

**American Board of Addiction Medicine Foundation (ABAM Foundation)  
Program Requirements for Graduate Medical Education  
In Addiction Medicine  
(March 25, 2011)**

*Common Program Requirements are in BOLD*

**(The Common Program Requirements are those specified by the ACGME, February 11, 2007, Effective: July 1, 2007.)**

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## Introduction

### Introduction A. Scope of Practice

The addiction medicine physician provides medical care within the bio-psycho-social framework for persons with addiction, for the individual with substance-related health conditions, for persons who manifest unhealthy substance use, and for family members whose health and functioning are affected by another's substance use or addiction.

The addiction medicine physician is specifically trained in a wide range of prevention, evaluation and treatment modalities addressing substance use and addiction in ambulatory care settings, acute care and long-term care facilities, psychiatric settings, and residential facilities. Addiction medicine specialists often offer treatment for patients with addiction or unhealthy substance use who have co-occurring general medical and psychiatric conditions.

The addiction medicine physician is a key member of the health care team and is trained to collaborate, coordinate and provide consultation services for other physicians and to use community resources when appropriate. Some addiction medicine physicians limit their practice to patients with addiction or other patterns of unhealthy substance use. Others focus their practice on patients within their initial medical specialty who have substance-related health conditions. Addiction medicine physicians work in clinical medicine, public health, educational, and research settings to advance the prevention and treatment of addiction and substance-related health conditions and to improve the health and functioning of persons with unhealthy substance use or who are affected family members of unhealthy substance users.

### Intro. B. Purpose, Pre-requisites, and Duration of Training

Intro. B. 1. Purpose: The purpose of post graduate medical education (GME) residency training in addiction medicine (ADM) is to provide physicians with a structured educational experience that will enable them to care for patients with substance use disorders, and for family members of persons with substance use disorders, as described in the Scope of Practice of ADM.

Intro. B. 2. Prerequisites: Physicians who wish to pursue residency training in ADM must be certified by a member specialty board of the American Board of Medical Specialties (ABMS) or have successfully completed all the training requirements and are eligible for board certification from an ABMS member board.

Intro. B. 3. Duration: Residency training in ADM is 1 or 2 years, and must be sponsored by an educational institution approved by the Accreditation Council for Graduate Medical Education (ACGME) to offer residency education. The **Year One** requirements may be fulfilled on a 12-month full-time equivalent basis or on a part-time basis over two years. The optional **Year Two** requirements may be fulfilled on a full-time basis over one year or on a part-time basis over 2-5 years; however, the optional Year Two training plan must be pre-approved by the ABAM Foundation Training and Accreditation Committee (ABAMF TAC).

## 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.

**1.A.1** The addiction medicine residency training program must be sponsored by an educational institution approved by the Accreditation Council for Graduate Medical Education (ACGME) to offer residency education.

**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 that routinely provide an educational experience, which is required for all residents in the program, whenever such experiences are of one month full time equivalent (FTE). The submissions are to be to the ABAMF TAC.

**1.B.3.** Participating sites may not be at such distance from the primary teaching sites that it would fragment the educational experience.

**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 ABAMF TAC.

**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 ABAMF TAC;

**II.A.3.b)** current certification in the specialty by the American Board of Addiction Medicine, or specialty qualifications that are acceptable to the ABAMF TAC;

- II.A.3.c) current medical licensure and appropriate medical staff appointment; and**
- 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 ABAMF TAC, including but not limited to the Program Accreditation Applications Forms and annual program resident updates, 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 ABAMF TAC 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 ABAMF TAC information or requests for the following:**
  - II.A.4.n).(1) **changes in resident complement;**
  - II.A.4.n).(2) **major changes in program structure or length of training;**
  - II.A.4.n).(3) **progress reports requested by the ABAMF TAC;**
  - II.A.4.n).(4) **responses to all proposed adverse actions;**
  - II.A.4.n).(5) **requests for increases or any change to resident duty hours;**
  - II.A.4.n).(6) **voluntary withdrawals of ACGME-accredited programs by the Sponsoring Institution;**
  - II.A.4.n).(7) **requests for appeal of an adverse action; and**
  - II.A.4.n).(8) **appeal presentations to a Board of Appeal or the ABAMF TAC.**
- 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) The Program Director must devote sufficient time to the residency program (i.e., at least 0.25 FTE per year) spent in resident administration, resident teaching, resident precepting and attending duties, and exclusive of time spent in direct patient care without the presence of residents.
- II.A.5. An acting or interim director must possess the qualifications listed in Section II.A.a-d, unless a specific waiver of this requirement is granted by the ABAMF TAC.

**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 Addiction Medicine, or possess qualifications acceptable to the ABAMF TAC.**

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

**II.B.4. The non-physician 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.B.6. Faculty/Resident Ratio**

In addition to the Program Director there must be at least a .25 FTE addiction medicine physician for each additional resident in the program.

**II.B.7. Faculty Role Modeling**

As is expected of the Program Director, the physician faculty should have a specific time commitment to patient care to maintain clinical skills.

II.B.8. Faculty Development

There must be a structured program of faculty development that involves regularly scheduled faculty development 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.C.1. Additional teaching staff will be needed to provide training in curricula areas in which the addiction medicine faculty are not trained or experienced.

II.C.2. Addiction medicine residents should be engaged in cross-disciplinary training as part of the addiction treatment team composed of addiction counselors, nurses, psychologists and members of other health care disciplines. Because addiction medicine engages physicians from several medical specialties, residents should also train in settings where there is meaningful clinical interaction, collaboration and consultation with other residents (e.g., emergency medicine, family medicine, geriatrics, internal medicine, obstetrics-gynecology, pain medicine, pediatrics and adolescent medicine, psychiatry and surgery).

**II.D. Resources**

**The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in these Program Requirements.**

**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.A.1. Applicants with one of the following qualifications, who are certified by a primary specialty board of the American Board of Medical Specialties (ABMS) or have successfully completed all training requirements for certification from an ABMS board, are eligible for appointment to programs:

III.A.1.a) Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).

III.A.1.b) Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).

- III.A.1.c) Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
- III.A.1.c).(1) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, or,
- III.A.1.c).(2) Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.
- III.A.1.d) Graduates of medical schools outside the United States who have completed a Fifth Pathway\*\* program provided by an LCME-accredited medical school.

**III.B. Number of Residents**

**The Program Director may not appoint more residents than approved by the ABAMF TAC, 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. Those accepted into the first year of training should have adequate funding available for 12 month equivalents of training (24 months for optional two year programs). Contracts may be renewed for each year of enrollment for 2 year programs.

**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, in written or electronic form;**

- 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.3.a)(1)

#### Year one training

The four main components of the year one structured clinical portion of ADM residency training are: 1) structured blocks of 12 clinical rotations; 2) longitudinal outpatient continuity clinical experiences, 3) longitudinal didactic sessions and other learning experiences and 4) scholarly activities.

#### IV.A.3.a).(2)

Approximately 4 hours per week, on average, must be devoted to longitudinal learning experiences such as didactic conferences, individual or small group tutoring sessions with program faculty, and mentored self-directed learning. These experiences must address the topics of the Core Curriculum of Addiction Medicine.

#### IV.A.3.a) (3).

Conferences should reflect the needs of the program and the residents. At least one faculty should attend each conference given by residents.

#### IV.A.3.a).(4)

Each program must have the following:

#### IV.A.3.a).(4).(a)

An educational rationale for use of conferences for the program;

#### IV.A.3.a) (4).(b)

A statement on how conferences are evaluated and how the resultant data are used by the program; and,

#### IV.A.3.a).(4).(c)

An explanation of resident involvement in conference design and presentations.

#### IV.A.3.a).(5)

The structured block clinical rotations and longitudinal clinical experiences are described in the ABAM Foundation's ***Compendium of Educational Objectives for Addiction Medicine Residency Training***, and the ***ADM Residency Training Core Curriculum with ACGME Competencies***.

#### IV.A.3.a).(6)

The clinical rotations consist of structured experiences over the Year One clinical training that can be scheduled either as traditional "block rotations" or longitudinally over several months.

#### IV.A.3.a) (7)

The block rotations (or longitudinal clinical experiences) will consist of 12 four-week blocks (each equivalent to 160 hours or "one month") and four weeks of vacation/continuity medical education (CME) activities:

480 hours (12 weeks or 3 months) of experience with outpatient chemical dependency treatment (a "core rotation").

*For example: intensive outpatient treatment or "day treatment" programs, addiction medicine consult services, opioid replacement or maintenance programs (using buprenorphine or methadone), and other medical services where the resident is directly involved with patient assessment, counseling, treatment planning, and coordination with community based services;*

320 hours (8 weeks or 2 months) of experience with inpatient chemical dependency treatment programs (a "core rotation").

*For example: hospital-based rehabilitation programs or medically managed residential programs where the resident is directly involved with patient assessment and treatment planning, which can include the management of withdrawal (i.e., “detoxification”).*

160 hours (4 weeks or 1 month) of experience in an inpatient general medical facility (a “core rotation”).

*For example: Teaching hospitals (that include acute care beds, critical care units, emergency departments, etc.) where the resident provides consultation services to other physicians for patients admitted with a primary medical, surgical, obstetrical, or psychiatric diagnosis.*

480 hours (12 weeks or 3 months) of program-specific requirements in addition to the 6 months of “core rotations” that serve to meet addiction medicine residency program requirements.

480 hours (12 weeks or 3 months) resident electives to compliment the resident’s prior training and/or meet residency program requirements.

160 hours (4 weeks or 1 month) Vacation /CME

*Each 4 week rotation consists of approximately 160 hours of experience that could be completed as a traditional block rotation, a longitudinal clinical experience or a combination of the two.*

IV.A.3.a). (8)

Longitudinal outpatient continuity care experiences. At least one half-day per week for 12 months must be devoted to providing continuity care to a panel of patients who have an addiction disorder. The resident may serve as either a specialty consultative physician with care focused on the addiction disorder or may serve as a primary care physician who provides comprehensive care for the patient panel. This clinical experience must occur during at least 6 continuous months.

IV.A.3.b)

Optional year two training

IV.A.3.b). (1)

The optional year two is a one year “practicum.” The three main elements of the year two are experiences during which the resident will acquire: 1) Administrative skills related to patient care (i.e., “case management”), 2) Teaching skills, and 3) Scholarly activities such as research relevant to the specialty of addiction medicine.

IV.A.3.b).(2)

Examples of this practicum include: 1) A one year clinical experience in the practice of addiction medicine, 2) A one year experience as an addiction medicine faculty member at a medical school or at an addiction medicine training program, 3) A one-year structured research fellowship.

IV.A.3.b). (3)

A combination of these experiences can be used to fulfill this requirement. An advanced academic degree (e.g., MPH) could also be used to fulfill all or a portion of the practicum requirement. The resident shall also prepare a thesis on a topic related to ADM in fulfillment of this requirement. The practicum and the thesis topic must be approved by the ABAMF TAC.

**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) The Program Director and faculty must develop a list of **Patient Care** competency educational objectives for each of the 15 rotations (12 block rotations and the 3 longitudinal experiences), and describe the clinical and didactic experiences where the competency will be acquired. The educational objectives should be tailored for each resident, taking into account the resident's prior training and experience. The objectives should be taken from the ABAM Foundation's ***Compendium of Competency Educational Objectives for Addiction Medicine Residency Training*** and the ***ADM Residency Core Curriculum with ACGME Competencies***.

IV.A.5.a).(2) Continuity of care is a recognized core value of the specialty of addiction medicine and must be a priority in each program.

**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) The Program Director and faculty must develop a list of **Medical Knowledge** competency educational objectives for each of the 15 rotations, and describe the clinical and didactic experiences where the competency will be acquired. The educational objectives should be tailored for each resident, taking into account the resident's prior training and experience. The objectives should be taken from the ABAM Foundation's ***Compendium of Competency Educational Objectives for Addiction Medicine Residency Training***, and the ***ADM Residency Core Curriculum with ACGME Competencies***.

**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.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 inter-professional 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.A.5.f).(7) The Program Director and faculty must develop a list of **Systems-based Practice** competence educational objectives, and describe the clinical and didactic experiences where the competence will be acquired objectives will be met. The educational objectives should be tailored for each resident, taking into account the resident's prior training and experience. The objectives should be taken from the ABAM Foundation's ***Compendium of Competency Educational Objectives for Addiction Medicine Residency Training***, and the ***ADM Residency Core Curriculum with ACGME Competencies***.

**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.2.a) Each program must provide supervised experiences for all residents in scholarly activities such as research, presentations at national, regional,

state, or local professional meetings, or presentation and/or publication of review articles and case presentations. Formal instruction and practical experience must ensure that each resident develops and demonstrates skills in locating sources of scientific data pertinent to the care of patients, analyzing the appropriateness of research design and statistical methods, obtaining information about diagnostic and therapeutic effectiveness, and applying evidence from pertinent clinical studies to patient care.

IV.B.2.b) The program must provide a supervised, ongoing forum in which residents explore and analyze emerging scientific evidence pertinent to the practice of medicine.

IV.B.2.c) Additionally, all residents must actively participate in scientific inquiry, either through direct participation in research, or undertaking scholarly projects that make use of the scientific methods noted above.

IV.B.2.d) Residents must also have guided experiences in the application of emerging clinical knowledge applicable to their own patient panels. The training environment must be in compliance with accepted evidence-based practices.

**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, 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). After each rotation, the resident will complete an anonymous evaluation of the rotation.**

**V.C.1.d).(3) 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

The ABAMF TAC 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 ABAMF TAC, 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 ABAMF TAC. 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 the ABAMF TAC 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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Footnote for III.A.1.d

\*\* A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions: (1) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school; (2) have studied at a medical school outside the United States and Canada but listed in the World Health Organization Directory of Medical Schools; (3) have completed all of the formal requirements of the foreign medical school except internship and/or social service; (4) have attained a score satisfactory to the sponsoring medical school on a screening examination; and (5) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).

*The Program Requirements were created by Directors of the ABAM Foundation, and revised by participants in The ABAM Foundation's Retreat on Addiction Medicine Residency Development of July 6 – 7, 2010.*

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