

ACGME Program Requirements for Graduate Medical Education in Medical Toxicology (Preventive Medicine)

Common Program Requirements are in BOLD

Effective: July 1, 2007

Introduction

Int.A. Definition and Description of the Subspecialty

Int.A.1. Medical toxicology is a clinical specialty that includes the monitoring, prevention, evaluation and treatment of injury and illness due to occupational and environmental exposures, pharmaceutical agents, as well as unintentional and intentional poisoning in all age groups. A medical toxicology residency program must provide residents with experience in the clinical practice of medical toxicology for all age groups. It must also prepare physicians as practitioners, educators, researchers, and administrators capable of practicing medical toxicology in academic and clinical settings.

Int.A.2. Residencies in medical toxicology must teach the basic skills and knowledge of medical toxicology practice and must provide progressive responsibility for and experience in the management of clinical problems. Residents will develop a satisfactory level of clinical maturity, judgment, and technical skill that will, on completion of the program, allow them to pursue independent practice in medical toxicology.

Int.A.3. Programs must provide residents a broad education in medical toxicology so that they may function as specialists capable of providing comprehensive patient care.

Int.B. Duration and Scope of Education

Int.B.1. Prerequisite training for entry into a medical toxicology program should include the satisfactory completion of an ACGME-accredited residency. Note: Candidates who do not meet this criterion should consult the American Board of Emergency Medicine, the American Board of Pediatrics, or the American Board of Preventive Medicine regarding their eligibility for subspecialty certification.

Int.B.2. The length of the educational program is 24 months. The program must be associated with an ACGME-accredited residency program in emergency medicine, pediatrics, or preventive medicine.

Int.B.3. Prior to entry into the program, each resident must be notified in writing of the required length of the program.

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.

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.

I.A.1. It is highly desirable that the program structure include the participation of a medical school, a school of public health, and a school of pharmacy or department of pharmacology.

I.A.2. Programs in medical toxicology should be based at a primary hospital (hereafter referred to as the primary clinical site). The majority of the didactic and clinical experiences should take place at the primary clinical site.

I.A.3. The program must develop an affiliation with another site to provide residents with clinical experiences unavailable at the primary clinical site/sponsoring institution.

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.

The PLA should:

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

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

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

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

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).

- I.B.3. All participating sites must provide appropriate support services to ensure an adequate educational experience. This includes support personnel in all categories and physical resources to ensure that residents have sufficient time and space to carry out their clinical and educational functions.
- I.B.4. The Review Committee will approve participating sites if sufficient opportunities for residents to manage, either as primary physicians or consultants, the entire course of critically poisoned patients in both the pediatric and adult categories.
- I.B.5. Programs using multiple participating sites must ensure the provision of a unified educational experience for the residents. Each participating site must offer significant educational opportunities to the overall program that do not duplicate experiences otherwise available within the program. An acceptable educational rationale must be provided for each participating site.
- I.B.6. Participating sites must not be geographically distant from the sponsoring institution unless special resources are provided that are not available at the primary clinical site.
- I.B.7. The number and geographic distribution of participating sites must not preclude all residents' participation in conferences and other educational exercises.

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. After approval, the program director must submit this change to the ACGME via the ADS.**
- 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.**
- 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;**
 - II.A.3.b) current certification in the specialty by the American Board of Emergency Medicine or the American Board of Preventive Medicine, or specialty qualifications that are acceptable to the Review Committee; and,**

- II.A.3.c) **current medical licensure and appropriate medical staff appointment.**
- II.A.3.d) certification in medical toxicology or suitable equivalent qualifications as determined 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. 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;**
 - II.A.4.b) **approve a local director at each participating site who is accountable for resident education;**
 - II.A.4.c) **approve the selection of program faculty as appropriate;**
 - II.A.4.d) **evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
 - II.A.4.e) **monitor resident supervision at all participating sites;**
 - II.A.4.f) **prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
 - II.A.4.g) **provide each resident with documented semiannual evaluation of performance with feedback;**
 - 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;**
 - II.A.4.i) **provide verification of residency education for all residents, including those who leave the program prior to completion;**
 - 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, and, to that end, must:**
 - II.A.4.j).(1) **distribute these policies and procedures to the residents and faculty;**
 - II.A.4.j).(2) **monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**

- II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
- 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.
- 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;
- 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;
- 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;
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:
- II.A.4.n).(1)** all applications for ACGME accreditation of new programs;
- II.A.4.n).(2)** changes in resident complement;
- II.A.4.n).(3)** major changes in program structure or length of training;
- II.A.4.n).(4)** progress reports requested by the Review Committee;
- II.A.4.n).(5)** responses to all proposed adverse actions;
- II.A.4.n).(6)** requests for increases or any change to resident duty hours;
- II.A.4.n).(7)** voluntary withdrawals of ACGME-accredited programs;
- II.A.4.n).(8)** requests for appeal of an adverse action;
- II.A.4.n).(9)** appeal presentations to a Board of Appeal or the ACGME; and,
- II.A.4.n).(10)** proposals to ACGME for approval of innovative educational approaches.

- II.A.4.o) **obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
 - II.A.4.o).(1) **program citations, and/or**
 - II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**
- II.A.4.p) in conjunction with the teaching staff, prepare and comply with written educational goals for the program. All educational components of a residency program should be related to program goals.

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.**

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**
- II.B.1.b) **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**
- II.B.2. **The physician faculty must have current certification in the specialty by the American Board of Emergency Medicine or the American Board of Preventive Medicine, or possess qualifications acceptable to the Review Committee.**
 - II.B.2.a) In addition to the qualifications and responsibilities of the program director and faculty described in the Program Requirements for Residency Education in the Subspecialties of Emergency Medicine or the Program Requirements for Residency Education in Preventive Medicine, there must be a minimum of two medical toxicology faculty who each devote a minimum of five hours per week of direct teaching time to the residents and whose medical practice makes them available to the residents for consultations on cases.
 - II.B.2.b) The faculty must be certified in medical toxicology or possess suitable equivalent qualifications as determined by the Review Committee.

- II.B.2.c) Consultants from appropriate medical subspecialties including those with special expertise in disaster and mass casualty incident management, hyperbaric medicine, immunology, industrial hygiene, occupational toxicology, pulmonary medicine, biostatistics, epidemiology, public health, botany, cardiology, dermatology, gastroenterology, nephrology, ophthalmology, pathology, pharmacology, surgical subspecialty, zoology, hazardous materials and mass exposure to toxins, laboratory toxicology, forensic toxicology and environmental toxicology, and nonmedical specialties, such as botany, herpetology, and mycology should be available for consultation and academic lectures.
- II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
- II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
- II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
- 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;**
- II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
- 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,**
- II.B.5.b).(4) participation in national committees or educational organizations.**
- II.B.5.c) Faculty should encourage and support residents in scholarly activities.**
- 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.**

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.

- II.D.1. Resources must be available to support the provision of clinical experience in adult and pediatric critical care areas for residents without prior experience of at least one month in an adult intensive care unit and one month in a pediatric intensive care unit.
- II.D.2. The following services must be organized and provided at the primary clinical site:
 - II.D.2.a) An emergency service for both adult and pediatric patients, adult and pediatric inpatient facilities, and adult and pediatric intensive care facilities;
 - II.D.2.b) Renal dialysis services with 24-hour availability;
 - II.D.2.c) Toxicology laboratory services with 24-hour availability; and,
 - II.D.2.d) Inpatient and outpatient facilities with staff who consult the toxicology service.
- II.D.2.d).(1) It is desirable that hyperbaric oxygen therapy is available.
- II.D.3. The program must provide residents with educational experiences in a regional poison control center certified by the American Association of Poison Control Centers or its equivalent. It is highly desirable that the poison control center be in physical proximity to the primary clinical site.
- II.D.4. The poison control center should have at least 1500 calls annually that require physician telephone consultation or intervention.

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.

III. Resident Appointments

III.A. Eligibility Criteria

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

III.B. Number of Residents

The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.

III.B.1. The Review Committee will approve the number of medical toxicology residents in the program. Approval will be based on the:

III.B.1.a) number, qualifications, and scholarly activity of the faculty;

III.B.1.b) volume and variety of the patient population available for educational purposes; and,

III.B.1.c) institutional resources available to the program.

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.**

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

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. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

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 distribute to residents and faculty annually;**

IV.A.2. **Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;**

IV.A.3. Regularly scheduled didactic sessions;

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,

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.a) Patient Care

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:

IV.A.5.a).(1) must have a minimum of 12 months of clinical experience as the primary or consulting physician responsible for providing direct/bedside patient evaluation, management, screening, and preventive services;

IV.A.5.a).(2) must be provided with experience in evaluating and managing patients with workplace and environmental exposures and must have experience in workplace evaluation, as well as in an occupational medicine or toxicology clinic;

IV.A.5.a).(3) must have opportunities to evaluate and manage patients with acute and long-term workplace and environmental toxic exposures. Clinical training should include experience in an industrial setting or an occupational medicine clinic or access to occupational medicine patients in a referral setting. The resident should also have the opportunity to evaluate and manage intoxicated patients in both industrial and referral setting, including responsibility for providing bedside evaluation, management, screening, and preventive services for a minimum of 12 months or its full-time equivalent;

IV.A.5.a).(4) must have 12 months' experience with a referral population of poisoned patients under the supervision of a physician who is certified in medical toxicology or who possesses suitable equivalent qualifications as determined by the Review Committee; and,

IV.A.5.a).(5) should have the opportunity to maintain their primary board skills during training. But, the program may not require that residents provide more than 12 hours per week of clinical practice not related to medical toxicology.

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:

- IV.A.5.b).(1) must have a curriculum that includes the following academic and clinical content:
- IV.A.5.b).(1).(a) clinical manifestations, differential diagnosis, and management of poisoning;
 - IV.A.5.b).(1).(b) biochemistry of metabolic processes, the pharmacology, pharmacokinetics, and teratogenesis, toxicity, and interactions of therapeutic drugs;
 - IV.A.5.b).(1).(c) biochemistry of toxins, kinetics, metabolism, mechanisms of acute and chronic injury, and carcinogenesis;
 - IV.A.5.b).(1).(d) experimental design and statistical analysis of data as related to laboratory, clinical, and epidemiologic research;
 - IV.A.5.b).(1).(e) laboratory techniques in toxicology;
 - IV.A.5.b).(1).(f) occupational toxicology, including acute and chronic workplace exposure to intoxicants and basic concepts of the workplace and industrial hygiene;
 - IV.A.5.b).(1).(g) prevention of poisoning, including prevention of occupational exposures by intervention methodologies, that take into account the epidemiology, environmental factors, and the role of regulation and legislation in prevention;
 - IV.A.5.b).(1).(h) environmental toxicology, including identification of hazardous materials and the basic principles of management of large-scale environmental contamination and mass exposures;
 - IV.A.5.b).(1).(i) function, management, and financing of poison control centers;
 - IV.A.5.b).(1).(j) oral and written communication skills and teaching techniques; and,

- IV.A.5.b).(1).(k) principles of epidemiology and risk communication, analytical laboratory techniques, and research methodologies in toxicology.
- IV.A.5.b).(2) must be offered an average of at least five hours per week of planned educational experiences (not including change-of-shift reports). These educational experiences should include presentations based on the defined curriculum, morbidity and mortality conferences, journal review, administrative seminars, and research methods. They may include but are not limited to problem-based learning, laboratory research, and computer-based instruction, as well as joint conferences cosponsored with other disciplines; and,
- IV.A.5.b).(3) must have the following included in the curriculum: pharmacology, pharmacokinetics, and drug interactions. This must be accomplished by:
- IV.A.5.b).(3).(a) an affiliation with a school of pharmacy or department of pharmacology that provides regular didactic experience and consultation to residents, or
- IV.A.5.b).(3).(b) the presence of a Doctor of Pharmacology or PhD pharmacologist as a participating member of the teaching faculty.

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. 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;**
- IV.A.5.c).(2) set learning and improvement goals;**
- IV.A.5.c).(3) identify and perform appropriate learning activities;**
- IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**
- IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice;**

- IV.A.5.c).(6) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;**
- IV.A.5.c).(7) **use information technology to optimize learning; and,**
- IV.A.5.c).(8) **participate in the education of patients, families, students, residents and other health professionals.**
- IV.A.5.c).(9) have progressive experience and responsibility in teaching medical toxicology to health care professionals. Residents in the second year of training should participate in the teaching and supervision of first-year residents and should be responsible for regular contributions to formal didactic experiences within the training program, in other academic departments at the site(s), and in the community. Research leading to publication should be encouraged.

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. 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;**
- IV.A.5.d).(2) **communicate effectively with physicians, other health professionals, and health related agencies;**
- IV.A.5.d).(3) **work effectively as a member or leader of a health care team or other professional group;**
- IV.A.5.d).(4) **act in a consultative role to other physicians and health professionals; and,**
- IV.A.5.d).(5) **maintain comprehensive, timely, and legible medical records, if applicable.**

IV.A.5.e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- IV.A.5.e).(1) **compassion, integrity, and respect for others;**
- IV.A.5.e).(2) **responsiveness to patient needs that supersedes self-interest;**

- IV.A.5.e).(3) respect for patient privacy and autonomy;
- IV.A.5.e).(4) accountability to patients, society and the profession; and,
- 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.

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. Residents are expected to:

- IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty;
- IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems;
- IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
- IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions.

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.
- IV.B.2. Residents should participate in scholarly activity.
- IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

V.A.1.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.

V.A.1.b) The program must:

V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,

V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.

V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must 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. This evaluation must:

V.A.2.a) document the resident's performance during the final period of education, and

V.A.2.b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

V.B. Faculty Evaluation

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

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.

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

V.C. Program Evaluation and Improvement

V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

V.C.1.a) resident performance;

V.C.1.b) faculty development;

V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,

V.C.1.d) program quality. Specifically:

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

V.C.1.d).(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.

V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Principles

VI.A.1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.

VI.A.2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.

VI.A.3. Didactic and clinical education must have priority in the allotment of residents' time and energy.

VI.A.4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

VI.B. Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

VI.C. Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

VI.D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.

VI.D.1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

VI.D.2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.

VI.D.3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

VI.E. On-call Activities

VI.E.1. In-house call must occur no more frequently than every third night, averaged over a four-week period.

VI.E.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

VI.E.3. No new patients may be accepted after 24 hours of continuous duty.

VI.E.4. At-home call (or pager call)

VI.E.4.a) The frequency of at-home call is not subject to the every-

third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.

VI.E.4.b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

VI.E.4.c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

VI.F. Moonlighting

VI.F.1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

VI.F.2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

VI.G. Duty Hours Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

VI.G.1. In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VII. Experimentation and Innovation

Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

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