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4 **ACGME Common Program Requirements in Bold**

5 ~~Deletions are noted with a strikethrough~~

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7 Additions are underscored

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9 **PROGRAM REQUIREMENTS FOR**
10 **RESIDENCY TRAINING IN PSYCHIATRY**

11 **I. Introduction**

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13 A. Definition

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15 An approved residency program in psychiatry ~~must provide an educational~~
16 ~~experience~~ is designed to ensure that its graduates will possess sound
17 clinical judgment, requisite skills, and a high order of knowledge about the
18 diagnosis, treatment, and prevention of all psychiatric disorders, together
19 with other common medical and neurological disorders that relate to the
20 practice of psychiatry. Upon completion of training residents are expected
21 to be able to render effective professional care to psychiatric patients.
22 ~~Although residents cannot be expected to achieve the highest possible~~
23 ~~degree of expertise in all of the diagnostic and treatment procedures used~~
24 ~~in psychiatry in 4 years of training, those individuals who satisfactorily~~
25 ~~complete residency programs in psychiatry must be competent to render~~
26 ~~effective professional care to patients.~~ They also must, furthermore, have a
27 keen awareness of their own strengths and limitations, and recognize ~~of~~
28 the necessity for continuing their own professional development. The
29 didactic and clinical program must be of sufficient breadth and depth to
30 provide residents with a thorough and well-balanced presentation of
31 psychological, sociocultural, and neurobiological observations, and
32 theories relevant to the practice of psychiatry along with the ~~and~~
33 knowledge of major diagnostic and therapeutic procedures in the field of
34 psychiatry. The program must prepare residents to ~~also provide the~~
35 ~~education and training necessary to~~ understand the major psychiatric
36 literature, to evaluate the reliability and validity of scientific studies, and
37 to ~~incorporate~~ appropriately incorporate new knowledge into the practice
38 of psychiatry. ~~medicine.~~
39 ~~Programs are expected to operate in accordance with the AAMA~~
40 ~~Principles of Ethics with Special Annotations for Psychiatry, and to ensure~~
41 ~~that the application and teaching of these principles are an integral part of~~
42 ~~the educational process.~~

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44 B. Duration and Scope of Education

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46 1. Admission Requirements

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Physicians may enter psychiatry programs at either the first-year or second-year postgraduate level. Physicians ~~entering may enter programs~~ at the second-year postgraduate level must document only after successful completion of one of the following: clinical year of training in an ACGME specialty requiring comprehensive and continuous patient care, such as a program in internal medicine, family practice, pediatrics, or transitional year program. For physicians entering at the PG-2 level after completion of such a program, the PG-1 year may be credited toward the 48 month requirement.

- a) ~~one clinical year of training in a program in internal medicine, family practice, or pediatrics accredited by the Accreditation Council for Graduate Medical Education (ACGME);~~
- b) ~~A transitional year program accredited by the ACGME;~~
- c) ~~one year of an ACGME accredited residency in a clinical specialty requiring comprehensive and continuous patient care;~~

~~For physicians entering at the PG-2 level, the PG-1 year may be credited toward the 48-month requirement~~

2. Length of the Program

- a) ~~A complete Training in psychiatry residency is requires 48 months; of which twelve of these months may be spent completed in an ACGME-approved accredited child and adolescent psychiatry program residency. Accreditation by the ACGME is required for all years of the training program. Programs may not permit residents to use vacation time or other benefit time to advance the date of graduation from training. Although residency is best completed on a full-time basis; part-time training at no less than half-time is permissible to accommodate residents with personal commitments (e.g., child care).~~
- b) ~~Any program that alters the length of training beyond these minimum requirements must present a clear educational rationale consistent with the Program Requirements and objectives for residency training. A program may petition the RC (Review Committee) to alter the length of training beyond these minimum requirements by presenting a clear~~

93 educational rationale consistent with the Program
94 Requirements and objectives for residency training. The
95 program director must obtain the approval of the
96 sponsoring institution and the ~~Residency Review~~
97 ~~Committee (RRC) RC~~ prior to implementation and at each
98 subsequent review of the program.
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- 100 c) Prior to entry into the program, each resident must be
101 notified in writing of the required length of training for
102 which the program is accredited. The required length of
103 training for a particular resident may not be changed
104 without mutual agreement during his or her program,
105 unless there is a break in the resident's training or unless
106 the resident requires remedial training.
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108 d) Programs should meet all of the Program Requirements of
109 Residency Training in Psychiatry. Under rare and unusual
110 circumstances, 1 or 2 year programs of ~~either one year or~~
111 ~~2 year duration~~ may be approved, even though they do not
112 meet all of the above requirements for psychiatry. Such
113 ~~one- 1 or 2-year~~ programs will be approved only if they
114 provide some highly specialized educational and/or
115 research program. ~~Also, such programs will be approved~~
116 ~~only if they~~ These programs may provide an alternative
117 specialized year or two but do not provide complete
118 Residency Training in Psychiatry. The traditional program
119 time and the specialized program must ensure that residents
120 will complete the didactic and clinical requirements
121 outlined in the Program Requirements.
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123 3. ~~Program Format by Year of Training~~ First Year of Training

124 a) First Year of Training

125 ~~A psychiatric first postgraduate year must include at least 4~~
126 ~~months in internal medicine, family practice, and/or~~
127 ~~pediatrics. This training must be in a clinical setting which~~
128 ~~provides comprehensive and continuous patient care.~~
129 The program director of the psychiatry residency program
130 must maintain contact with residents during the first
131 postgraduate-year while they are on services other than
132 psychiatry. A psychiatric first postgraduate-year must
133 include at least

- 134 (1) (a) ~~Neurology rotations may not be used to fulfill this~~
135 ~~4-months requirement.~~ in internal medicine, family
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medicine, and/or pediatrics. This training must be in a clinical setting that provides comprehensive and continuous patient care. Neurology rotations may not be used to fulfill this 4-month requirement. 1 month, but no more of this requirement may be fulfilled by an emergency medicine or intensive care rotation, provided the experience is predominantly with medical evaluation and treatment and not surgical procedures.

- (b) 6 but no more than 8 months in psychiatry.
- (c) 2 or more FTE months of neurology, of which one month may be inpatient or outpatient child neurology. It is highly desirable that neurology is completed during the first postgraduate-year.
- ~~(2) — One month, but no more, of this requirement may be fulfilled by an emergency medicine or intensive care rotation, provided the experience is predominantly with medical evaluation and treatment and not surgical procedures.~~
- ~~(3) — A psychiatric first postgraduate year should not include more than 6 months in psychiatry, and must not include more than 8 months in psychiatry.~~
- ~~(4) — A minimum of 2 months of neurology, or its full-time equivalent on a part-time basis, is required prior to completion of training. It is highly desirable that this experience occur during a psychiatric first postgraduate year, and it may include a maximum of one month of supervised inpatient or outpatient child neurology.~~
- ~~(5) — The program director of the Department of Psychiatry must maintain contact with residents during the first postgraduate year while they are on services other than psychiatry.~~

b) Second through Fourth Years of Training

~~Although some of the training described below may be offered in the first postgraduate year, all must be completed prior to graduation from the program.~~

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- (1) ~~The program must have an explicitly described educational curriculum which covers the broad spectrum of clinical psychiatry as outlined in Section V B 1 a) through m).~~

- (2) ~~The formal didactic instruction must include regularly scheduled lectures, teaching rounds, seminars, clinical conferences, and required reading assignments covering the topics identified in Section V.~~

- (3) ~~There must be an educationally sound balance among time spent in direct patient care, clinical and didactic teaching, and supervision. Formal educational activity shall have high priority in the allotment of the resident's time and energies. Service needs and clinical responsibilities must not prevent the resident from obtaining the requisite didactic educational activities and formal instruction.~~

- (4) ~~Planned Educational Experiences. Each program must offer its residents planned and sufficient educational experiences. These educational experiences should include presentations based on a defined curriculum, journal review, administrative seminars, and research methods. They may include, but are not limited to, problem based learning, laboratories, and computer based instruction, as well as joint conferences cosponsored with other disciplines. The program should ensure that residents are relieved of non emergent clinical duties in order to attend these planned educational experiences. Although release from some off-service rotations may not be possible, the program should require that each resident participate in at least 70% of the planned psychiatry educational experiences offered (excluding vacations). Attendance must be monitored and documented.~~

II. Institutions

A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this

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responsibility extends to resident assignments at all participating institutions.

- ~~1. Programs should be conducted under the sponsorship of an institution that meets the Institutional Requirements that apply to residency programs in all specialties, as outlined in the Essentials of Accredited Residencies.~~
1. The administration of the sponsoring institution(s) should be understanding of and sympathetic to the attainment of educational goals, and should evidence its willingness and ability to support these goals philosophically and financially. The latter includes a commitment by the institution and by the program that embraces appropriate compensation for faculty and residents, adequate offices and educational facilities, support services, and opportunities for research.

B. Participating Institutions

- 1. The sponsoring institution’s Designated Institutional Officer (DIO) must review and approve all participating institutions and submit changes to the ACGME through the Accreditation Data System.**
2. Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.
- 3. Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:**
 - a) Identify the faculty who will assume both educational and supervisory responsibilities for residents;**
 - b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
 - c) specify the duration and content of the educational experience; and**
 - d) state the policies and procedures that will govern resident education during the assignment;**

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- e) state the expected educational outcomes; and
- f) specify the mechanism for formal evaluation of residents.

3. ~~It is important that each affiliated institution demonstrate significant commitment to the overall program. The educational rationale for including each institution within the program must be stated.~~ The number and distribution of participating training sites must not preclude satisfactory participation by residents in teaching and didactic exercises. Geographic proximity will be one factor in evaluating program cohesion, continuity, and peer interaction. ~~critical mass. Affiliated training sites will be evaluated on the basis of whether they contribute to a well integrated educational program, with respect to both didactic and clinical experiences.~~

III. Program Personnel and Resources

A. Chair of Psychiatry

The chair of psychiatry must be:

1. licensed to practice medicine in the state where the institution that sponsors the program is located. (Certain federal programs are exempted.)
2. a member of the program's core teaching faculty;
3. qualified and have at least three years' experience as a clinician, administrator, and educator in psychiatry;
4. certified in psychiatry by the American Board of Psychiatry and Neurology or possess appropriate qualifications judged to be acceptable by the RC;
5. actively involved in psychiatry through:
 - a) continuing medical education,
 - b) professional societies,
 - c) scholarly activities, and
6. capable of mentoring medical faculty, residents, administrators and other health care professionals, and possess medical

321 leadership qualifications consistent with other physician chairs
322 within the sponsoring institution.

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324 **B. Program Director**

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327 **1. There must be a single program director responsible for the**
328 **program. The person designated with this authority is**
329 **accountable for the operation of the program. In the event of a**
330 **change of either program director or department chair, the**
331 **program director should promptly notify the executive**
332 **director of the Residency Review Committee (RRC) through**
333 **the Web Accreditation Data System of the Accreditation**
334 **Council for Graduate Medical Education (ACGME).**
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336 **2. The program director, together with the faculty, is responsible**
337 **for the general administration of the program, and for the**
338 **establishment and maintenance of a stable educational**
339 **environment. Adequate lengths of appointment for both the**
340 **program director and faculty are essential to maintaining such**
341 **an appropriate continuity of leadership.**
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343 **3. Qualifications of the program director are as follows:**
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345 **a) The program director must possess the requisite**
346 **specialty expertise, as well as documented educational**
347 **and administrative abilities.**
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349 **b) The program director must be certified in the specialty**
350 **by the American Board of Psychiatry and Neurology, or**
351 **possess qualifications judged to be acceptable by the**
352 **RRC.**
- 353
354 **c) The program director must be appointed in good**
355 **standing and based at the primary teaching site.**
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357 **4. Responsibilities of the program director are as follows:**
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359 **a) The program director must oversee and organize the**
360 **activities of the educational program in all institutions**
361 **that participate in the program. This includes selecting**
362 **and supervising the faculty and other program**
363 **personnel at each participating institution, appointing a**
364 **local site director, and monitoring appropriate resident**
365 **supervision at all participating institutions.**
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- b) **The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME’s Accreditation Data System.**
- c) **The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**
- d) **The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:**
 - (1) **the addition or deletion of a participating institution;**
 - (2) **a change in the format of the educational program;**
 - (3) **a change in the approved resident complement for those specialties that approve resident complement.**

On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.

- 5. The Program Director must be provided a minimum of 50% protected time to fulfill program leadership responsibilities that include:
 - a) oversight and organization of didactic and clinical education in all institutions that participate in the program;
 - b) supervision of the faculty and other program personnel at each participating institution;
 - c) authority to appoint a local site director who is accountable for resident experience at the participating site;
 - d) supervision of residents at all participating institutions;

- 413 e) provision of input in the selection of program faculty as
414 appropriate
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- 416 f) compliance with grievance and due process procedures as
417 set forth in the Institutional Requirements and implemented
418 by the sponsoring institution; and,
- 419
- 420 g) Obtaining the prior approval of the DIO and the RC for any
421 changes in the program that may significantly alter the
422 educational experience of the residents. Significant
423 program changes may result in an immediate site visit and
424 program review.
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427 C. Associate Program Director

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429 An Associate Program Director is a member of the teaching faculty who assists
430 the program director in the administrative and clinical oversight of the educational
431 program. The sponsoring Institution must provide Associate Program Directors
432 based on program size. At a minimum, one Associate Program Director is
433 required for an approved complement of 24 and 40 residents, and two Associate
434 Program Directors for an approved complement of 41 to 79 residents. When a
435 program is approved for 80 or more residents, there must be additional support for
436 a third Associate Program Director. Associate Program Directors must be
437 provided a minimum of 25% protected time to fulfill program responsibilities.

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439 **D. Faculty**

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- 441 **1. At each participating institution, there must be a**
442 **sufficient number of faculty with documented**
443 **qualifications to instruct and supervise adequately all**
444 **residents in the program. . Programs with large patient**
445 **populations, multiple institutions, and large resident**
446 **complements will be expected to have the number of**
447 **physician faculty appropriate to the program's size and**
448 **structure.**
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- 451 **2. The faculty, furthermore, must devote sufficient time to**
452 **the educational program to fulfill their supervisory and**
453 **teaching responsibilities. They must demonstrate a**
454 **strong interest in the education of residents, and must**
455 **support the goals and objectives of the educational**
456 **program of which they are a member.**
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- 458 **3. Qualifications of the physician faculty are as follows:**

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- a) **The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.**
- b) **The physician faculty must be certified in the specialty by the American Board of Psychiatry and Neurology, or possess qualifications judged to be acceptable by the RRC.**
- c) **The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**
- d) In addition, the faculty must
 - (1) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities;
 - (2) demonstrate a strong interest in the education of residents by supporting the goals and objectives of the educational program of which they are members, and
 - (3) participate in the planning, organization, and presentation of conferences as well as in clinical teaching and supervision

4. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. *Scholarship* is defined as the following:

- a) **the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;**
- b) **the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks; and,**
- c) **the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.**

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Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities, as evidenced by the following:

1. peer-reviewed funding or publication of original research in peer-reviewed journals or review articles or chapters in textbooks;
2. publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings;
3. regular participation in organized clinical discussions, rounds, journal clubs, and research conferences; and
4. provision of support for residents' participation in scholarly activities.

5. Qualifications of the nonphysician faculty are as follows:

- a) **Nonphysician faculty must be appropriately qualified in their field.**
- b) **Nonphysician faculty must possess appropriate institutional appointments.**

C. Other Program Personnel

Additional necessary professional, technical, and clerical personnel must be provided to support the program.

D. Resources

- 1) **The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available. The percent of dedicated time for a residency coordinator should be adequate for the size and complexity of the training program.**

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2) Other Resource Support

- a. Training programs must have available to them adequate inpatient and outpatient facilities and other suitable clinical placements where the residents can meet the educational objectives of the program. The program should specify the facilities in which the goals and objectives are to be implemented.
- b. All residents must have available to them offices adequate in size and decor to allow them to interview patients and accomplish their duties in a professional manner. The facility must also provide adequate and specifically-designated areas in which residents can perform basic physical examination and other necessary diagnostic procedures and treatment interventions.
- c. The administration of the facility where the program is located must provide ample space and equipment for educational activities. There must be adequate space and equipment specifically designated for seminars, lectures, and other teaching exercises.
- d. The program must have available audiovisual equipment and teaching material such as films, DVD, audio cassettes, and/or videotapes, as well as the capability to record and play back educational technology.

E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format and to computerized literature search capabilities and electronic medical databases in each participating institution at all times.

~~There must be evidence of scholarly activity among the faculty psychiatrists. Although not all members of a faculty need to be investigators, scholarly activities should be present on a continuous basis. There should also be evidence of participation in a spectrum of academic and professional activities within the institution, as well as within local and national associations.~~

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6. — ~~The faculty must participate regularly and systematically in the training program, and must be readily available for consultation whenever a resident is faced with a major therapeutic or diagnostic problem.~~
7. — ~~The faculty psychiatrists should actively participate in the planning, organization, and presentation of conferences as well as in clinical teaching and supervision.~~
8. — ~~A member of the teaching staff of each participating institution must be designated to assume responsibility for the day-to-day activities of the program at that institution, with overall coordination by the program director.~~
9. — ~~The teaching staff must be organized, and have regular documented meetings to review program goals and objectives as well as program effectiveness in achieving them. At least one resident representative should participate in these reviews.~~
1. — ~~All programs must have adequate patient populations for each mode of required training and, minimally, must include organized clinical services in inpatient, outpatient, emergency, consultation/liaison, and child and adolescent psychiatry.~~
2. — ~~Training programs must have available to them adequate inpatient and outpatient facilities and other suitable clinical placements where the residents can meet the educational objectives of the program. The program should specify the facilities in which the goals and objectives are to be implemented.~~
3. — ~~All residents must have available to them offices adequate in size and decor to allow them to interview patients and accomplish their duties in a professional manner. The facility must also provide adequate and specifically designated areas in which residents can perform basic physical examination and other necessary diagnostic procedures and treatment interventions.~~
4. — ~~Other Educational Resources~~
 - a) — ~~The administration of the facility where the program is located must provide ample space and equipment for educational activities. There must be adequate space and~~

- 640 equipment specifically designated for seminars, lectures,
641 and other teaching exercises.
- 642 _____
- 643 b) ~~the program must have available audiovisual equipment and~~
644 ~~teaching material such as films, audio cassettes, and~~
645 ~~videotapes, as well as the capability to record and play back~~
646 ~~educational videotapes.~~
- 647 _____
- 648 c) ~~residents must have ready access to a major medical~~
649 ~~library, either at the institution where the residents are~~
650 ~~located or through arrangement with convenient nearby~~
651 ~~institutions. Library services should include the electronic~~
652 ~~retrieval of information from medical databases.~~
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- 654 d) ~~there must be access to an on site library and/or to an~~
655 ~~electronic collection of appropriate texts and journals. On-~~
656 ~~site libraries and/or collections of texts and journals~~
657 ~~must be readily available during nights and weekends. This~~
658 ~~library should provide:~~
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- 660 (1) ~~a substantial number of current basic textbooks in~~
661 ~~psychiatry, neurology and general medicine;~~
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- 663 (2) ~~a number of the major journals in psychiatry,~~
664 ~~neurology, and medicine sufficient for an excellent~~
665 ~~educational program;~~
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- 667 (3) ~~the capability to obtain textbooks and journals on~~
668 ~~loan from major medical libraries;~~
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- 670 (4) ~~the capability to perform MEDLINE or other~~
671 ~~medical information searches (or ready access to a~~
672 ~~library that has this capacity); and~~
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- 674 (5) ~~access to the internet.~~
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- 676 e) ~~Each clinical service must have a mechanism that ensures~~
677 ~~that charts are appropriately maintained and readily~~
678 ~~accessible for regular review for supervisory and~~
679 ~~educational purposes. Randomly selected charts will be~~
680 ~~reviewed at the time of survey.~~

681 E. ~~Chair of Psychiatry~~

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684 ~~The chair of psychiatry must be a physician, and must either be certified~~
685 ~~by the American Board of Psychiatry and Neurology or judged by the~~
686 ~~RRC to possess appropriate educational qualifications.~~

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688 ~~F. Education Policy Committee~~

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690 ~~The director of the residency program should have an educational policy~~
691 ~~committee composed of members of the psychiatry program teaching staff~~
692 ~~that includes representation from the residents as well as a member of the~~
693 ~~teaching staff from each ACGME approved subspecialty residency that~~
694 ~~may be affiliated with the psychiatry residency. There should be a written~~
695 ~~description of the committee, including its responsibility to the sponsoring~~
696 ~~department or institution and to the program director. This committee~~
697 ~~should participate actively in:~~

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699 ~~1. planning, developing, implementing, and evaluating all significant~~
700 ~~features of the residency program, including the selection of~~
701 ~~residents (unless there is a separate residency selection committee);~~

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704 ~~2. determining curriculum goals and objectives; and~~

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706 ~~3. evaluating both the teaching staff and the residents.~~

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708 **IV. Resident Appointments**

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710 **A. Eligibility Criteria**

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

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716 **B. Number of Residents**

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718 **The RRC may approve the number of residents based upon**
719 **established written criteria that include the adequacy of resources for**
720 **resident education (e.g., the quality and volume of patients and**
721 **related clinical material available for education), faculty-resident**
722 **ratio, institutional funding, and the quality of faculty teaching.**

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724 To promote an educationally sound, intellectually stimulating atmosphere
725 and effective graded responsibility, programs must maintain a critical
726 mass of at least three residents at each level of training, except at the PG-4
727 level when critical mass is less than three owing to residents entering child
728 and adolescent psychiatry.

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C. Resident Transfers

To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.

- 1) The level at which a transferring resident will enter the receiving program is based upon written verification of previous educational experiences and the performance evaluation of the resident from the program he or she is leaving. This information must be received in writing prior to acceptance into the receiving program. A program director will provide timely verification of residency education for residents who leave the program prior to completion of training.
- 2) A documented procedure must be in place for evaluating the credentials, clinical training experiences, past performance, and professional integrity of residents transferring from one program to another, including from a general psychiatry to a child and adolescent psychiatry program.

D. Appointment of Fellows and Other Students

The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities available to regularly appointed residents.

- ~~1. The program director is responsible for maintaining a process for selecting resident physicians who are personally and professionally suited for training in psychiatry. It is highly desirable that each program have a residency selection committee to advise the program director.~~
- ~~2. All programs should state specifically and as clearly as possible the objectives and competencies required for successful completion of the program. These objectives and criteria should be made available to residency applicants.~~
- ~~3. The residency program director must accept only those applicants whose qualifications for residency include sufficient command of~~

776 English to facilitate accurate, unimpeded communication with
777 patients and teachers.
778
779 4. All programs should state specifically and as clearly as possible the
780 objectives and competencies required for successful completion of
781 the program. These objectives and criteria should be made
782 available to residency applicants.
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784
785 1. In order to promote an educationally sound, intellectually
786 stimulating atmosphere of effective and graded responsibility,
787 programs must maintain a critical mass of at least 3 residents at
788 each level of training. Programs that fall below this prescribed
789 critical mass will be reviewed, and if this deficiency is not
790 corrected, they may be cited for noncompliance, except when the
791 number of PG 4 residents is below critical mass owing to residents
792 entering child and adolescent psychiatry training.
793
794 2. Programs in which the number of residents exceeds the resources
795 of patient population, faculty, or facilities for adequate training
796 will be found deficient on the basis of size.
797
798 3. Any permanent change in the number of approved positions
799 requires prior approval by the RRC (Programs seeking interim
800 approval of a permanent increase in the number of approved
801 resident positions should contact the Executive Director of the
802 RRC). Prior approval is not required for temporary changes in
803 resident numbers owing to makeup or remedial time for currently
804 enrolled residents, or to fill vacancies. Approval of permanent
805 increases above the approved range of residents will require
806 documentation that didactic and clinical training, including
807 supervision, will not be compromised.
808
809
810 1. The program must document the procedures used to select
811 residents. Application records must contain complete information
812 from medical schools and graduate medical education programs. A
813 documented procedure must be in place for evaluating the
814 credentials, clinical training experiences, past performance, and
815 professional integrity of residents transferring from one program to
816 another, including from a general psychiatry to a child and
817 adolescent psychiatry program. This procedure must include
818 solicitation and documentation of relevant information from the
819 training directors of the previous programs participated in by the
820 transferring resident. This documentation must specify all clinical
821 and didactic experiences for which the resident has been given

822 credit. Those residents selected at the second postgraduate year or
823 above must have satisfied the training objectives cited above for
824 reaching that level of training.

825

826 2. ~~A transferring resident's educational program must be sufficiently~~
827 ~~individualized so that he/she will have met all the educational and clinical~~
828 ~~experiences of the program, as accredited, prior to graduation.~~

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831 V. Educational Program

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833 A. Program Design

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835 All programs must have an adequate number of teaching faculty and patient
836 populations for each mode of required training and, minimally, must include
837 organized clinical services in inpatient, outpatient, emergency psychiatry,
838 consultation/liaison, and child and adolescent psychiatry.

839

840

841 1. Goals and Objectives

842

843 **The program must possess a written statement that outlines its**
844 **educational goals with respect to the knowledge, skills, and**
845 **other attributes of residents for each major assignment and for**
846 **each level of the program. This statement must be distributed**
847 **to residents and faculty, and must be reviewed with residents**
848 **prior to their assignments. All educational components of a**
849 **residency program should be related to program goals.**

850

851 a) — Objectives of Training

852

853 (1) — First Year

854

855 ~~The training obtained during the first postgraduate~~
856 ~~year should provide residents with medical skills~~
857 ~~most relevant to psychiatric practice. These include~~
858 ~~being able to:~~

859

860 (a) — perform a complete initial history and
861 physical examination, including appropriate
862 diagnostic studies;

863

864 (b) — diagnose common medical and surgical
865 disorders, and to formulate appropriate
866 initial treatment plans;

867

- 868 (e) — provide limited, but appropriate, continuous
869 care of patients with medical illnesses, and
870 to make appropriate referrals;
871
872 (d) — be especially conversant with medical
873 disorders displaying symptoms likely to be
874 regarded as psychiatric, and with psychiatric
875 disorders displaying symptoms likely to be
876 regarded as medical;
877
878 (e) — be especially cognizant of the nature of the
879 interactions between psychiatric treatments
880 and medical and surgical treatments; and
881
882 (f) — be able to relate to patients and their
883 families, as well as other members of the
884 healthcare team with compassion, respect,
885 and professional integrity.
886

887 (2) — Second Through Fourth Years
888

889 The program must provide a well planned,
890 high-quality curriculum that includes
891 specific, assessable objectives for program
892 components as well as criteria for
893 graduation. These must be stated in writing
894 and provided to each resident and faculty
895 member. Residents must be taught to
896 conceptualize all illnesses in terms of
897 biological, psychological, and sociocultural
898 factors that determine normal and abnormal
899 behavior. They must be educated to gather
900 and organize data, integrate these data
901 within a comprehensive formulation of the
902 problem to support a well reasoned
903 differential diagnosis, formulate a treatment
904 plan, and implement treatment and follow-
905 up care as required. The program must
906 provide residents with sufficient
907 opportunities to develop knowledge, clinical
908 skills, sensitivity to cultural diversity, and
909 professional principles.
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- 911 (a) — The didactic curriculum should include:
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- i) — critical appraisals of the major theories and viewpoints in psychiatry, together with a thorough grounding in the generally accepted clinical facts;
 - ii) — presentation of the biological, psychological, socio-cultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle;
 - iii) — presentation of the etiologies, prevalence, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, socio-cultural, and iatrogenic factors that affect the long term course and treatment of psychiatric disorders and conditions;
 - iv) — comprehension of the diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, such as neoplasms, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, multiple sclerosis, Parkinson's disease, seizure disorders, stroke, intractable pain, and other related disorders;
 - v) — the use, 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;

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- vi) — the financing and regulation of psychiatric practice, including information about the structure of public and private organizations that influence mental health care;
 - vii) — medical ethics as applied to psychiatric practice;
 - viii) — the history of psychiatry and its relationship to the evolution of medicine;
 - ix) — the legal aspects of psychiatric practice;
 - x) — when and how to refer; and
 - xi) — research methods in the clinical and behavioral sciences related to psychiatry.
- b) — Clinical training should provide sufficient experiences in:
- _____
 - i) — the elements of clinical diagnosis with all age groups (of both sexes, to include some ethnic minorities), such as interviewing; clear and accurate history taking; physical, neurological, and mental status examination; and complete and systematic recording of findings;
 - _____
 - ii) — relating history and clinical findings to the relevant biological, psychological, behavioral, and socio-cultural issues associated with etiology and treatment;
 - _____
 - iii) — formulating a differential diagnosis and treatment plan for all psychiatric disorders in the current standard nomenclature, taking into consideration all relevant data;

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- iv) — the major types of therapy, including short and long term individual psychotherapy, psychodynamic psychotherapy, family/couples therapy, group therapy, cognitive and behavior therapy, crisis intervention, drug and alcohol detoxification, and pharmacological regimens, including concurrent use of medications and psychotherapy;
 - v) — electroconvulsive therapy, a somatic therapy that is viewed as so important that its absence must be justified (Examples of other somatic therapies include biofeedback and phototherapy.);
 - vi) — providing continuous care for a variety of patients from different age groups, seen regularly and frequently for an extended time, in a variety of treatment modalities;
 - vii) — psychiatric consultation in a variety of medical and surgical settings;
 - viii) — providing care and treatment for the chronically mentally ill with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions;
 - ix) — psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance and performance improvement;
 - x) — providing psychiatric care to patients who are receiving treatment from nonmedical therapists and coordinating such treatment;
 - xi) — knowledge of the indications for and limitations of the more common

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psychological and
neuropsychological tests;

xii) —critically appraising the professional
and scientific literature; and

xiii) —teaching psychiatry to medical
students, residents, and others in the
health professions.

B. Specialty Curriculum

The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.

1. Clinical Experience

Carefully supervised clinical care of patients is the core of an adequate program. The clinical services must be so organized that residents have major responsibility for the care of a significant proportion of all patients assigned to them, and have sufficient and ongoing high quality supervision. The number of patients for which residents have primary responsibility at any one time must be adequate enough to permit them to provide each patient with appropriate treatment, and to have sufficient time for other aspects of their educational program. At the same time, the total number must be large enough to provide an adequate depth and variety of clinical experiences. The amount and type of patient care responsibility a resident assumes must increase as the resident advances in training. Each resident must have major responsibility for the diagnosis and treatment of a reasonable number and adequate variety of patients with both acute and chronic illnesses representing the major psychotic and nonpsychotic categories of psychiatric diagnoses/conditions. Adequate experience in the diagnosis and management of the medical and neurological disorders encountered in psychiatric practice also must be ensured. Each resident must have supervised experience in the evaluation and treatment of patients of different ages throughout the life cycle and from a variety of ethnic, racial, sociocultural, and economic backgrounds. It is desirable that residents have didactic learning and supervised experiences in the delivery of psychiatric services in the public sector and in managed care health systems. The

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clinical experiences are to be designed to develop the requisite skills as outlined in Section V A 2 a) (2) (b) above. Specific clinical experiences must include the following:

- a) ~~Neurology: Two months of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions. This 2-month experience (or its equivalent if done on a part-time basis) may occur in an inpatient, outpatient, or consultation/liaison setting. A maximum of one month of child neurology may be used toward the 2-month requirement. The 2-month training experience must provide opportunities to conduct initial evaluations, to participate in the subsequent diagnostic process, and to follow patients during the treatment and/or evolution of their neurological disorders/conditions. The training in neurology should have sufficient didactic and clinical experience for residents to develop expertise in the diagnosis of those neurological disorders/conditions that might reasonably be expected to be encountered in psychiatric practice and which must be considered in the differential diagnosis of psychiatric disorders/conditions.~~

- b) ~~Inpatient: Significant responsibility for the assessment, diagnosis, and treatment of an appropriate number and variety of general psychiatric inpatients for a period of not less than 9 months, but no more than 18 months (or its full-time equivalent if done on a part-time basis). In general, it is highly desirable that the minimum general inpatient experience be 12 months, although it is recognized that in some settings other training opportunities might lead to the absolute minimum of 9 months. The experience must provide residents with sufficient opportunities to develop competence in the intensive biopsychosocial assessment and management of patients with acute mental disorders/conditions. It is recognized that the setting in which this care occurs may vary according to the health care delivery system. Rotations on specialized clinical services such as addiction psychiatry, adolescent psychiatry, forensic psychiatry, geriatric psychiatry, research units, and day and/or partial hospitalization may not totally substitute for the general psychiatric inpatient experience. These may be included to meet the required minimum experiences, with adequate documentation to demonstrate that the experience on such specialized units is with acutely ill patients, and is comparable in breadth, depth, and experience to training on general inpatient~~

1143 psychiatry units. Up to 3 months of rotations on specialized
1144 clinical services as noted above may be applied to the
1145 minimum 9 month requirement. However, no portion of
1146 this experience may be counted to meet the timed
1147 requirement in child and adolescent psychiatry. Experience
1148 in any special unit used to provide inpatient psychiatry
1149 must be under the direction and supervision of a
1150 psychiatrist.

1151
1152 e) — Outpatient: An organized, continuous, and supervised
1153 clinical experience in the assessment, diagnosis, and
1154 treatment of outpatients of at least one year (or its full time
1155 equivalent if done on a part time basis) that emphasizes a
1156 developmental and biopsychosocial approach to outpatient
1157 treatment. At least 80% of this experience must be with
1158 adult patients. A minimum of 20% of the overall
1159 experience (clinical time and patient volume) must be
1160 continuous and followed for a duration of at least one year.
1161 The outpatient requirement must include experience with a
1162 wide variety of disorders, patients, and treatment
1163 modalities, with experience in both brief and long term
1164 care of patients, using individual psychotherapy (including
1165 psychodynamic, cognitive, behavioral, supportive, brief),
1166 and biological treatments and psychosocial rehabilitation
1167 approaches to outpatient treatment. Long term
1168 psychotherapy experience must include a sufficient number
1169 of patients, seen at least weekly for at least one year, under
1170 supervision. Other long term treatment experiences should
1171 include patients with differing disorders and patients who
1172 are chronically mentally ill. No portion of this experience
1173 may be counted to meet the timed requirements in child and
1174 adolescent psychiatry.

1175
1176 d) — Child and Adolescent Psychiatry: An organized clinical
1177 experience under the supervision of child and adolescent
1178 psychiatrists in the evaluation, diagnosis, and treatment of
1179 children, adolescents, and their families. Such experiences
1180 should be no less than 2 months full time equivalent and
1181 involve a sufficient number and variety of patients, by both
1182 age and psychopathology, treated with a variety of
1183 interventional modalities. Residents should have
1184 experiences in determining the developmental status and
1185 needs for intervention with the children of some of their
1186 adult patients, and in consulting with these patients
1187 regarding the referral of their children for psychiatric
1188 services. Residents must have patient care responsibility

1189 under the supervision of child and adolescent psychiatrists
1190 who are certified in child and adolescent psychiatry by the
1191 American Board of Psychiatry and Neurology, or who
1192 possess appropriate educational qualifications. This 2-
1193 month experience may be provided in a variety of settings
1194 (e.g., outpatient). Although adolescent inpatient units may
1195 be used to satisfy a portion of this requirement, rotations to
1196 student health services may not.

1197 e) — Consultation/Liaison: Supervised psychiatric
1198 consultation/liaison responsibility for a minimum of 2
1199 months full-time equivalent, involving adult patients on
1200 other medical and surgical services. On call experiences
1201 may be a part of this training. Up to one month of pediatric
1202 consultation/liaison psychiatry may be credited toward the
1203 2-month requirement.

1204

1205 f) — Emergency Psychiatry: Supervised responsibility on an
1206 organized, 24-hour psychiatric emergency service that is
1207 responsible for evaluation, crisis management, and triage of
1208 psychiatric patients. Instruction and experience should be
1209 provided in the evaluation and management of suicidal
1210 patients. A psychiatric emergency service that is a part of,
1211 or works with, other medical emergency services is
1212 desirable because of the opportunities for collaboration and
1213 educational exchange with colleagues in other specialties.
1214 There must be organized instruction and supervised clinical
1215 opportunities available to residents in emergency
1216 psychiatry that lead to the development of knowledge and
1217 skills in the emergency evaluation, crisis management, and
1218 triage of patients. This should include the assessment and
1219 management of patients who are a danger to themselves or
1220 others, the evaluation and reduction of risk to caregivers,
1221 and knowledge of relevant issues in forensic psychiatry.
1222 There should be sufficient continued contact with patients
1223 to enable the resident to evaluate the effectiveness of
1224 clinical interventions. Although on call experiences may be
1225 a part of this training, such experiences alone will not be
1226 sufficient to constitute adequate training in emergency
1227 psychiatry. A portion of this experience may occur in
1228 ambulatory urgent care settings, but must be separate and
1229 distinct from the 12 months of training designated for the
1230 outpatient requirement.

1231

1232 g) — Community Psychiatry: Supervised responsibility for the
1233 care of persistently and chronically ill patients in the
1234 public sector, (e.g., community mental health centers and

1235 public hospitals and agencies, or other community based
1236 settings). Experiential settings may include residential
1237 treatment centers, community mental health agencies,
1238 vocational rehabilitation centers, and senior citizen
1239 agencies. Opportunities should exist to consult with, learn
1240 about, and use community resources and services in
1241 planning patient care, and to work collaboratively with case
1242 managers, crisis teams, and other mental health
1243 professionals.

1244

1245 h) — Geriatric Psychiatry: One month FTE supervised clinical
1246 management of geriatric patients with a variety of
1247 psychiatric disorders, including familiarity with long term
1248 care in a variety of settings. This may be fulfilled as part of
1249 the inpatient or outpatient requirement.

1250

1251 i) — Addiction Psychiatry: One month FTE supervised
1252 evaluation and clinical management of patients within
1253 inpatient and/or outpatient settings, and familiarity with
1254 rehabilitation and self help groups. This may be fulfilled as
1255 part of the inpatient or outpatient requirement.

1256

1257 j) — Forensic Psychiatry: Experience under the supervision of a
1258 psychiatrist in evaluation of patients with forensic
1259 problems.

1260

1261 k) — Supervised clinical experience in the evaluation and
1262 treatment of couples, families, and groups.

1263

1264 l) — Psychological Testing: Supervised experience with the
1265 more common psychological test procedures, including
1266 neuropsychological assessment, in a number of cases
1267 sufficient to give the resident an understanding of the
1268 clinical usefulness of these procedures and of the
1269 correlation of psychological test findings with clinical data.
1270 Under the supervision and guidance of a qualified clinical
1271 psychologist, residents should have experience with the
1272 interpretation of the psychological tests most commonly
1273 used, some of which experience should be with their own
1274 patients.

1275

1276 m) — Supervised, active collaboration with psychologists,
1277 psychiatric nurses, social workers, and other professional
1278 and paraprofessional mental health personnel in the
1279 treatment of patients.

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~~The didactic and clinical curriculum must be of sufficient breadth and depth to provide residents with a thorough, well balanced presentation of the generally accepted theories, schools of thought, and major diagnostic and therapeutic procedures in the field of psychiatry.~~

1. ACGME General Competencies

The following ACGME competencies must be integrated in an Educational Plan

a. Patient Care

1. Each resident must have supervised experience in the evaluation and treatment of patients of different ages and gender throughout the life cycle and from a variety of ethnic, racial, sociocultural, and economic backgrounds.
2. Residents should be familiar with Axis III conditions that can affect evaluation and care (CNS lesions, HIV/AIDS, GI effects, etc.).
3. Clinical training should be organized to provide patient care experience in the following activities to facilitate trainee's ability to develop competence in:
 - a) formulating a clinical diagnosis for patients in all age groups (of both sexes, to include some ethnic minorities) by conducting patients interviews, conducting a clear and accurate history; physical, neurological, and mental status examination; and completing a systematic recording of findings; relating history and clinical findings to the relevant biological, psychological, behavioral, and sociocultural issues associated with etiology and treatment;
 - a) ~~The curriculum must include a significant number of interdisciplinary clinical conferences and didactic seminars for residents in which psychiatric faculty members collaborate with neurologists, internists, and colleagues from other medical specialties and mental health disciplines.~~

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- b) formulating a differential diagnosis and treatment plan for all psychiatric disorders in the current standard nomenclature, i.e., DSM, taking into consideration all relevant data;
 - ~~b) Clinical training must include adequate, regularly scheduled, individual supervision. Each resident must have at least 2 hours of individual supervision weekly, in addition to teaching conferences and rounds, except when on non-psychiatric rotations.~~
 - c) using pharmacological regimens, including concurrent use of medications and psychotherapy;
 - ~~e) Didactic instruction must be systematically organized, thoughtfully integrated, based on sound educational principles, and include prepared lectures, seminars, and assigned readings that are carried out on a regularly-scheduled basis. In a progressive fashion, it should expose residents to topics appropriate to their level of training, as outlined in Section V A 2. Staff meetings, clinical case conferences, journal clubs, and lectures by visiting professors are desirable adjuncts, but must not be used as substitutes for an organized didactic curriculum.~~
 - d) Understanding the indications and uses of electroconvulsive therapy;
 - ~~d) The curriculum must include adequate and systematic instruction in neurobiology; psychopharmacology, and other clinical sciences relevant to psychiatry, child and adult development; major psychological theories, including learning theory, psychodynamic theory, and appropriate material from the sociocultural and behavioral sciences such as sociology and anthropology. The curriculum should address development, psychopathology, and topics relevant to treatment modalities employed with patients with severe psychiatric disorders/conditions.~~
 - e) applying supportive, psychodynamic, and cognitive-behavioral psychotherapies (including brief and long-term individual practice), and exposure to other evidenced based individual-based psychotherapies, family/couples, group therapies;

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- e) ~~The residency program should provide its residents with instruction about American culture and subcultures, particularly those found in the patient community associated with the training program. This instruction should include such issues as gender, race, ethnicity, socioeconomic status, religion/spirituality, and sexual orientation. Many physicians may not be sufficiently familiar with attitudes, values, and social norms prevalent among various groups of contemporary Americans. Therefore, the curriculum should contain enough instruction about these issues to enable residents to render competent care to patients from various cultural and ethnic backgrounds. Providing an understanding of cultural diversity by devoting sufficient didactic training to residents whose cultural backgrounds are different from those of their patients, and provide a suitable educational program for them as well.~~
- f) providing continuous care for a variety of patients from different age groups, seen regularly and frequently for an extended time, in a variety of treatment modalities;
- f) ~~Didactic exercises must include resident presentation and discussion of clinical case material at conferences attended by faculty and fellow residents. This training should involve experiences in integrative case formulation that includes neurobiological, phenomenological, psychological, and sociocultural issues involved in the diagnosis and management of cases presented.~~
- g) providing psychiatric consultation in a variety of medical and surgical settings;
- h) providing care and treatment for the chronically-mentally ill with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions;
- i) participating in psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance and performance improvement;
- j) providing psychiatric care to patients who are receiving treatment from nonmedical therapists and coordinating such treatment

1417 k) recognizing and appropriately responding to family
1418 violence (e.g., child, partner, and elder physical, emotional,
1419 and sexual abuse and neglect) and its effect on both victims
1420 and perpetrators

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1422 ~~3. Clinical Records~~

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1424 4. Other Patient Care Experiences and Rotations

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1426 ~~Clinical records must reflect the residents' ability to:~~

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1428 ~~a) record an adequate history and perform mental status, physical,~~
1429 ~~and neurological examinations;~~

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1431 a) Clinical services must be organized to allow residents to
1432 have major responsibility for the care of a significant
1433 number of patients with acute and chronic psychiatric
1434 illnesses.

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1436 ~~b) organize a comprehensive differential diagnosis and discussion of~~
1437 ~~relevant psychological and sociocultural issues;~~

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1439 b) Patient care assignments must permit residents provide
1440 appropriate treatment, and to have sufficient time for other
1441 aspects of their educational program. The total number of
1442 patients assigned must be large enough to provide a variety
1443 of clinical experiences.

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1445 ~~e) proceed with appropriate laboratory and other diagnostic~~
1446 ~~procedures;~~

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1449 5) Residents must be provided structured clinical experiences
1450 that are organized to provide opportunities to conduct
1451 initial evaluations, to participate in the subsequent
1452 diagnostic process, and to follow patients during the
1453 treatment phase. and/or evolution of their neurological
1454 disorders/conditions. Required experiences include the
1455 following:

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1457 ~~d) develop and implement an appropriate treatment plan followed by~~
1458 ~~regular and relevant progress notes; and~~

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1460 ~~e) prepare an adequate discharge summary and plan.~~

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(a) Neurology: Two FTE²³ months of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions.

(b) Inpatient Psychiatry: A program may provide up to 16 months of inpatient psychiatry of which there must be 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, day hospital programs, research units, residential treatment programs, and other settings that meet the following criteria:

(1) The patient population is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and gender; and,

(2) Patient services are comprehensive and continuous and allied medical and ancillary staff are available for backup support (24/7)

(c) Outpatient Psychiatry: A 12-month FTE organized, continuous, and supervised clinical experience in the assessment, diagnosis, and treatment of outpatients with a wide variety of disorders, patients, and treatment modalities, with experience in both brief and long-term care of patients. During the outpatient psychiatry experience at least 80% of the patient population must be adults, and a minimum of 1 of every 5 patients must be seen longitudinally for at least one year. This longitudinal experience should include:

(1) evaluation and treatment of ongoing individual psychotherapy patients, some of whom must be seen at least weekly under supervision

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All timed full time equivalent (FTE) experiences may be completed on a full or part-time basis so long as the stated full-time equivalent experience is met.

- 1503 (2) exposure to multiple treatment modalities that
1504 emphasize developmental, biological, psychological
1505 and social approaches to outpatient treatment, and
1506
1507 (3) opportunities to apply psychosocial rehabilitation
1508 techniques, and to evaluate and treat differing
1509 disorders in a chronically ill patient population

1510
1511 Up to 20% of the patients seen may be children and
1512 adolescents. This portion of training may be used to fulfill
1513 the 2-month Child and Adolescent Psychiatry requirements,
1514 so long as this component of outpatient psychiatry V.B.3
1515 below.

1516
1517 d. Child and Adolescent Psychiatry: A two-month FTE
1518 organized clinical experience in which the residents are:

- 1519
1520 (1) supervised by child and adolescent psychiatrists
1521 who are certified by ABPN or judged by the RC to
1522 have equivalent qualifications,
1523 (2) provided opportunities to assess development and to
1524 evaluate and treat both children and adolescents of
1525 both genders and their families with a variety of
1526 diagnoses and interventional modalities,

1527
1528 e. Geriatric Psychiatry: A one-month FTE organized
1529 experience focused on the evaluation, diagnosis and
1530 treatment of patients with late-life mental disorders.
1531 Training may occur in a variety of settings ranging across
1532 inpatient services, outpatient clinics and long term care
1533 facilities.

1534
1535 f. Addiction Psychiatry: A 1-month FTE organized
1536 experience focused on the evaluation and clinical
1537 management of patients with substance abuse/dependence
1538 problems, including dual diagnosis. Treatment modalities
1539 should include detoxification, management of overdose,
1540 maintenance pharmacotherapy, use of the psychological
1541 and social consequences of addiction in confronting and
1542 intervening in chronic addiction rehabilitation techniques

- 1543 used in recovery stages from pre-contemplation to
1544 maintenance, and the use of self-help groups.⁴
1545
1546 g. Consultation/Liaison: A 2-month FTE organized
1547 experience focused on exposing residents to adult patients
1548 on other medical and surgical services. On-call
1549 experiences may be a part of this training. One month of
1550 pediatric consultation/liaison psychiatry is an acceptable
1551 equivalent for meeting 1 month of the 2-month
1552 requirement.
1553
1554 h. Forensic Psychiatry: This un-timed experience must
1555 expose residents to the evaluation of patients with forensic
1556 problems, such as patients who face criminal charges,
1557 competency to stand trial, criminal responsibility,
1558 commitment, assessment of dangerousness and/or writing a
1559 forensic report. Giving testimony in court where feasible is
1560 highly desirable.
1561
1562 i. Emergency Psychiatry: This un-timed experience must be
1563 conducted in an organized, 24-hour psychiatric emergency
1564 service, a portion of which may occur in ambulatory
1565 urgent-care settings, but not as part of the 12-month
1566 outpatient requirement. Residents must be provided
1567 experiences in evaluation, crisis evaluation and
1568 management, and triage of psychiatric patients. On-call
1569 experiences may be a part of this training (no more than
1570 50%).
1571
1572 k. Community Psychiatry: This un-timed experience must
1573 expose residents to persistently- and chronically-ill patients
1574 in the public sector, (e.g., community mental health centers
1575 and public hospitals and agencies, or other community-
1576 based settings). Opportunities should exist to consult with,
1577 learn about, and use community resources and services in
1578 planning patient care, and to work collaboratively with case

⁴ Addiction, Community, Forensic, and Geriatric psychiatry can be met as part of the inpatient requirements above the minimum six months, and/or part of the outpatient requirement.

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managers, crisis teams, and other mental health professionals

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. The medical knowledge curriculum must:

1. provide didactic instruction that is systematically organized, thoughtfully integrated, based on sound educational principles, and include prepared lectures, seminars, and assigned readings that are carried out on a regularly- scheduled basis;
2. incorporate systematic instruction in neurobiology; psychopharmacology, genetics, and other clinical sciences relevant to psychiatry, child and adult development; major psychological theories, including learning theory, psychodynamic theory, and appropriate material from the sociocultural and behavioral sciences such as sociology and anthropology;
3. address development, psychopathology, and topics relevant to treatment modalities employed with patients with severe psychiatric disorders/conditions;
4. provide residents with instruction about American culture and subcultures, particularly those found in the patient community associated with the training program;
5. review cultural variables (e.g. gender roles, hierarchies, kinship patterns, value systems, religious/

1612 spiritual beliefs, indigenous medical beliefs) that shape
1613 human development, psychopathology and treatments;
1614 6. provide training in cultural diversity as an essential
1615 characteristic of rendering competent care, especially
1616 for those residents with cultural backgrounds that are
1617 different from those of their patients, and provide a
1618 suitable educational program for them as well; and,
1619 7. involve experiences in integrative case formulation
1620 that includes neurobiological, phenomenological,
1621 psychological, and sociocultural issues involved in the
1622 diagnosis and management of cases presented. The
1623 didactic program must include presentation of the
1624 following:
1625
1626 a) the major theoretical approaches to
1627 understanding the patient-doctor
1628 relationship
1629 b) the biological, psychological,
1630 sociocultural, economic, ethnic, gender,
1631 religious/spiritual, sexual orientation,
1632 and family factors that significantly
1633 influence physical and psychological
1634 development throughout the life cycle;
1635
1636 c) the fundamental principles of the
1637 epidemiology, etiologies, diagnosis,
1638 treatment, and prevention of all major
1639 psychiatric disorders in the current
1640 standard diagnostic statistical manual,
1641 including the biological, psychological,
1642 sociocultural, and iatrogenic factors that
1643 affect the prevention, incidence,
1644 prevalence and long-term course and
1645 treatment of psychiatric disorders and
1646 conditions;
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- d) comprehensive discussions of the diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, such as neoplasm, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, multiple sclerosis, seizure disorders, stroke, intractable pain, and other related disorders;
- e) the use, 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;
- f) the history of psychiatry and its relationship to the evolution of medicine
- g) the legal aspects of psychiatric practice; and when and how to refer
- h) the use and interpretation of psychological testing (under the supervision and guidance of a qualified clinical psychologist, residents should have experience with the interpretation of the psychological tests most commonly used, some of which experience should be with their own patients),
- i) supervised, active collaboration with psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel in the treatment of patients.
- j) learning research methods in the clinical, biological, and behavioral sciences related to psychiatry, and appraising the professional and scientific literature and applying findings to patient care.

8. Each program must provide the following:

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- a. Teaching, for all residents, of research literacy. Research literacy is the ability to critically appraise and understand the relevant research literature and to apply research findings appropriately to clinical practice. The concepts and process of Evidence Based Clinical Practice include skill development in question formulation, information searching, critical appraisal, and medical decision-making, thus providing a structure for teaching research literacy to psychiatry residents. The program must promote an atmosphere of scholarly inquiry, including the provision of access to ongoing research activity in psychiatry Residents must be taught the design and interpretation of data.
- b. A plan to provide research opportunities and the development of research skills for residents interested in conducting research in psychiatry or related fields. The program must provide interested residents access to and the opportunity to participate actively in ongoing research under a mentor. When unavailable in the local program, efforts to establish distant mentoring programs are encouraged.
- c. Active participation of the teaching staff in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states, and the application of current knowledge to practice.
- d. Participation of residents and faculty in journal clubs, research

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conferences, didactics, and/or other activities that address critical appraisal of the literature and understanding of the research process.

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. Specific knowledge, skills, and attitudes in Practice-based Learning and Improvement should include:

- 1) taking primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and rotation specific goals and objectives and attendance at conferences;
- 2) analyzing practice experience to recognize one's strengths, deficiencies, and limits in knowledge and expertise through participation in a quality improvement activity;
 - a) There must be a record that demonstrates that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. In the case of transferring residents, the records should include the experiences in the prior as well as the current program.
 - b) this record must be reviewed periodically with the program director or a designee, and must be made available to the surveyor of the program. The record may be maintained in a number of ways and is not limited to a paper driven patient log.

- 1778 3) using evaluations of performance provided by peers,
1779 patients, superiors, and junior colleagues to improve
1780 practice;
- 1781
- 1782 4) locating, appraising, and assimilating evidence from
1783 scientific studies related to their patient’s health
1784 problems;
- 1785
- 1786 5) using information technology to optimize lifelong
1787 learning; and
- 1788
- 1789 6) actively participating in the education of patients,
1790 families, students, residents and other health
1791 professionals, which should be documented by
1792 evaluations of a resident’s teaching abilities by faculty
1793 and/or learners.

1794 **d. Interpersonal and Communication Skills**

1795 Residents must demonstrate interpersonal and
1796 communication skills that result in the effective exchange
1797 of information and teaming with patients, their families,
1798 and professional associates. Specific knowledge, skills,
1799 and attitudes in Interpersonal and Communication Skills
1800 should include:

- 1801
- 1802
- 1803 1) communicating effectively in a developmentally-
1804 appropriate manner with patients and families to
1805 create and sustain a professional and therapeutic
1806 relationship across a broad range of socioeconomic
1807 and cultural backgrounds;
- 1808 2) demonstrating sensitivity and responsiveness to a
1809 diverse patient population, including but not limited
1810 to, diversity in gender, age, culture, race, religion,
1811 disabilities, and sexual orientation;
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- 3) communicating effectively with physicians, other health professionals, and health related agencies;
- 4) working effectively as a member or leader of a health care team or other professional group;
- 5) acting in a consultative role to other physicians and health professionals,
- 6) maintaining comprehensive, timely, and legible medical records, and
- 7) Interviewing patients and family that results in effective diagnosis and biological, psychological and social formulation.

e. Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diversity. Specific knowledge, skills, and attitudes in Professionalism should include demonstrating:

- 1) respect, compassion, integrity, and honesty; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession;
- 2) high standards of ethical behavior which include respect for patient privacy and autonomy, and maintaining appropriate professional boundaries, understanding the nuances specific to psychiatric practice. Programs are expected to operate in accordance with the AMA Principles of Ethics,” with “Special Annotations for Psychiatry,” as developed by the American Psychiatric Association to ensure that the application and teaching of these principles are an integral part of the educational process;
- 3) sensitivity and responsiveness to a diverse patient population, including but not limited to, diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

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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. Specific knowledge, skills, and attitudes in Systems-based Practice should include:

- 1) knowing how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;
- 2) practicing cost-effective health care and resource allocation that does not compromise quality of care; including an understanding of the financing and regulation of psychiatric practice, including information about the structure of public and private organizations that influence mental health care;
- 3) advocating for quality patient care and assisting patients in dealing with system complexities;
- 4) partnering with health care managers and health care providers to assess, coordinate, and improve health care;
- 5) knowing how to advocate for the promotion of health and the prevention of disease and injury in populations; and
- 6) acknowledging the importance of medical errors and examining systems to prevent them.
- 7) The program must establish a mechanism to ensure that charts are appropriately maintained and readily accessible for regular review for supervisory and educational purposes. This must include a formal annual review to monitor residents in history taking, clinical evaluation, treatment, and medication management.
- 8) Clinical records must also be reviewed to assess resident competencies to:

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- a. document an adequate history and perform mental status, physical, and neurological examinations;
- b. organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues;
- c. proceed with appropriate laboratory and other diagnostic procedures;
- d. develop and implement an appropriate treatment plan followed by regular and relevant progress notes; and,
- e. prepare an adequate discharge summary and plan.

D. — ACGME Competencies

~~The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:~~

- ~~1. — Patient care that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health;~~**
- ~~2. — Medical Knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;~~**
- ~~3. — Practice-based learning and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;~~**
- ~~4. — Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;~~**
- ~~5. — Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;~~**
- ~~6. — Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger~~**

1948 ~~context and system of health care, as well as the ability to call~~
1949 ~~effectively on other resources in the system to provide optimal~~
1950 ~~health care.~~

1951
1952 E. ~~Other Required Components~~

1953
1954 1. ~~Progressive Responsibility~~

1955 ~~Under supervision, resident clinical experience in patient~~
1956 ~~management should demonstrate graduated and progressive~~
1957 ~~responsibility.~~

1958
1959 2. ~~Teaching Opportunities~~

1960 ~~Residents must be instructed in appropriate methods of teaching,~~
1961 ~~and have ample opportunity to teach students in the health~~
1962 ~~professions.~~

1963
1964 3. ~~Electives~~

1965 ~~All programs should provide residents an opportunity to pursue~~
1966 ~~individually chosen electives.~~

1967
1968 4. ~~Record of Clinical Experience~~

1969 ~~There must be a record maintained of specific cases treated by~~
1970 ~~residents, in a manner that does not identify patients, but which~~
1971 ~~illustrates each resident's clinical experience in the program. This~~
1972 ~~record must demonstrate that each resident has met the educational~~
1973 ~~requirements of the program with regard to variety of patients,~~
1974 ~~diagnoses, and treatment modalities. In the case of transferring~~
1975 ~~residents, the records should include the experiences in the prior as~~
1976 ~~well as the current program. This record must be reviewed~~
1977 ~~periodically with the program director or a designee, and must be~~
1978 ~~made available to the surveyor of the program.~~

1979
1980 F. ~~Resident Policies~~

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1982 1. ~~The program should not allow on-call schedules and activities~~
1983 ~~outside the residency that interfere with education, clinical~~
1984 ~~performance, or clinical patient care responsibilities.~~

1985
1986 2. ~~Each resident must be given a copy of the Essentials of Accredited~~
1987 ~~Residencies at the beginning of training.~~

1988
1989 3. ~~Readily available procedures for assisting the resident to obtain~~
1990 ~~appropriate help for significant personal or professional problems~~
1991 ~~should be in place.~~

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1993 VI. **Resident Duty Hours and the Working Environment**

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Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

A. Supervision of Residents

- 1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.**
- 2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.**
- 3. Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.**

B. Duty Hours

- 1. Duty hours are defined as all clinical and academic activities related to the residency 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.**
- 2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
- 3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.**

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4. 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.

C. On-call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.
2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.
3. No new patients may be accepted after 24 hours of continuous duty.
4. At-home call (or pager call) is defined as a call taken from outside the assigned institution.
 - a) The frequency of at-home call is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
 - b) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

2085 c) The program director and the faculty
2086 must monitor the demands of at-home
2087 call in their programs, and make
2088 scheduling adjustments as necessary to
2089 mitigate excessive service demands and/or
2090 fatigue.
2091

2092 **D. Moonlighting**

- 2093
- 2094 1. Because residency education is a full-time endeavor, the
2095 program director must ensure that moonlighting does
2096 not interfere with the ability of the resident to achieve
2097 the goals and objectives of the educational program.
2098
 - 2099 2. The program director must comply with the sponsoring
2100 institution's written policies and procedures regarding
2101 moonlighting, in compliance with the ACGME
2102 Institutional Requirements.
2103
 - 2104 3. Any hours a resident works for compensation at the
2105 sponsoring institution or any of the sponsor's primary
2106 clinical sites must be considered part of the 80-hour
2107 weekly limit on duty hours. This refers to the practice
2108 of internal moonlighting.
2109

2110 **E. Oversight**

- 2111
- 2112 1. Each program must have written policies and
2113 procedures consistent with the Institutional and
2114 Program Requirements for resident duty hours and the
2115 working environment. These policies must be
2116 distributed to the residents and the faculty. Duty hours
2117 must be monitored with a frequency sufficient to ensure
2118 an appropriate balance between education and service.
2119
 - 2120 2. Back-up support systems must be provided when
2121 patient care responsibilities are unusually difficult or
2122 prolonged, or if unexpected circumstances create
2123 resident fatigue sufficient to jeopardize patient care.
2124

2125 **F. Duty Hours Exceptions**

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2127 An RRC may grant exceptions for up to 10% of the 80-hour limit to
2128 individual programs based on a sound educational rationale. Prior
2129 permission of the institution's GMEC, however, is required.
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VII. Evaluation

A. Resident

1. Formative Evaluation

The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.

- a) **Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.**

- b) **Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident. ~~These will be made available on review of the program.~~
~~Regular, systematic, documented evaluation of the knowledge, skills, and professional growth of each resident, using appropriate criteria and procedures, must be maintained, including complete records of evaluations containing explicit statements on the resident's progress toward meeting educational objectives and his or her major strengths and weaknesses. Each evaluation should be communicated to the resident in an ongoing and timely manner.~~**

B. The program must formally examine the

- 1. cognitive knowledge of each resident at least annually in the PG-2 through PG-4 years, and
- 2. conduct a clinical examination at least annually in the PG-2 through PG-4 years of clinical skills across biological, psychological and social spheres. A required component of this assessment is an annual evaluation of the resident's

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- a) interviewing skills and his/her
- b) ability to elicit an appropriate present and past psychiatric, medical, social, and developmental history.
- c) assess mental status, and provide a relevant formulation, differential diagnosis and provisional treatment plan.

C. Performance on this evaluation must be quantified and provided to the resident and, where necessary, remediation opportunities must be provided. Residents must not advance to the next year of training, or graduate from the program, unless the competence for their level of training in each area is documented. Demonstration of competence in psychiatric interviewing must be attained prior to completion of the program.

~~e) — Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.~~

~~d) — The program must demonstrate that residents have achieved competency in at least the following forms of treatment:~~

~~(1) — brief therapy;~~

~~(2) — cognitive behavioral therapy;~~

~~(3) — combined psychotherapy and psychopharmacology;~~

~~(4) — psychodynamic therapy; and~~

~~(5) — supportive therapy.~~

~~e) — The program must provide documented evidence to demonstrate that the proficiency/competence of each resident is assessed using techniques that may include supervisory reports, videotapes, oral examinations, case reports, patient care observations, or other methods.~~

~~f) — The program must provide opportunity for and document regularly scheduled meetings between the resident and the program director or designated faculty members. These meetings should be of sufficient frequency, length and depth to ensure that the residents are continually aware of~~

2223 the quality of their progress toward attainment of
 2224 professional goals and objectives. These evaluation
 2225 sessions should be held at least semiannually and
 2226 preferably more frequently. The program should give
 2227 residents opportunities to assess the program and the
 2228 faculty in a manner that ensures resident confidentiality.
 2229 Provision should be made for remediation in cases of
 2230 unsatisfactory performance.
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2232 g) — The program must formally examine the cognitive
 2233 knowledge of each resident at least annually in the PG-2
 2234 through PG-4 years, and conduct an organized examination
 2235 of clinical skills at least twice during the 4 years of training.
 2236 In a timely manner, the program must develop specific
 2237 remedial plans for residents who do not perform
 2238 satisfactorily. Residents must not advance to the next year
 2239 of training, or graduate from the program, unless the
 2240 outcome from the remedial plan results in the attainment of
 2241 educational and clinical goals established for the program.
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2243 h) — Residents should be advanced to positions of higher
 2244 responsibility only on the basis of evidence of their
 2245 satisfactory progressive scholarship and professional,
 2246 educational, and clinical growth.
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2248 i) — A written set of due process procedures must be in place
 2249 for resolving problems that occur when a resident's
 2250 performance fails to meet required standards. These
 2251 procedures must conform to those policies and procedures
 2252 adopted by the sponsoring institution for the provision of
 2253 due process to all residents training in sponsored programs,
 2254 and must include the criteria for any adverse action, such as
 2255 placing a resident on probation, or for terminating a
 2256 resident whose performance is unsatisfactory. The
 2257 procedures should be fair to the residents, to patients under
 2258 their care, and to the training program. A copy should be
 2259 provided to the residents at the beginning of training.
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2261 j) — Upon any resident's departure from a program (including
 2262 by graduation), the program director must prepare a letter
 2263 describing the nature and length of the rotations for which
 2264 the resident has been given credit. If a resident departs the
 2265 program without receiving full credit for all educational
 2266 experiences, the reasons for withholding credit must be
 2267 specified in the letter. The resident must be given the letter,
 2268 and a copy must be retained in the resident's permanent file.

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- k) ~~When a resident leaves the program (including by graduation), the program director will affirm in the training record that there is no documented evidence of unethical or unprofessional behavior, nor any serious question regarding clinical competence. Where there is such evidence, it will be comprehensively recorded, along with the responses of the trainee. The evaluation should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation should be part of the resident's permanent record maintained by the institution.~~

- l) ~~For residents transferring to child and adolescent psychiatry, it is essential that the program director document the nature and length of the rotations for which the resident has been given credit and include a listing of any remaining requirements needed to successfully complete the general psychiatry program. The resident must be informed that eligibility for certification by the American Board of Psychiatry and Neurology is not possible unless all general psychiatry program requirements are met, even if the resident completes the requirements for training in child and adolescent psychiatry. A copy of this notification must be provided to the resident and a copy included in the resident's permanent file.~~

2. Final Evaluation

- a. **The program director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.**
- b. The Program Director must provide a summative evaluation for each resident who completes the program. This evaluation must:
 - 1. review the resident's performance during the final period of education,

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2. verify that the resident has demonstrated sufficient professional ability to practice competently and independently, and
 3. become a part of the resident's permanent record maintained by the institution.
 4. include a summary of any documented evidence of unethical behavior, unprofessional behavior, or clinical incompetence or a statement that none such have occurred. Where there is such evidence, it must be comprehensively recorded, along with the responses of the resident
- c. Upon any resident's departure from a program (including by graduation), the program director must prepare a letter to:
1. Describe the nature and length of the rotations for which the resident has been given credit.
 2. Document credit granted for all educational experiences that have been successfully completed
 3. List reasons for experiences completed for which no credit is granted
 4. Delineate all remaining psychiatry residency requirements that are outstanding and must be completed prior to finishing psychiatry training
 5. Inform each resident, especially those transferring into Child and Adolescent Psychiatry that the qualifications for certification by the American Board of Psychiatry and Neurology require that general psychiatry program requirements are met, even if the resident complete training in child and adolescent psychiatry.⁶

⁶ For residents entering child and adolescent psychiatry, certain clinical experiences with children adolescents and families taken during the period when the person 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 requirements must be met for these experiences:

- i. limited to child and adolescent psychiatry patients
- ii. up to a maximum of 12 months that can be double counted
- iii. documentation by CAP PD of all areas for which credit is given in both programs
- iv. no reduction in total length of time devoted to training in child and adolescent psychiatry, which must remain at 2 years

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B. Faculty

The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by residents.

C. Program

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

- 1. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most**

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- v. Only the following experiences can be used to meet requirements in both general and child and adolescent psychiatry training:
 - a) 1 month FTE of child neurology**
 - b) 1 month FTE of pediatric consultation**
 - c) 1 month FTE of addiction psychiatry**
 - d) forensic psychiatry experience**
 - e) community psychiatry experience**
 - f) Up to 20% of outpatient experience of the Program Requirements for Psychiatry****

2370 recent report of the GMEC of the sponsoring institution, and
2371 the residents' confidential written evaluations. If deficiencies
2372 are found, the group should prepare an explicit plan of action,
2373 which should be approved by the faculty and documented in
2374 the minutes of the meeting.

2375
2376 3. The program should use resident performance and outcome
2377 assessment in its evaluation of the educational effectiveness of
2378 the residency program. Performance of program graduates on
2379 the certification examination should be used as one measure of
2380 evaluating program effectiveness. The program should
2381 maintain a process for using assessment results together with
2382 other program evaluation results to improve the residency
2383 program.⁷

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2385 4. Programs must demonstrate that they have an ongoing mechanism
2386 to evaluate the effectiveness of their didactic and clinical teaching.

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2388 **VIII. Experimentation and Innovation**

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2390 Since responsible innovation and experimentation are essential to improving
2391 professional education, experimental projects along sound educational
2392 principles are encouraged. Requests for experimentation or innovative
2393 projects that may deviate from the program requirements must be approved
2394 in advance by the RRC, and must include the educational rationale and
2395 method of evaluation. The sponsoring institution and program are jointly
2396 responsible for the quality of education offered to residents for the duration
2397 of such a project.

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2399 **IX. Certification**

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2401 Residents who plan to seek certification by the American Board of Psychiatry and
2402 Neurology should communicate with the office of the board regarding the full
2403 requirements for certification.

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2405 ~~IX. I—Inquiries Concerning Accreditation and Certification~~

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2407 ~~A.——All inquiries concerning the accreditation of psychiatry residencies should~~
2408 ~~be addressed to Executive Director, Residency Review Committee for~~
2409 ~~Psychiatry, 515 N. State St. / Ste 2000, Chicago, IL 60610.~~

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⁷ In its evaluation of residency programs, the RRC will take into consideration the information provided by the American Board of Psychiatry and Neurology regarding resident performance on the certifying examinations during the most recent 5 years. The expectation is that the rate of those passing the examination on their first attempt is 50% and that 70% of those who complete the program will take the certifying examination.

2411 ~~B. All inquiries as to whether a physician is qualified to be admitted for~~
2412 ~~examination for certification in psychiatry should be addressed to~~
2413 ~~Executive Vice President, American Board of Psychiatry and Neurology,~~
2414 ~~500 Lake Cook Rd / Ste 335, Deerfield, IL 60015.~~

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2416 ~~ACGME: February 2000 Effective: January 2001~~

2417 ~~Minor Revision: ACGME: September 2004 Effective: November 12, 2004~~