



**Accreditation Council for  
Graduate Medical Education**

**ACGME Program Requirements for  
Graduate Medical Education  
in Psychiatry**

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# ACGME Program Requirements for Graduate Medical Education in Psychiatry

## Common Program Requirements are in BOLD

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.**

Int.B. Psychiatry is a medical specialty focused on the prevention, diagnosis, and treatment of psychiatric mental, addictive, and emotional disorders. Graduates will possess sound clinical judgment, requisite skills, and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders, together with other common medical and neurological disorders that relate to the practice of psychiatry.

Int.C. The educational program in psychiatry must be 48 months in length. (Core)\*

### 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.** <sup>(Core)</sup>

I.A.1. The sponsoring institution must:

I.A.1.a) provide at least 50 percent salary support and protected time of 50 percent FTE (at least 20 hours per week) for the program director dedicated to direct program administration and education; and, <sup>(Core)</sup>

I.A.1.b) provide additional dedicated time and salary support either for the program director or for associate program directors, based on program size. <sup>(Core)</sup>

I.A.1.b).(1) At a minimum, the following total hours per week must be provided for the program director or combined program director and associate program director: <sup>(Core)</sup>

Residents	Hours/Week
24-40	30
41-79	40
>80	40 + additional time* allocated for directing program (*10 additional hours for every 20 residents)

I.A.1.b).(2) If the associate program director is used for this support, the associate program director must report directly to the program director. <sup>(Core)</sup>

I.A.2. There must be a residency coordinator who has adequate time and institutional support, based on program size and complexity, to support the program. <sup>(Core)</sup>

**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.** <sup>(Core)</sup>

**The PLA should:**

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

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

**I.B.1.c) specify the duration and content of the educational**

**experience; and,** <sup>(Detail)</sup>

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

**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).** <sup>(Core)</sup>

**I.B.3. The number of and distance between participating sites must allow for full participation by residents in all organized educational aspects of the program.** <sup>(Core)</sup>

## **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.** <sup>(Core)</sup>

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

**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.** <sup>(Detail)</sup>

**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;** <sup>(Core)</sup>

**II.A.3.b) current certification in the specialty by the American Board of Psychiatry and Neurology (ABPN), or specialty qualifications that are acceptable to the Review Committee; and,** <sup>(Core)</sup>

**II.A.3.c) current medical licensure and appropriate medical staff appointment.** <sup>(Core)</sup>

**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.** <sup>(Core)</sup>

**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;** <sup>(Core)</sup>

- II.A.4.b) **approve a local director at each participating site who is accountable for resident education;** <sup>(Core)</sup>
- II.A.4.c) **approve the selection of program faculty as appropriate;** <sup>(Core)</sup>
- II.A.4.d) **evaluate program faculty;** <sup>(Core)</sup>
- II.A.4.e) **approve the continued participation of program faculty based on evaluation;** <sup>(Core)</sup>
- II.A.4.f) **monitor resident supervision at all participating sites;** <sup>(Core)</sup>
- II.A.4.g) **prepare and submit all information required and requested by the ACGME.** <sup>(Core)</sup>
- 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.** <sup>(Core)</sup>
- 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;** <sup>(Detail)</sup>
- II.A.4.i) **provide verification of residency education for all residents, including those who leave the program prior to completion;** <sup>(Core)</sup>
- 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,** <sup>(Core)</sup>
- and, to that end, must:**
- II.A.4.j).(1) **distribute these policies and procedures to the residents and faculty;** <sup>(Detail)</sup>
- II.A.4.j).(2) **monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;** <sup>(Core)</sup>
- II.A.4.j).(3) **adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,** <sup>(Detail)</sup>
- 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.** <sup>(Detail)</sup>
- 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;** <sup>(Detail)</sup>

- 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;** <sup>(Detail)</sup>
- 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;** <sup>(Detail)</sup>
- II.A.4.n)** **obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting information or requests to the ACGME, including:** <sup>(Core)</sup>
- II.A.4.n).(1)** **all applications for ACGME accreditation of new programs;** <sup>(Detail)</sup>
  - II.A.4.n).(2)** **changes in resident complement;** <sup>(Detail)</sup>
  - II.A.4.n).(3)** **major changes in program structure or length of training;** <sup>(Detail)</sup>
  - II.A.4.n).(4)** **progress reports requested by the Review Committee;** <sup>(Detail)</sup>
  - II.A.4.n).(5)** **requests for increases or any change to resident duty hours;** <sup>(Detail)</sup>
  - II.A.4.n).(6)** **voluntary withdrawals of ACGME-accredited programs;** <sup>(Detail)</sup>
  - II.A.4.n).(7)** **requests for appeal of an adverse action; and,** <sup>(Detail)</sup>
  - II.A.4.n).(8)** **appeal presentations to a Board of Appeal or the ACGME.** <sup>(Detail)</sup>
- 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:** <sup>(Detail)</sup>
- II.A.4.o).(1)** **program citations, and/or,** <sup>(Detail)</sup>
  - II.A.4.o).(2)** **request for changes in the program that would have significant impact, including financial, on the program or institution.** <sup>(Detail)</sup>
- II.A.4.p)** **monitor performance and maintain contact with residents during the first post-graduate year while they are on services other than**

psychiatry; and, <sup>(Detail)</sup>

II.A.4.q) monitor resident stress, including physical or emotional conditions which inhibit performance or learning, as well as drug- or alcohol-related dysfunction. <sup>(Detail)</sup>

## 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.** <sup>(Core)</sup>

**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,** <sup>(Core)</sup>

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

**II.B.2. The physician faculty must have current certification in the specialty by the American Board of Psychiatry and Neurology, or possess qualifications judged acceptable to the Review Committee.** <sup>(Core)</sup>

**II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.** <sup>(Core)</sup>

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

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

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

**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;** <sup>(Detail)</sup>

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

**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,** <sup>(Detail)</sup>

**II.B.5.b).(4) participation in national committees or educational organizations.** <sup>(Detail)</sup>

**II.B.5.c) Faculty should encourage and support residents in scholarly activities.** <sup>(Core)</sup>

**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.** <sup>(Core)</sup>

**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.** <sup>(Core)</sup>

II.D.1. Organized clinical services in inpatient, outpatient, emergency, consultation/liaison, and child and adolescent psychiatry must be available. <sup>(Core)</sup>

II.D.2. There must be offices designated for residents to use to interview patients and accomplish their clinical duties in a professional manner. <sup>(Core)</sup>

II.D.3. There must be specifically-designated areas for residents to use to perform basic physical examinations and other necessary diagnostic procedures and treatment interventions. <sup>(Core)</sup>

II.D.4. There must be educational space and equipment, with the capability to record and playback specifically designated for seminars, lectures, and other educational activities. <sup>(Core)</sup>

II.D.5. There must be equipment with the capacity for recording and viewing clinical encounters available to residents. <sup>(Core)</sup>

II.D.6. There should be patients of different ages and genders from across the life cycle and from a variety of ethnic, racial, sociocultural, and economic backgrounds. <sup>(Detail)</sup>

II.D.7. There should be an inpatient population that is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and genders. <sup>(Detail)</sup>

II.D.8. Patient services that are comprehensive and continuous should be available. <sup>(Detail)</sup>

II.D.9. Allied medical and ancillary staff members should be available for back-up support. <sup>(Detail)</sup>

**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.1.e) Prior to appointment in the program, applicants must demonstrate sufficient command of English to permit accurate and unimpeded communication.** (Core)

**III.A.1.f) Prior to entry in the program, each resident must be notified, in writing, of the required length of education for which the program is accredited.** (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. <sup>(Core)</sup>**

**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. <sup>(Core)</sup>**

#### **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: <sup>(Core)</sup>**

**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 <sup>(Core)</sup>**

**III.A.2.b).(2) Review and approval of the applicant’s exceptional qualifications by the GMEC or a subcommittee of the GMEC; and <sup>(Core)</sup>**

**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; <sup>(Core)</sup>**

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

**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.** <sup>(Core)</sup>

**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.** <sup>(Core)</sup>

**\*\* 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.**

**III.B. Number of Residents**

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

**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.** <sup>(Core)</sup>

**III.B.2. Programs should have at least three residents at each level of education.** <sup>(Detail)</sup>

**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.** <sup>(Detail)</sup>

**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.** <sup>(Detail)</sup>

**III.C.3. If previous ACGME-accredited education was not in a psychiatry**

program, residents may receive up to but no more than 12 months' credit for prior education as part of the expected 48 months of the educational program. <sup>(Core)</sup>

### **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.** <sup>(Core)</sup>

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

## **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;** <sup>(Core)</sup>

**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;** <sup>(Core)</sup>

**IV.A.3. Regularly scheduled didactic sessions;** <sup>(Core)</sup>

**IV.A.3.a) Each resident should attend a minimum of 70 percent of regularly scheduled didactic sessions.** <sup>(Detail)</sup>

**IV.A.3.b) Residents and faculty members should participate in journal clubs, research conferences, didactics, and/or other activities that address critical appraisal of the literature and understanding of the research process.** <sup>(Detail)</sup>

**IV.A.3.c) Didactic instruction should include regularly scheduled lectures, seminars, and assigned readings that are coordinated with concurrent clinical experiences and are specific to each resident's level of education.** <sup>(Detail)</sup>

**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.** <sup>(Core)</sup>

**IV.A.5. ACGME Competencies**

**The program must integrate the following ACGME competencies into the curriculum:** <sup>(Core)</sup>

**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:** <sup>(Outcome)</sup>

IV.A.5.a).(1).(a)

must demonstrate competence in the evaluation and treatment of patients of different ages and genders from diverse backgrounds, and from a variety of ethnic, racial, sociocultural, and economic backgrounds; and; <sup>(Outcome)</sup>

IV.A.5.a).(1).(b)

must demonstrate competence in:

IV.A.5.a).(1).(b).(i)

forging a therapeutic alliance with patients and their families of all ages and genders, from diverse backgrounds, and from a variety of ethnic, racial, sociocultural, and economic backgrounds; <sup>(Outcome)</sup>

IV.A.5.a).(1).(b).(ii)

formulating a clinical diagnosis for patients by conducting patient interviews; <sup>(Outcome)</sup>

IV.A.5.a).(1).(b).(iii)

eliciting a clear and accurate history; <sup>(Outcome)</sup>

IV.A.5.a).(1).(b).(iv)

performing a physical, neurological, and mental status examination, including use of appropriate diagnostic studies; <sup>(Outcome)</sup>

IV.A.5.a).(1).(b).(v)

completing a systematic recording of findings in the medical record; <sup>(Outcome)</sup>

IV.A.5.a).(1).(b).(vi)

formulating an understanding of a patient's biological, psychological, behavioral, and sociocultural issues associated with etiology and treatment; <sup>(Outcome)</sup>

IV.A.5.a).(1).(b).(vii)

developing a differential diagnosis and treatment plan for patients with psychiatric disorders; <sup>(Outcome)</sup>

IV.A.5.a).(1).(b).(viii)

managing and treating patients using pharmacological regimens, including concurrent use of medications and psychotherapy; <sup>(Outcome)</sup>

IV.A.5.a).(1).(b).(ix)

managing and treating patients using both brief and long-term supportive, psychodynamic, and cognitive-behavioral psychotherapies; <sup>(Outcome)</sup>

- IV.A.5.a).(1).(b).(x) providing psychiatric consultation in a variety of medical and surgical settings; (Outcome)
- IV.A.5.a).(1).(b).(xi) managing and treating chronically-mentally ill patients with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions; (Outcome)
- IV.A.5.a).(1).(b).(xii) providing psychiatric care to patients receiving treatment from non-medical therapists and coordinating such treatment; and, (Outcome)
- IV.A.5.a).(1).(b).(xiii) recognizing and appropriately responding to family violence (e.g., child, partner, and elder physical, emotional, and sexual abuse and neglect) and its effect on both victims and perpetrators. (Outcome)

**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. (Outcome)**

**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)**

must demonstrate competence in their knowledge of:

- IV.A.5.b).(1) major theoretical approaches to understanding the patient-doctor relationship; (Outcome)
- IV.A.5.b).(2) biological, genetic, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle; (Outcome)
- IV.A.5.b).(3) fundamental principles of the epidemiology, etiologies, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, family, sociocultural, and iatrogenic factors that affect the prevention, incidence, prevalence, and long-term course and treatment of psychiatric disorders and conditions;

(Outcome)

- IV.A.5.b).(4) diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, including neoplasm, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, neurocognitive disorders, seizure disorders, stroke, intractable pain, and other related disorders; (Outcome)
- IV.A.5.b).(5) reliability and validity of the generally-accepted diagnostic techniques, including physical examination of the patient, laboratory testing, imaging, neurophysiologic and neuropsychological testing, and psychological testing; (Outcome)
- IV.A.5.b).(6) indications for and uses of electroconvulsive and neuromodulation therapies; (Outcome)
- IV.A.5.b).(7) history of psychiatry and its relationship to the evolution of medicine; (Outcome)
- IV.A.5.b).(8) legal aspects of psychiatric practice; (Outcome)
- IV.A.5.b).(9) aspects of American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the resident and the patient, including the dynamics of differences in cultural identity, values and preferences, and power; and, (Outcome)
- IV.A.5.b).(10) medical conditions that can affect evaluation and care of patients. (Outcome)

#### 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)

**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)

**IV.A.5.e) Professionalism**

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



**care systems;** <sup>(Outcome)</sup>

**IV.A.5.f).(5)** **work in interprofessional teams to enhance patient safety and improve patient care quality;** <sup>(Outcome)</sup>

**IV.A.5.f).(6)** **participate in identifying system errors and implementing potential systems solutions;** <sup>(Outcome)</sup>

IV.A.5.f).(7) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, ensuring quality, and allocating resources; <sup>(Outcome)</sup>

IV.A.5.f).(8) practice cost-effective health care and resource allocation that is aligned with high quality of care, including an understanding of the financing and regulation of psychiatric practice, as well as information about the structure of public and private organizations that influence mental health care; <sup>(Outcome)</sup>

IV.A.5.f).(9) assist patients in dealing with system complexities and disparities in mental health care resources; and, <sup>(Outcome)</sup>

IV.A.5.f).(10) advocate for the promotion of mental health and the prevention of mental disorders. <sup>(Outcome)</sup>

IV.A.6. Curriculum Organization and Resident Experiences

IV.A.6.a) Required Clinical Experiences

IV.A.6.a).(1) Residents must have major responsibility for the care of a sufficient number of patients to demonstrate competence with acute and chronic psychiatric illnesses. <sup>(Core)</sup>

IV.A.6.a).(2) There must be patient care assignments that permit residents to practice appropriate treatment, and to have sufficient time for other aspects of their educational program. <sup>(Core)</sup>

IV.A.6.a).(2).(a) These clinical responsibilities must be coordinated with and not impinge on the non-patient care aspects of the educational program. <sup>(Core)</sup>

IV.A.6.a).(3) There must be structured clinical experiences that are organized to provide opportunities to conduct initial evaluations, to participate in the subsequent diagnostic process, and to follow patients during the treatment phase and/or evolution of their psychiatric disorders/conditions. <sup>(Core)</sup>

IV.A.6.a).(4) The first year in psychiatry must include:

- IV.A.6.a).(4).(a) a minimum of four months in a clinical setting that provides comprehensive clinical care; and, <sup>(Core)</sup>
- IV.A.6.a).(4).(a).(i) This requirement should be met in a primary care specialty setting. <sup>(Detail)</sup>
- IV.A.6.a).(4).(b) no more than eight months FTE in psychiatry. <sup>(Core)</sup>
- IV.A.6.a).(5) Resident experience in neurology must include two months FTE of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions. <sup>(Core)</sup>
- IV.A.6.a).(5).(a) At least one month of this experience should occur in the first or second year of the program. <sup>(Detail)</sup>
- IV.A.6.a).(6) Resident experience in inpatient psychiatry must include at least six months, but no more than 16 months FTE, of inpatient psychiatry. <sup>(Core)</sup>
- IV.A.6.a).(6).(a) This must include a minimum of six months of significant responsibility for the assessment, diagnosis, and treatment of general psychiatric patients who are admitted to traditional psychiatry units. <sup>(Core)</sup>
- IV.A.6.a).(7) Resident experience in outpatient psychiatry must include 12 months FTE of organized, continuous, and supervised clinical experience. <sup>(Core)</sup>
- IV.A.6.a).(7).(a) Each resident must have significant experience treating outpatients longitudinally for at least one year, to include: <sup>(Core)</sup>
- IV.A.6.a).(7).(a).(i) initial evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly; <sup>(Core)</sup>
- IV.A.6.a).(7).(a).(ii) participation in multiple treatment modalities that emphasize developmental, biological, psychological, and social approaches to outpatient treatment; <sup>(Core)</sup>
- IV.A.6.a).(7).(a).(iii) application of psychosocial rehabilitation techniques for the evaluation and treatment of differing disorders in a chronically-ill patient population; and, <sup>(Core)</sup>
- IV.A.6.a).(7).(a).(iv) no more than 20 percent children and adolescent patients. <sup>(Core)</sup>

- IV.A.6.a).(8) Resident experience in child and adolescent psychiatry: must include two months FTE of organized clinical experience. <sup>(Core)</sup>
- IV.A.6.a).(8).(a) Supervising faculty members must have current ABPN certification in child and adolescent psychiatry. <sup>(Core)</sup>
- IV.A.6.a).(8).(b) Residents must participate in assessing, evaluating, and treating a variety of diagnoses in male and female children and adolescents and their families, using a variety of interventional modalities. <sup>(Core)</sup>
- IV.A.6.a).(9) Resident experience in geriatric psychiatry must include one month FTE of organized experience focused on areas unique to the care of the elderly. <sup>(Core)</sup>
- IV.A.6.a).(9).(a) Each resident's geriatric psychiatry experience must include:
- IV.A.6.a).(9).(a).(i) diagnosis and management of mental disorders in geriatric patients with coexistent medical disorders; <sup>(Core)</sup>
- IV.A.6.a).(9).(a).(ii) diagnosis and management, including management of the cognitive component, of degenerative disorders; <sup>(Core)</sup>
- IV.A.6.a).(9).(a).(iii) basic neuropsychological testing of cognitive functioning in the elderly; and, <sup>(Core)</sup>
- IV.A.6.a).(9).(a).(iv) management of drug interactions. <sup>(Core)</sup>
- IV.A.6.a).(10) Resident experience in addiction psychiatry must include one month FTE of organized experience focused on the evaluation and clinical management of patients with substance abuse/dependence problems, including dual diagnosis. <sup>(Core)</sup>
- IV.A.6.a).(10).(a) Residents must have experience with treatment modalities that include:
- IV.A.6.a).(10).(a).(i) detoxification, overdose management, and maintenance pharmacotherapy; <sup>(Core)</sup>
- IV.A.6.a).(10).(a).(ii) the use of therapeutic techniques that address the psychological and social consequences of addiction, to include confronting and intervening in chronic

- addiction rehabilitation used in recovery stages from pre-contemplation to maintenance; and, <sup>(Core)</sup>
- IV.A.6.a).(10).(a).(iii) self-help groups. <sup>(Core)</sup>
- IV.A.6.a).(11) Resident experience in consultation-liaison must include two months FTE in which residents consult, under supervision, on other medical and surgical services. <sup>(Core)</sup>
- IV.A.6.a).(12) Resident experience in forensic psychiatry must include experience evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency. <sup>(Core)</sup>
- IV.A.6.a).(13) Resident experience in emergency psychiatry must be conducted in an organized, supervised psychiatric emergency service. <sup>(Core)</sup>
- IV.A.6.a).(13).(a) This experience must not be counted as part of the 12-month outpatient requirement. <sup>(Core)</sup>
- IV.A.6.a).(13).(b) Resident experiences must include crisis evaluation and management, and triage of psychiatric patients. <sup>(Core)</sup>
- IV.A.6.a).(13).(c) On-call experiences alone must not fulfill the requirement for resident experience in emergency psychiatry. <sup>(Detail)</sup>
- IV.A.6.a).(14) Resident experience in community psychiatry must provide residents with a cohort of persistently and chronically-ill patients in the public sector, such as in community mental health centers, public hospitals and agencies, and other community-based settings. <sup>(Core)</sup>
- IV.A.6.a).(14).(a) This experience must include learning about, and using community resources and services in planning patient care, as well as consulting and working collaboratively with case managers, crisis teams, and other mental health professionals. <sup>(Core)</sup>
- IV.A.6.a).(15) Electives must have written curriculum with goals and objectives, and learning experiences that lead to specified learning outcomes. <sup>(Core)</sup>
- IV.A.6.a).(15).(a) The choice of electives must be made with the advice and approval of the program director and the appropriate preceptor. <sup>(Core)</sup>
- IV.A.6.b) Residents at all levels must be provided at least two hours of

faculty preceptorship weekly, one hour of which must be individual. <sup>(Core)</sup>

- IV.A.6.c) Residents must have experience participating in psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance, and performance improvement. <sup>(Core)</sup>
- IV.A.6.d) For residents who enter subspecialty education in child and adolescent psychiatry prior to completing general psychiatry requirements, certain clinical experiences with children, adolescents, and families taken during the period when the resident is designated as a child and adolescent psychiatry resident may be counted toward general psychiatry requirements as well as child and adolescent requirements, thereby fulfilling program requirements in both general and child and adolescent psychiatry. The following guidelines must be met for these experiences: <sup>(Core)</sup>
- IV.A.6.d).(1) experience is limited to child and adolescent psychiatry patients; <sup>(Core)</sup>
- IV.A.6.d).(2) no more than 12 months may be double-counted; <sup>(Core)</sup>
- IV.A.6.d).(3) there must be documentation from the child and adolescent psychiatry program director for all areas for which credit is given in both programs; <sup>(Core)</sup>
- IV.A.6.d).(4) there must be no reduction in total length of time devoted to education in child and adolescent psychiatry; and, <sup>(Core)</sup>
- IV.A.6.d).(5) only the following experiences should be used to meet requirements in both general and child and adolescent psychiatry:
- IV.A.6.d).(5).(a) one month FTE of child neurology; <sup>(Core)</sup>
- IV.A.6.d).(5).(b) one month FTE of pediatric consultation; <sup>(Core)</sup>
- IV.A.6.d).(5).(c) one month FTE of addiction psychiatry; <sup>(Core)</sup>
- IV.A.6.d).(5).(d) forensic psychiatry experience; <sup>(Core)</sup>
- IV.A.6.d).(5).(e) community psychiatry experience; and, <sup>(Core)</sup>
- IV.A.6.d).(5).(f) no more than 20 percent of the resident's psychiatry outpatient experience. <sup>(Core)</sup>

## **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.** <sup>(Core)</sup>

**IV.B.2. Residents should participate in scholarly activity.** <sup>(Core)</sup>

IV.B.2.a) The program must provide residents with opportunities for research and development of research skills for residents interested in conducting research in psychiatry or related fields. <sup>(Core)</sup>

IV.B.2.b) The program must provide interested residents access to and the opportunity to participate actively in ongoing research under a mentor. <sup>(Core)</sup>

IV.B.2.c) All residents must be educated in research literacy and in the concepts and process of evidence-based clinical practice to develop skills in question formulation, information searching, critical appraisal, and medical decision-making. <sup>(Core)</sup>

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

## **V. Evaluation**

### **V.A. Resident Evaluation**

**V.A.1. The program director must appoint the Clinical Competency Committee.** <sup>(Core)</sup>

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

**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.** <sup>(Core)</sup>

**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.** <sup>(Core)</sup>

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



each resident. <sup>(Core)</sup>

- V.A.2.e).(1) This examination should include an annual evaluation of the resident's:
- V.A.2.e).(1).(a) ability to interview patients and families; <sup>(Detail)</sup>
- V.A.2.e).(1).(b) ability to establish an appropriate doctor/patient relationship; <sup>(Detail)</sup>
- V.A.2.e).(1).(c) ability to elicit an appropriate present and past psychiatric, medical, social, and developmental history; <sup>(Detail)</sup>
- V.A.2.e).(1).(d) ability to assess mental status; <sup>(Detail)</sup>
- V.A.2.e).(1).(e) ability to provide a relevant formulation, differential diagnosis, and provisional treatment plan; and, <sup>(Detail)</sup>
- V.A.2.e).(1).(f) ability to make an organized presentation of the pertinent history, including the mental status examination. <sup>(Detail)</sup>
- V.A.2.f) The program must monitor clinical records on major rotations to assess resident competence to: <sup>(Core)</sup>
- V.A.2.f).(1) document an adequate history and perform mental status, physical, and neurological examinations; <sup>(Core)</sup>
- V.A.2.f).(2) organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues; <sup>(Core)</sup>
- V.A.2.f).(3) proceed with appropriate laboratory and other diagnostic procedures; <sup>(Core)</sup>
- V.A.2.f).(4) develop and implement an appropriate treatment plan followed by regular and relevant progress notes regarding both therapy and medication management; and, <sup>(Core)</sup>
- V.A.2.f).(5) prepare an adequate discharge summary and plan. <sup>(Core)</sup>
- V.A.2.g) Residents' teaching abilities must be documented by evaluations from faculty members and/or learners. <sup>(Core)</sup>
- V.A.2.h) The record of evaluation must demonstrate that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. <sup>(Core)</sup>
- V.A.2.h).(1) In the case of transferring residents, the records must include the experiences in the prior and current program.

(Core)

### **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;** (Detail)

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

**V.A.3.b).(4) include a summary of any documented evidence of unethical behavior, unprofessional behavior, or clinical incompetence, or a statement that none has occurred.** (Core)

**V.A.3.b).(4).(a) Where there is such evidence, it must be comprehensively recorded, along with the resident's response(s) to that evidence.** (Core)

**V.A.3.c) In at least three evaluations with any patient type, in any clinical setting, and at any time during the program, residents must demonstrate satisfactory competence in: establishing an appropriate doctor/patient relationship, psychiatric interviewing, performing the mental status examination, and case presentation.** (Outcome)

**V.A.3.c).(1) Each of the three required evaluations must be conducted by an ABPN-certified psychiatrist, and at least two of the evaluations must be conducted by different ABPN-certified psychiatrists.** (Core)

**V.A.3.c).(2) Satisfactory demonstration of the competencies during the three required evaluations must be documented prior to completion of the program.** (Core)

### **V.B. Faculty Evaluation**

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

**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. <sup>(Detail)</sup>

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

**V.C. Program Evaluation and Improvement**

**V.C.1.** The program director must appoint the Program Evaluation Committee (PEC). <sup>(Core)</sup>

**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; <sup>(Core)</sup>

**V.C.1.a).(2)** must have a written description of its responsibilities; and, <sup>(Core)</sup>

**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; <sup>(Detail)</sup>

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

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

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

**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. <sup>(Core)</sup>

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

**V.C.2.a)** resident performance; <sup>(Core)</sup>

**V.C.2.b)** faculty development; <sup>(Core)</sup>

- V.C.2.c) graduate performance, including performance of program graduates on the certification examination;** <sup>(Core)</sup>
- V.C.2.c).(1) At least 70 percent of a program’s graduates who completed the program in the preceding three years should take the certifying examination in general psychiatry. <sup>(Outcome)</sup>
- V.C.2.c).(2) At least 70 percent of a program’s graduates from the preceding three years who take the ABPN certifying examination in general psychiatry for the first time must pass. <sup>(Outcome)</sup>
- V.C.2.c).(3) At least 70 percent of the program’s eligible graduates from the preceding three years taking the American Osteopathic Board of Neurology and Psychiatry (AOBNP) psychiatry written qualifying examination for the first time must pass. <sup>(Outcome)</sup>
- V.C.2.c).(4) At least 70 percent of the program’s eligible graduates from the preceding three years taking the AOBNP psychiatry oral/clinical certifying examination for the first time must pass. <sup>(Outcome)</sup>
- V.C.2.d) program quality; and,** <sup>(Core)</sup>
- V.C.2.d).(1) **Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and** <sup>(Detail)</sup>
- 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.** <sup>(Detail)</sup>
- V.C.2.e) progress on the previous year’s action plan(s).** <sup>(Core)</sup>
- 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.** <sup>(Core)</sup>
- V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.** <sup>(Detail)</sup>

## **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.***



## 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. <sup>(Core)</sup>

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

Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. <sup>(Detail)</sup>

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. <sup>(Core)</sup>

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. <sup>(Core)</sup>

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. <sup>(Core)</sup>

VI.A.1.b).(3).(a).(i)

This should include activities aimed at reducing health care disparities. <sup>(Detail)</sup>

**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)

**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).** <sup>(Core)</sup>

**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. <sup>(Outcome)</sup>

**VI.A.2.e).(1).(a)** Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. <sup>(Core)</sup>

**VI.A.2.e).(1).(b)** PGY-1 residents should progress to being supervised indirectly with direct supervision available only after demonstrating competence in:

**VI.A.2.e).(1).(b).(i)** the ability and willingness to ask for help when indicated; <sup>(Detail)</sup>

**VI.A.2.e).(1).(b).(ii)** gathering an appropriate history; <sup>(Detail)</sup>

**VI.A.2.e).(1).(b).(iii)** the ability to perform an emergent psychiatric assessment; and, <sup>(Detail)</sup>

**VI.A.2.e).(1).(b).(iv)** presenting patient findings and data accurately to a supervisor who has not seen the patient. <sup>(Detail)</sup>

**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. <sup>(Core)</sup>

## **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. <sup>(Core)</sup>

**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; <sup>(Core)</sup>

**VI.B.2.b)** be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, <sup>(Core)</sup>

**VI.B.2.c)** ensure manageable patient care responsibilities. <sup>(Core)</sup>

**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. <sup>(Core)</sup>

**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; <sup>(Outcome)</sup>

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

**VI.B.4.c)** assurance of their fitness for work, including: <sup>(Outcome)</sup>

**VI.B.4.c).(1)** management of their time before, during, and after clinical assignments; and, <sup>(Outcome)</sup>

**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. <sup>(Outcome)</sup>

**VI.B.4.d)** commitment to lifelong learning; <sup>(Outcome)</sup>

**VI.B.4.e)** monitoring of their patient care performance improvement indicators; and, <sup>(Outcome)</sup>

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

**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. <sup>(Outcome)</sup>

**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. <sup>(Core)</sup>

**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; <sup>(Core)</sup>**
  - VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; <sup>(Core)</sup>**
  - VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; <sup>(Core)</sup>**
  - VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and, <sup>(Core)</sup>**
  - 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. <sup>(Core)</sup>**
  - 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: <sup>(Core)</sup>**
  - 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; <sup>(Core)</sup>**
  - VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, <sup>(Core)</sup>**
  - 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. <sup>(Core)</sup>

**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. <sup>(Core)</sup>

**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; <sup>(Core)</sup>

**VI.D.1.b)** educate all faculty members and residents in alertness management and fatigue mitigation processes; and, <sup>(Core)</sup>

**VI.D.1.c)** encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. <sup>(Detail)</sup>

**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. <sup>(Core)</sup>

**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. <sup>(Core)</sup>

**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. <sup>(Core)</sup>

**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. <sup>(Core)</sup>

**VI.E.2.a)** Contributors to effective interprofessional teams should include

consulting physicians, psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients. <sup>(Detail)</sup>

### **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. <sup>(Core)</sup>**
- 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. <sup>(Core)</sup>**
- VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. <sup>(Outcome)</sup>**
- VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. <sup>(Core)</sup>**
- 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. <sup>(Core)</sup>**

### **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. <sup>(Core)</sup>**

#### **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. <sup>(Core)</sup>**

- VI.F.2.b)** Residents should have eight hours off between scheduled clinical work and education periods. <sup>(Detail)</sup>
- 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. <sup>(Detail)</sup>
- VI.F.2.c)** Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. <sup>(Core)</sup>
- 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. <sup>(Core)</sup>
- 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. <sup>(Core)</sup>
- 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. <sup>(Core)</sup>
- VI.F.3.a).(1).(a)** Additional patient care responsibilities must not be assigned to a resident during this time. <sup>(Core)</sup>
- 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; <sup>(Detail)</sup>
- VI.F.4.a).(2)** humanistic attention to the needs of a patient or family; or, <sup>(Detail)</sup>
- VI.F.4.a).(3)** to attend unique educational events. <sup>(Detail)</sup>
- VI.F.4.b)** These additional hours of care or education will be counted toward the 80-hour weekly limit. <sup>(Detail)</sup>
- VI.F.4.c)** A Review Committee may grant rotation-specific exceptions



**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. <sup>(Core)</sup>**

**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. <sup>(Core)</sup>**

**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. <sup>(Detail)</sup>**

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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.

**Osteopathic Recognition**

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.

[http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic\\_Recognition\\_Requirements.pdf](http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf)