required course and clerkship of the medical education program whenever teacher-student interaction permits this form of assessment.

9.6 Setting Standards of Achievement

A medical school ensures that faculty members with appropriate knowledge and expertise set standards of achievement in each required learning experience in the medical education program.

9.7 Formative Assessment and Feedback

The medical school's curricular governance committee ensures that each medical student is assessed and provided with formal formative feedback early enough during each required course or clerkship to allow sufficient time for remediation. Formal feedback occurs at least at the midpoint of the course or clerkship. A course or clerkship less than four weeks in length provides alternate means by which a medical student can measure his or her progress in learning.

9.8 Fair and Timely Summative Assessment

A medical school has in place a system of fair and timely summative assessment of medical student achievement in each course and clerkship of the medical education program. Final grades are available within six weeks of the end of a course or clerkship.

9.9 Student Advancement and Appeal Process

A medical school ensures that the medical education program has a single standard for the advancement and graduation of medical students across all locations and a fair and formal process for taking any action that may affect the status of a medical student, including timely notice of the impending action, disclosure of the evidence on which the action would be based, an opportunity for the medical student to respond, and an opportunity to appeal any adverse decision related to advancement, graduation, or dismissal.

STANDARD 10: MEDICAL STUDENT SELECTION, ASSIGNMENT, AND PROGRESS

A medical school establishes and publishes admission requirements for potential applicants to the medical education program, and uses effective policies and procedures for medical student selection, enrollment, and assignment.

10.1 Premedical Education/Required Coursework

Through its requirements for admission, a medical school encourages potential applicants to the medical education program to acquire a broad undergraduate education that includes the study of the humanities, natural sciences, and social sciences, and confines its specific premedical course requirements to those deemed essential preparation for successful completion of its medical curriculum.

10.2 Final Authority of Admission Committee

The final responsibility for accepting students to a medical school rests with a formally constituted admission committee. The authority and composition of the committee and the rules for its operation, including voting privileges and the definition of a quorum, are specified in bylaws or other medical school policies. Faculty members constitute the majority of voting members at all meetings. The selection of individual medical students for admission is not influenced by any political or financial factors.

10.3 Policies Regarding Student Selection/Progress and Their Dissemination

The faculty of a medical school establish criteria for student selection and develop and implement effective policies and procedures regarding, and make decisions about, medical student application, selection, admission, assessment, promotion, graduation, and any disciplinary action. The medical school makes available to all interested parties its criteria, standards, policies, and procedures regarding these matters.

10.4 Characteristics of Accepted Applicants

A medical school selects applicants for admission who possess the intelligence, integrity, and personal and emotional characteristics necessary for them to become competent physicians.

10.5 Technical Standards

A medical school develops and publishes technical standards for the admission, retention, and graduation of applicants or medical students in accordance with legal requirements.

10.6 Content of Informational Materials

A medical school's catalog and other informational, advertising, and recruitment materials present a balanced and accurate representation of the mission and objectives of the medical education program, state the academic and other (e.g., immunization) requirements for the MD degree and all associated joint degree programs, provide the most recent academic calendar for each curricular option, and describe all required courses and clerkships offered by the medical education program.

10.7 Transfer Students

A medical school ensures that any student accepted for transfer or admission with advanced standing demonstrates academic achievements, completion of relevant prior coursework, and other relevant characteristics comparable to those of the medical students in the class that he or she would join. A medical school accepts a transfer medical student into the final year of a medical education program only in rare and extraordinary personal or educational circumstances.

10.8 Visiting Students

A medical school does all of the following:

- Verifies the credentials of each visiting medical student
- Ensures that each visiting medical student demonstrates qualifications comparable to those of the medical students he or she would join in educational experiences
- Maintains a complete roster of visiting medical students
- Approves each visiting medical student's assignments
- Provides a performance assessment for each visiting medical student
- Establishes health-related protocols for such visiting medical students
- Identifies the administrative office that fulfills these responsibilities

10.9 Student Assignment

A medical school assumes ultimate responsibility for the selection and assignment of medical students to each location and/or parallel curriculum (i.e., track) and identifies the administrative office that fulfills this responsibility. A process exists whereby a medical student with an appropriate rationale can request an alternative assignment when circumstances allow for it.

STANDARD 11: MEDICAL STUDENT ACADEMIC SUPPORT, CAREER ADVISING, AND EDUCATIONAL RECORDS

A medical school provides effective academic support and career advising to all medical students to assist them in achieving their career goals and the school's medical education program objectives. All medical students have the same rights and receive comparable services.

11.1 Academic Advising

A medical school has an effective system of academic advising in place for medical students that integrates the efforts of faculty members, course and clerkship directors, and student affairs staff with its counseling and tutorial services and ensures that medical students can obtain academic counseling from individuals who have no role in making assessment or promotion decisions about them.

11.2 Career Advising

A medical school has an effective career advising system in place that integrates the efforts of faculty members, clerkship directors, and student affairs staff to assist medical students in choosing elective courses, evaluating career options, and applying to residency programs.

11.3 Oversight of Extramural Electives

If a medical student at a medical school is permitted to take an elective under the auspices of another medical school, institution, or organization, a centralized system exists in the dean's office at the home school to review the proposed extramural elective prior to approval and to ensure the return of a performance assessment of the student and an evaluation of the elective by the student. Information about such issues as the following are available, as appropriate, to the student and the medical school in order to inform the student's and the school's review of the experience prior to its approval:

- Potential risks to the health and safety of patients, students, and the community
- The availability of emergency care
- The possibility of natural disasters, political instability, and exposure to disease
- The need for additional preparation prior to, support during, and follow-up after the elective
- The level and quality of supervision
- Any potential challenges to the code of medical ethics adopted by the home school

11.4 Provision of MSPE

A medical school provides a Medical Student Performance Evaluation required for the residency application of a medical student only on or after October 1 of the student's final year of the medical education program.

11.5 Confidentiality of Student Educational Records

At a medical school, medical student educational records are confidential and available only to those members of the faculty and administration with a need to know, unless released by the student or as otherwise governed by laws concerning confidentiality.

11.6 Student Access to Educational Records

A medical school has policies and procedures in place that permit a medical student to review and to challenge his or her educational records, including the Medical Student Performance Evaluation, if he or she considers the information contained therein to be inaccurate, misleading, or inappropriate.

STANDARD 12: MEDICAL STUDENT HEALTH SERVICES, PERSONAL COUNSELING, AND FINANCIAL AID SERVICES

A medical school provides effective student services to all medical students to assist them in achieving the program's goals for its students. All medical students have the same rights and receive comparable services.

12.1 Financial Aid/Debt Management Counseling/Student Educational Debt

A medical school provides its medical students with effective financial aid and debt management counseling and has mechanisms in place to minimize the impact of direct educational expenses (i.e., tuition, fees, books, supplies) on medical student indebtedness.

12.2 Tuition Refund Policy

A medical school has clear, reasonable, and fair policies for the refund of a medical student's tuition, fees, and other allowable payments (e.g., payments made for health or disability insurance, parking, housing, and other similar services for which a student may no longer be eligible following withdrawal).

12.3 Personal Counseling/Well-Being Programs

A medical school has in place an effective system of personal counseling for its medical students that includes programs to promote their well-being and to facilitate their adjustment to the physical and emotional demands of medical education.

12.4 Student Access to Health Care Services

A medical school provides its medical students with timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of their required educational experiences and has policies and procedures in place that permit students to be excused from these experiences to seek needed care.

12.5 Non-Involvement of Providers of Student Health Services in Student Assessment/Location of Student Health Records

The health professionals who provide health services, including psychiatric/psychological counseling, to a medical student have no involvement in the academic assessment or promotion of the medical student receiving those services. A medical school ensures that medical student health records are maintained in accordance with legal requirements for security, privacy, confidentiality, and accessibility.

12.6 Student Health and Disability Insurance

A medical school ensures that health insurance and disability insurance are available to each medical student and that health insurance is also available to each medical student's dependents.

12.7 Immunization Requirements and Monitoring

A medical school follows accepted guidelines in determining immunization requirements for its medical students and monitors students' compliance with those requirements.

12.8 Student Exposure Policies/Procedures

A medical school has policies in place that effectively address medical student exposure to infectious and environmental hazards, including the following:

- The education of medical students about methods of prevention
- The procedures for care and treatment after exposure, including a definition of financial responsibility
- The effects of infectious and environmental disease or disability on medical student learning activities

All registered medical students (including visiting students) are informed of these policies before undertaking any educational activities that would place them at risk.

GLOSSARY OF TERMS FOR LCME ACCREDITATION STANDARDS AND ELEMENTS

Adequate types and numbers of patients (e.g., acuity, case mix, age, gender): Medical student access, in both ambulatory and inpatient settings, to a sufficient mix of patients with a range of severity of illness and diagnoses, ages, and both genders to meet medical educational program objectives and the learning objectives of specific courses, modules, and clerkships. (Element 5.5)

Admission requirements: A comprehensive listing of both objective and subjective criteria used for screening, selection, and admission of applicants to a medical education program. (Standard 10)

Admission with advanced standing: The acceptance by a medical school and enrollment in the medical curriculum of an applicant (e.g., a doctoral student), typically as a second or third-year medical student, when that applicant had not previously been enrolled in a medical education program. (Element 10.7)

Any related enterprises: Any additional medical school-sponsored activities or entities. (Element 1.2)

Assessment: The systematic use of a variety of methods to collect, analyze, and use information to determine whether a medical student has acquired the competencies (e.g., knowledge, skills, behaviors, and attitudes) that the profession and the public expect of a physician. (Element 1.4)

Benefits of diversity: In a medical education program, the facts that having medical students and faculty members from a variety of socioeconomic backgrounds, racial and ethnic groups, and other life experiences can: 1) enhance the quality and content of interactions and discussions for all students throughout the preclinical and clinical curricula; and 2) result in the preparation of a physician workforce that is more culturally aware and competent and better prepared to improve access to healthcare and address current and future health care disparities. (Standard 3)

Central [or centralized] monitoring: Tracking by institutional (e.g., decanal) level offices and/or committees (e.g., the curriculum committee) of desired and expected learning outcomes by students and their completion of required learning experiences. (Element 8.6)

Clinical affiliates: Those institutions providing inpatient medical care that have formal agreements with a medical school to provide clinical experiences for the education of its medical students. (Element 1.4)

Clinical and translational research: The conduct of medical studies involving human subjects, the data from which are intended to facilitate the translation and application of the studies' findings to medical practice in order to enhance the prevention, diagnosis, and treatment of medical conditions. (Element 7.3)

Clinical reasoning: The integration, organization, and interpretation of information gathered as a part of medical problem-solving.

Community service: Services designed to improve the quality of life for community residents or to solve particular problems related to their needs. Community service opportunities provided by the medical school complement and reinforce the medical student's educational program. (Element 6.6)

Comparable educational experiences: Learning experiences that are sufficiently similar so as to ensure that medical students are achieving the same learning objectives at all educational sites at which those experiences occur. (Element 8.7)

Coherent and coordinated curriculum: The design of a complete medical education program, including its content and modes of presentation, to achieve its overall educational objectives. Coherence and coordination

include the following characteristics: 1) the logical sequencing of curricular segments, 2) coordinated and integrated content within and across academic periods of study (i.e., horizontal and vertical integration), and 3) methods of instruction and student assessment appropriate to the achievement of the program's educational objectives. (Element 8.1)

Competency: Statements of defined skills or behavioral outcomes (i.e., that a physician should be able to do) in areas including, but not limited to, patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and ethics, and systems-based practice for which a medical student is required to demonstrate mastery prior to completion of his or her medical education program and receipt of the MD degree. (Element 8.7)

Core curriculum: The required components of a medical curriculum, including all required courses/modules and clinical clerkships/rotations. (Element 7.9)

Critical judgment/critical thinking: The consideration, evaluation, and organization of evidence derived from appropriate sources and related rationales during the process of decision-making. The demonstration of critical thinking requires the following steps: 1) the collection of relevant evidence; 2) the evaluation of that evidence; 3) the organization of that evidence; 4) the presentation of appropriate evidence to support any conclusions; and 5) the coherent, logical, and organized presentation of any response. (Elements 7.4)

Curriculum management: Involves the following activities: leading, directing, coordinating, controlling, planning, evaluating, and reporting. An effective system of curriculum management exhibits the following characteristics: 1) evaluation of program effectiveness by outcomes analysis, using national norms of accomplishment as a frame of reference, 2) monitoring of content and workload in each discipline, including the identification of omissions and unplanned redundancies, and 3) review of the stated objectives of each individual curricular component and of methods of instruction and student assessment to ensure their linkage to and congruence with programmatic educational objectives. (Element 8.1)

Direct educational expenses: The following educational expenses of an enrolled medical student: tuition, mandatory fees, books and supplies, and a computer, if one is required by the medical school. (Element 12.1)

Direct faculty participation in decision-making: Faculty involvement in institutional governance wherein faculty input to decisions are made by the faculty members themselves or by representatives chosen by faculty members (e.g., versus appointed by administrators). (Element 1.3)

Diverse sources [of financial revenues]: Multiple sources of predictable revenues that include, but are not unduly dependent upon any one of, the following: tuition, gifts, clinical revenue, governmental support, research grants, endowment, etc. (Element 5.1)

Effective: Supported by evidence that the policy, practice, and/or process has produced the intended or expected result(s). (Standard 1)

Eligibility requirements...for initial and continuing accreditation: Receipt and maintenance of authority to grant the MD degree from the appropriate governmental agency and initial and continuing accreditation by one of the six regional accrediting bodies. (Element 1.6)

Equivalent methods of assessment: The use of methods of medical student assessment that are as close to identical as possible across all educational sites at which core curricular activities take place, but which may not occur in the same timeframe. (Element 8.7)

Evaluation: The systematic use of a variety of methods to collect, analyze, and use information to determine whether a program is fulfilling its mission(s) and achieving its goal(s). (Element 3.3)

Fair and formal process for taking any action that may affect the status of a medical student: The use of policies and procedures by any institutional body (e.g., student promotions committee) with responsibility for making decisions about the academic progress, continued enrollment, and/or graduation of a medical student in a manner that ensures: 1) that the student will be assessed by individuals who have not previously formed an opinion of the student's abilities, professionalism, and/or suitability to become a physician; and 2) that the student has received timely notice of the proceedings, information about the purpose of the proceedings, and any evidence to be presented at the proceedings; his or her right to participate in and provide information or otherwise respond to participants in the proceedings; and any opportunity to appeal any adverse decision resulting from the proceedings. (Element 9.9)

Fair and timely summative assessment: A criterion-based determination, made as soon as possible after the conclusion of a curricular component (e.g., course/module, clinical clerkship/rotation) by individuals familiar with a medical student's performance, regarding the extent to which he or she has achieved the learning objective(s) for that component such that the student can use the information provided to improve future performance in the medical curriculum. (Element 9.8)

Final responsibility for accepting students rests with a formally constituted admission committee: Ensuring that the sole basis for selecting applicants for admission to the medical education program are the decisions made by the faculty committee charged with medical student selection in accordance with appropriately approved selection criteria. (Element 10.2)

Formative feedback: Information communicated to a medical student in a timely manner that is intended to modify the student's thinking or behavior in order to improve his or her subsequent learning and performance in the medical curriculum. (Element 9.7)

Functionally integrated: Coordination of the various components of the medical school and medical education program by means of policies, procedures, and practices that define and inform the relationships among them. (Element 2.6)

Health care disparities: Differences between groups of people, based on a variety of factors including, but not limited to, race, ethnicity, residential location, sex, age, and socioeconomic status, educational status, and disability status, that affect their access to health care, the quality of the health care they receive, and the outcomes of their medical conditions. (Element 7.6)

Independent study: Opportunities either for medical student-directed learning in one or more components of the core medical curriculum, based on structured learning objectives to be achieved by students with minimal faculty supervision, or for student-directed learning on elective topics of specific interest to the student. (Element 6.3)

Integrated institutional responsibility: Oversight by an appropriate central institutional body (commonly a curriculum committee) of the medical education program as a whole. An effective central curriculum authority exhibits the following characteristics: 1) participation by faculty, students, and administrators; 2) the availability of expertise in curricular design and methods of instruction, student assessment, and program evaluation; and 3) empowerment, through bylaws or decanal mandate, to work in the best interests of the medical education program without regard for parochial or political influences or departmental pressures. (Element 8.1)

Learning objectives: A statement of the specific, observable, and measurable expected outcomes (i.e., what the medical students will be able to do) of each specific component (e.g., course, module, clinical clerkship, rotation) of a medical education program that defines the content of the component and the assessment

methodology and that is linked back to one or more of the medical education program objectives. (Element 6.1)

Major location for required clinical learning experiences: A clinical affiliate of the medical school that is the site of one or more required clinical experiences for its medical students. (Element 5.6)
Medical education program objectives: Broad statements, in measurable terms, of the knowledge, skills, behaviors, and attitudes (typically linked to a statement of expected competencies) that a medical student is expected to exhibit as evidence of his or her achievement of all programmatic requirements by the time of medical education program completion. (Standard 6 and Element 6.1)

Medical education parallel curriculum (track): A parallel program of study for a subset of the medical student body that requires participating students to complete specific programmatic learning objectives (e.g., in research, primary care, leadership) in addition to the medical educational program objectives required of all medical students. (Element 5.12)

Medical problem-solving: The initial generation of hypotheses that influence the subsequent gathering of information. (Elements 7.4)

Mission-appropriate diversity: The inclusion, in a medical education program's student body and among its faculty and staff and based on the program's mission, goals, and policies, of persons from different racial, ethnic, economic, and/or social backgrounds and with differing life experiences to enhance the educational environment for all medical students. (Element 3.3)

Narrative assessment: Written comments from faculty that assess student performance and achievement in meeting the objectives of a course or clerkship. (Element 9.5)

National norms of accomplishment: Those data sources that would permit comparison of relevant medical school-specific medical student performance data to national data for all medical schools and medical students (e.g., USMLE scores, AAMC GQ data, specialty certification rates). (Element 8.4)

Need to know: The requirement that information in a medical student's educational record be provided only to those members of the medical school's faculty or administration who have a legitimate reason to access that information in order to fulfill the responsibilities of their faculty or administrative position. (Element 11.5)

Outcome-based terms: Descriptions of observable and measurable desired and expected outcomes of learning experiences in a medical curriculum (e.g., knowledge, skills, attitudes, and behavior). (Element 6.1)

Primacy of the medical education program's authority over academic affairs and the education/assessment of medical students: The affirmation and acknowledgement that all decisions regarding the creation and implementation of educational policy and the teaching and assessment of medical students are, first and foremost, the prerogative of the medical education program. (Element 1.4)

Principal academic officer at each campus is administratively responsible to the dean: The administrator identified by the dean or the dean's designee (e.g., associate or assistant dean, site director) as having primary responsibility for implementation and evaluation of the components of the medical education program that occur at that campus. (Element 2.5)

Program objectives: See definition for Medical education program objectives above.

Publishes: Communicates in hard-copy and/or on-line in a manner that is easily available to and accessible by the public. (Standard 10)

Regional accrediting body: The six bodies recognized by the US Department of Education that accredit institutions of higher education located in their regions of the US: 1) Higher Learning Commission; 2) Middle States Commission on Higher Education; 3) New England Association of Schools and Colleges Commission on Institutions of Higher Education;4) Northwest Commission on Colleges and Universities;5) Southern Association of Colleges and Schools Commission on Colleges; and 6) Western Association of Schools and Colleges Senior Colleges and University Commission. (Element 1.6)

Regional campus: A regional campus is an instructional site that is distinct from the central/administrative campus of the medical school and at which some students spend one or more complete curricular years. (Element 2.5)

Regularly scheduled and timely feedback: Information communicated periodically and sufficiently often (based on institutional policy, procedure, or practice) to a faculty member to ensure that the faculty member is aware of the extent to which he or she is (or is not) meeting institutional expectations regarding future promotion and/or tenure. (Element 4.4)

Scientific method: A method of procedure consisting in systematic observation, measurement, and experiment, and the formulation, testing, and modification of hypotheses. Typically the method consists of the following steps: 1) identifying and defining a problem; 2) accumulating relevant data; 3) formulating a tentative hypothesis; 4) conducting experiments to test the hypothesis; 5) interpreting the results objectively; and 6) repeating the steps until an acceptable solution is found. (Element 7.3)

Self-directed learning: Includes all of the following components as a unified sequence: 1) the medical student's self-assessment of his/her learning needs; 2) the medical student's independent identification, analysis, and synthesis of relevant information; and 3) the medical student's appraisal of the credibility of information sources. (Element 6.3)

Senior administrative staff: People in academic leadership roles, to include but not limited to, associate/assistant deans, directors, academic department chairs, and people who oversee the operation of affiliated clinical facilities and other educational sites. Many, if not most, of these people also have faculty appointments, and for tracking purposes should only be counted in one category when completing tables such as those listed in the DCI under Element 3.3. (Standard 2 and Elements 2.1, 2.4, and 3.3)

Service-learning: Educational experiences that involve all of the following components: 1) medical students' service to the community in activities that respond to community-identified concerns; 2) student preparation; and 3) student reflection on the relationships among their participation in the activity, their medical school curriculum, and their roles as citizens and medical professionals. (Element 6.6)

Single standard for the promotion and graduation of medical students across all locations: The academic and non-academic criteria and levels of performance defined by a medical education program and published in programmatic policies that must be met by all medical students on all medical school campuses at the conclusion of each academic year for promotion to the next academic year and at the conclusion of the medical education program for receipt of the MD degree and graduation. (Element 9.9)

Standards of achievement: Criteria by which to measure a medical student's attainment of relevant learning objectives and that contribute to a summative grade. (Element 9.6)

Technical standards for admission, retention, and graduation of medical students: A statement by a medical school of the: 1) essential academic and non-academic abilities, attributes, and characteristics in the areas of intellectual-conceptual, integrative, and quantitative abilities; 2) observational skills; 3) physical abilities; 4) motor functioning; 5) emotional stability; 6) behavioral and social skills; and 7) ethics and

professionalism that a medical school applicant or enrolled medical student must possess or be able to acquire, with or without reasonable accommodation, in order to be admitted to, be retained in, and graduate from that school's medical educational program. (Element 10.5)

Transfer: The permanent withdrawal by a medical student from one medical school followed by his or her enrollment (typically in the second or third year of the medical curriculum) in another medical school. (Element 5.10)

Visiting students: Students enrolled at one medical school who participate in clinical (typically elective) learning experiences for a grade sponsored by another medical school without transferring their enrollment from one school to the other. (Element 5.10)

MAPPING OF THE 2014-15 STANDARDS AND 2018-19 STANDARDS AND ELEMENTS SORTED BY THE 2014-15 STANDARDS

2014-15 STANDARD		2018-19 ELEMENT
IS-1		1.1
IS-2		deleted
IS-3		1.6
IS-4		1.5
IS-5		1.2
IS-6		deleted
IS-7		2.1
IS-8		2.3
IS-9		2.3
IS-10		2.2
IS-11		2.4
IS-12		6.7
IS-13		3.2
IS-14		3.2
IS-14-A		6.6
IS-16		3.3 and 7.6

2014-15 STANDARD		2018-19 ELEMENT
ED-1		8.2
ED-1-A		6.1
ED-2		6.2 and 8.6
ED-3		6.1
ED-4		6.8
ED-5		reflected in Standard 7
ED-5-A		6.3
ED-6		7.4
ED-7		deleted
ED-8		8.7
ED-9		5.12
ED-10		7.1 and 7.2
ED-11		7.1
ED-12		7.3
ED-13		7.2
ED-14		7.2
ED-15		7.2
ED-16		6.4

2014-15 STANDARD		2018-19 ELEMENT
ED-17		requested in data collection instrument
ED-17-A		7.3
ED-18		6.5
ED-19		7.8
ED-19-A		7.9
ED-20		7.5
ED-21		7.6
ED-22		7.6
ED-23		7.7
ED-24		9.1
ED-25		9.2
ED-25-A		9.3
ED-26		9.4
ED-27		9.4
ED-28		9.4
ED-29		9.6
ED-30		4.5 and 9.8
ED-31		9.7
ED-32		9.5
ED-33		8.1
ED-34		8.3 and Standard 6
ED-35		8.3
ED-36		5.2
ED-37		8.3
ED-38		8.8
ED-39		2.5
ED-40		2.5
ED-41		2.6
ED-42		9.9
ED-43		10.9
ED-44		reflected in Standards 11 and 12
ED-46		8.4
ED-47		8.5

2014-15 STANDARD		2018-19 ELEMENT
MS-1		10.1
MS-2		10.1
MS-3		10.3
MS-4		10.2
MS-5		10.4
MS-6		10.4
MS-7		10.2
MS-8		3.3
MS-9		10.5
MS-10		10.6
MS-11		10.3
MS-12		5.10
MS-13		10.7
MS-14		10.7
MS-15		10.7
MS-16		10.8
MS-17		10.8
MS-18		11.1
MS-19		11.2
MS-20		11.3
MS-21		deleted
MS-22		11.4
MS-23		12.1
MS-24		12.1
MS-25		12.2
MS-26		12.3
MS-27		12.4
MS-27-A		12.5
MS-28		12.6
MS-29		12.7
MS-30		12.8
MS-31		3.4
MS-31-A		3.5
MS-32		3.6
MS-33		10.3
MS-34		9.9
MS-35		11.5
MS-36		11.6
MS-37		5.11

2014-15 STANDARD		2018-19 ELEMENT
FA-2		4.1
FA-3		deleted
FA-4		4.5
FA-5		4.2
FA-6		10.3 and 11.2
FA-7		4.3
FA-8		1.2
FA-9		4.3
FA-10		4.4
FA-11		4.5
FA-12		4.6
FA-13		1.3
FA-14		1.3

2014-15 STANDARD		2018-19 ELEMENT
ER-1		5.12
ER-2		5.1
ER-3		5.3
ER-4		5.4
ER-5		5.7
ER-6		5.5
ER-7		5.6 and 5.11
ER-8		3.1
ER-9		1.4 and 5.12
ER-10		1.4
ER-11		5.8
ER-12		5.8
ER-13		5.9
ER-14		5.9

MAPPING OF THE 2014-15 STANDARDS AND 2018-19 STANDARDS AND ELEMENTS SORTED BY THE 2018-19 ELEMENTS

2018-19 ELEMENT		2014-15 STANDARD
1.1		IS-1
1.2		IS-5 and FA-8
1.3		FA-13 and FA-14
1.4		ER-9 and ER-10
1.5		IS-4
1.6		IS-3

2018-19 ELEMENT		2014-15 STANDARD
2.1		IS-7
2.2		IS-10
2.3		IS-8 and IS-9
2.4		IS-11
2.5		ED-39 and ED-40
2.6		ED-41

2018-19 ELEMENT		2014-15 STANDARD
3.1		ER-8
3.2		IS-13 and IS-14
3.3		IS-16 and MS-8
3.4		MS-31
3.5		MS-31-A
3.6		MS-32

2018-19 ELEMENT		2014-15 STANDARD
4.1		FA-2
4.2		FA-5
4.3		FA-7 and FA-9
4.4		FA-10
4.5		ED-30, FA-4, FA-11
4.6		FA-12

2018-19 ELEMENT		2014-15 STANDARD
5.1		ER-2
5.2		ED-36
5.3		ER-3
5.4		ER-4
5.5		ER-6
5.6		ER-7
5.7		ER-5
5.8		ER-11 and ER-12
5.9		ER-13 and ER-14
5.10		MS-12
5.11		MS-37 and ER-7
5.12		ED-9, ER-1, ER-9

2018-19 ELEMENT		2014-15 STANDARD
6.1		ED-1-A and ED-3
6.2		ED-2
6.3		ED-5-A
6.4		ED-16
6.5		ED-18
6.6		IS-14-A
6.7		IS-12
6.8		ED-4

2018-19 ELEMENT		2014-15 STANDARD
7.1		ED-10 and ED-11
7.2		ED-10, ED-13, ED-14, ED-15
7.3		ED-12 and ED-17-A
7.4		ED-6
7.5		ED-20
7.6		IS-16, ED-21, ED-22
7.7		ED-23
7.8		ED-19
7.9		ED-19-A

2018-19 ELEMENT		2014-15 STANDARD
8.1		ED-33
8.2		ED-1
8.3		ED-34, ED-35, ED-37
8.4		ED-46
8.5		ED-47
8.6		ED-2
8.7		ED-8
8.8		ED-38

2018-19 ELEMENT		2014-15 STANDARD
9.1		ED-24
9.2		ED-25
9.3		ED-25-A
9.4		ED-26, ED-27, ED-28
9.5		ED-32
9.6		ED-29
9.7		ED-31
9.8		ED-30
9.9		ED-42 and MS-34

2018-19 ELEMENT		2014-15 STANDARD
10.1		MS-1 and MS-2
10.2		MS-4 and MS-7
10.3		MS-3, MS-11, MS-33, FA-6
10.4		MS-5, MS-6
10.5		MS-9
10.6		MS-10
10.7		MS-13, MS-14, MS-15
10.8		MS-16, MS-17
10.9		ED-43

2018-19 ELEMENT		2014-15 STANDARD
11.1		MS-18
11.2		MS-19 and FA-6
11.3		MS-20
11.4		MS-22
11.5		MS-35
11.6		MS-36

2018-19 ELEMENT		2014-15 STANDARD
12.1		MS-23 and MS-24
12.2		MS-25
12.3		MS-26
12.4		MS-27
12.5		MS-27-A
12.6		MS-28
12.7		MS-29
12.8		MS-30

EXHIBIT D

Accreditation Council for
Graduate Medical Education

ACGME

Common Program Requirements

ACGME approved revisions to Sections I-V: effective 2007, 2013, 2015, 2016
ACGME approved major revision of Section VI: February, 2017; effective: July 1, 2017

Common Program Requirements

Note: The term "resident" in this document refers to both specialty residents and subspecialty fellows. Once the Common Program Requirements are inserted into each set of specialty and subspecialty requirements, the terms "resident" and "fellow" will be used respectively.

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.

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites. (Core)*

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program. (Core)

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years. (Core)

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents; (Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document; (Detail)

I.B.1.c) specify the duration and content of the educational experience; and, (Detail)

I.B.1.d) state the policies and procedures that will govern resident education during the assignment. (Detail)

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS). (Core)

[As further specified by the Review Committee]

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. (Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. (Core)

[As further specified by the Review Committee]

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. (Detail)

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

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; (Core)

II.A.3.b) current certification in the specialty by the American Board of _____, or specialty qualifications that are acceptable to the Review Committee; and, (Core)

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

[As further specified by the Review Committee]

II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. (Core)

The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; (Core)

II.A.4.b) approve a local director at each participating site who is accountable for resident education; (Core)

II.A.4.c) approve the selection of program faculty as appropriate; (Core)

II.A.4.d) evaluate program faculty; (Core)

II.A.4.e) approve the continued participation of program faculty based on evaluation; (Core)

II.A.4.f) monitor resident supervision at all participating sites; (Core)

II.A.4.g) prepare and submit all information required and requested by the ACGME. (Core)

II.A.4.g).(1) This includes but is not limited to the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete. (Core)

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; (Detail)

II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion; (Detail)

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, (Core)

and, to that end, must:

II.A.4.j).(1) distribute these policies and procedures to the residents and faculty; (Detail)

II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; (Core)

II.A.4.j).(3) adjust schedules as necessary to mitigate excessive

service demands and/or fatigue; and, (Detail)

II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. (Detail)

II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; (Detail)

II.A.4.l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents; (Detail)

II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; (Detail)

II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including: (Core)

II.A.4.n).(1) all applications for ACGME accreditation of new programs; (Detail)

II.A.4.n).(2) changes in resident complement; (Detail)

II.A.4.n).(3) major changes in program structure or length of training; (Detail)

II.A.4.n).(4) progress reports requested by the Review Committee; (Detail)

II.A.4.n).(5) requests for increases or any change to resident duty hours; (Detail)

II.A.4.n).(6) voluntary withdrawals of ACGME-accredited programs; (Detail)

II.A.4.n).(7) requests for appeal of an adverse action; and, (Detail)

II.A.4.n).(8) appeal presentations to a Board of Appeal or the ACGME. (Detail)

II.A.4.o) obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses: (Detail)

II.A.4.o).(1) program citations, and/or, (Detail)

II.A.4.o).(2) request for changes in the program that would have

significant impact, including financial, on the program or institution. (Detail)

[As further specified by the Review Committee]

II.B. Faculty

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

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents; and, (Core)

II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas. (Core)

II.B.2. The physician faculty must have current certification in the specialty by the American Board of _____, or possess qualifications judged acceptable to the Review Committee. (Core)

[As further specified by the Review Committee]

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. (Core)

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Detail)

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding; (Detail)

II.B.5.b).(2) publication of original research or review articles in peer reviewed journals, or chapters in textbooks; (Detail)

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)

II.B.5.b).(4) participation in national committees or educational

organizations. (Detail)

II.B.5.c) Faculty should encourage and support residents in scholarly activities. (Core)

[As further specified by the Review Committee]

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. (Core)

[As further specified by the Review Committee]

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements. (Core)

[As further specified by the Review Committee]

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. (Detail)

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements. (Core)

III.A.1. Eligibility Requirements – Residency Programs

III.A.1.a) All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant's level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program. (Core)

III.A.1.b) A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1

level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

III.A.1.c) A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission. (Core)

III.A.1.d) Review Committees will grant no other exceptions to these eligibility requirements for residency education. (Core)

III.A.2. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC- accredited residency program located in Canada. (Core)

III.A.2.a) Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program. (Core)

III.A.2.b) Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions: (Core)

III.A.2.b).(1) Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and (Core)

III.A.2.b).(2) Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and (Core)

III.A.2.b).(3) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and; (Core)

III.A.2.b).(4) For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, (Core)

III.A.2.b).(5) Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program. (Core)

III.A.2.b).(5).(a) If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. (Core)

** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.

[Each Review Committee will decide no later than December 31, 2013 whether the exception specified above will be permitted. If the Review Committee will not allow this exception, the program requirements will include the following statement]:

III.A.2.c) The Review Committee for _____ does not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.2. (Core)

III.B. Number of Residents

The program's educational resources must be adequate to support the number of residents appointed to the program. (Core)

III.B.1. The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. (Core)

[As further specified by the Review Committee]

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident. (Detail)

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who may leave the program prior to completion. (Detail)

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. (Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. (Detail)

[As further specified by the Review Committee]

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must make available to residents and faculty; (Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form; (Core)

IV.A.3. Regularly scheduled didactic sessions; (Core)

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and, (Core)

IV.A.5. ACGME Competencies

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

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents: (Outcome)

[As further specified by the Review Committee]

IV.A.5.a).(2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents: (Outcome)

[As further specified by the Review Committee]

IV.A.5.b) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents: (Outcome)

[As further specified by the Review Committee]

IV.A.5.c) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. (Outcome)

Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise; (Outcome)

IV.A.5.c).(2) set learning and improvement goals; (Outcome)

IV.A.5.c).(3) identify and perform appropriate learning activities; (Outcome)

IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome)

IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice; (Outcome)

IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; (Outcome)

IV.A.5.c).(7) use information technology to optimize learning; and, (Outcome)

IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals. (Outcome)

[As further specified by the Review Committee]

IV.A.5.d) Interpersonal and Communication Skills

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

Residents are expected to:

IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Outcome)

IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies; (Outcome)

IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group; (Outcome)

IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and, (Outcome)

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable. (Outcome)

[As further specified by the Review Committee]

IV.A.5.e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Residents are expected to demonstrate:

IV.A.5.e).(1) compassion, integrity, and respect for others; (Outcome)

IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest; (Outcome)

IV.A.5.e).(3) respect for patient privacy and autonomy; (Outcome)

IV.A.5.e).(4) accountability to patients, society and the profession; and, (Outcome)

IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome)

[As further specified by the Review Committee]

IV.A.5.f) Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (Outcome)

Residents are expected to:

IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)

IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)

IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)

IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems; (Outcome)

IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and, (Outcome)

IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions. (Outcome)

[As further specified by the Review Committee]

IV.B. Residents' Scholarly Activities

IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)

IV.B.2. Residents should participate in scholarly activity. (Core)

[As further specified by the Review Committee]

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities. (Detail)

[As further specified by the Review Committee]

V. Evaluation

V.A. Resident Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. (Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care settings. (Core)

V.A.1.a).(1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee. (Core)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. (Core)

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all resident evaluations semi-annually; (Core)

V.A.1.b).(1).(b) prepare and ensure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, (Core)

V.A.1.b).(1).(c) advise the program director regarding resident progress, including promotion, remediation, and dismissal. (Detail)

V.A.2. Formative Evaluation

V.A.2.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. (Core)

V.A.2.b) The program must:

V.A.2.b).(1) provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; (Core)

V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); (Detail)

V.A.2.b).(3) document progressive resident performance improvement

appropriate to educational level; and, (Core)

V.A.2.b).(4) provide each resident with documented semiannual evaluation of performance with feedback. (Core)

V.A.2.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy. (Detail)

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program. (Core)

V.A.3.b) The program director must provide a summative evaluation for each resident upon completion of the program. (Core)

This evaluation must:

V.A.3.b).(1) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Detail)

V.A.3.b).(2) document the resident's performance during the final period of education; and, (Detail)

V.A.3.b).(3) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision. (Detail)

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. (Core)

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. (Detail)

V.B.3. This evaluation must include at least annual written confidential evaluations by the residents. (Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). (Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one resident; (Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, (Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; (Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; (Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, (Detail)

V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, residents, and others, as specified below. (Detail)

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. (Core)

The program must monitor and track each of the following areas:

V.C.2.a) resident performance; (Core)

V.C.2.b) faculty development; (Core)

V.C.2.c) graduate performance, including performance of program graduates on the certification examination; (Core)

V.C.2.d) program quality; and, (Core)

V.C.2.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and (Detail)

V.C.2.d).(2) The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program. (Detail)

V.C.2.e) progress on the previous year's action plan(s). (Core)

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)

VI. The Learning and Working Environment

Residency 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 residents today*
- *Excellence in the safety and quality of care rendered to patients by today's residents 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 students, residents, faculty members, and all members of the health care team*

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

VI.A.1. Patient Safety and Quality Improvement

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

Residents 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 residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

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

VI.A.1.a) Patient Safety

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

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

VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, 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) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site; (Core)

VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, (Core)

VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution's patient safety reports. (Core)

VI.A.1.a).(3).(b) Residents must participate as team members in real and/or simulated interprofessional 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) Resident 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

residents to develop and apply.

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

VI.A.1.a).(4).(b) Residents 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 in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) Residents 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.

VI.A.1.b).(2).(a) Residents 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.

VI.A.1.b).(3).(a) Residents must have the opportunity to participate in interprofessional quality improvement activities. (Core)

VI.A.1.b).(3).(a).(i) This should include activities aimed at reducing health care disparities. (Detail)

VI.A.2. Supervision and Accountability

VI.A.2.a) *Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring*

Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident'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 (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core)

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

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

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

VI.A.2.b).(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident'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)

[The Review Committee may specify which activities require different levels of supervision.]

VI.A.2.c) Levels of Supervision

To promote oversight of resident 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 resident and patient. (Core)

VI.A.2.c).(2) Indirect Supervision:

VI.A.2.c).(2).(a) with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core)

VI.A.2.c).(2).(b) with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide 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 resident must be assigned by the program director and faculty members. (Core)

VI.A.2.d).(1) The program director must evaluate each resident's 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 residents based on the needs of the patient and the skills of each resident. (Core)

VI.A.2.d).(3) Senior residents or fellows should serve in a supervisory role to junior 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 residents must communicate with the supervising faculty member(s). (Core)

VI.A.2.e).(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)

VI.A.2.e).(1).(a) Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents

progress to be supervised indirectly with direct supervision available.] (Core)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident 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 residents 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 residents to fulfill non-physician obligations; and, (Core)

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

[As further specified by the Review Committee]

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. Residents 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; and, (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; and, (Outcome)

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

VI.B.5. All residents 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 must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

VI.C.1. This responsibility must include:

VI.C.1.a) efforts to enhance the meaning that each resident 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 resident well-being; (Core)

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

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

VI.C.1.d).(1) Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring

Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents 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 residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, (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 residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. (Core)

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

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

VI.D.1.c) encourage residents 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 referenced in VI.C.2, in the event that a resident 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 residents 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 resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)

[Optimal clinical workload may be further specified by each Review Committee.]

VI.E.2. Teamwork

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

[Each Review Committee will define the elements that must be present in each specialty.]

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 residents 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 residents 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 referenced in VI.C.2, in the event that a resident 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 residents 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, clinical work done from home, and all moonlighting. (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 residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

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

VI.F.2.b).(1) There may be circumstances when residents 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) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

VI.F.2.d) Residents 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 residents 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 resident education. (Core)

VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a resident 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 resident, 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.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

VI.F.4.c).(1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*. (Core)

VI.F.4.c).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core)

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)

VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)

VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)

VI.F.6. In-House Night Float

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

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

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

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

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

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***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 residents or fellows at key stages of their graduate medical education.