

# ACGME Program Requirements for Graduate Medical Education in Psychiatry

Common Program Requirements are in BOLD

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## Introduction

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

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

**Int.B. Definition of the Specialty**

Psychiatry is a medical specialty focused on the prevention, diagnosis, and treatment of mental, addictive, and emotional disorders. An approved residency program in psychiatry is designed to ensure that its graduates are able to render effective professional care to psychiatric patients. The graduates will possess sound clinical judgment, requisite skills, and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders, together with other common medical and neurological disorders that relate to the practice of psychiatry. Graduates must have a keen awareness of their own strengths and limitations, and recognize the necessity for continuing their own professional development.

**Int.C. Duration and Scope of Education**

**Int.C.1. Admission Requirements**

Physicians may enter psychiatry programs at either the first-year or second-year postgraduate level. Physicians entering at the second-year

postgraduate level must document successful completion of a clinical year of education in an ACGME-accredited specialty requiring comprehensive and continuous patient care, such as a program in internal medicine, family medicine, 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.

Int.C.2. Length of the Program

- Int.C.2.a) Residency education in psychiatry requires 48 months, of which twelve months may be completed in an ACGME-accredited child and adolescent psychiatry program. 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).
- Int.C.2.b) A program may petition the residency review committee to alter the length of education beyond these minimum requirements by presenting a clear educational rationale consistent with the program requirements. The program director must obtain the approval of the sponsoring institution and the Review Committee prior to implementation and at each subsequent review of the program.
- Int.C.2.c) Prior to entry into the program, each resident must be notified in writing of the required length of education for which the program is accredited. The required length of education for a particular resident may not be changed during his or her program without mutual agreement, unless there is a break in education or the resident requires remedial education.
- Int.C.2.d) Programs should meet all of the Program Requirements of Residency Education in Psychiatry. Under rare and unusual circumstances, one- or two-year programs may be approved, even though they do not meet the above requirements for psychiatry. Such one- or two-year programs will be approved only if they provide some highly specialized educational and/or research program. These programs may provide an alternative specialized year or two of training, but do not provide complete residency education in psychiatry. The traditional program time and the specialized program must ensure that residents will complete the didactic and clinical requirements outlined in the program requirements.
- Int.C.2.e) Electives should enrich the educational experience of residents in conformity to their needs, interest, and/or future professional plans. Electives must have written goals and objectives, and must be well constructed, purposeful, and lead to effective learning experiences. The choice of electives must be made with the advice and approval of the program director and the appropriate

preceptor.

Int.C.2.e).(1) The Review Committee encourages programs to identify residents who may be interested in academic psychiatry by introducing subspecialty education and research electives early in the residency program. This will provide an opportunity for education in general psychiatry, and exposure to a psychiatry fellowship (e.g., geriatric psychiatry) through electives.

Int.C.2.e).(2) All such electives must demonstrate compliance with the requirements in general psychiatry, and be submitted to the committee prior to implementation for review and approval. Submissions must also outline the educational curriculum necessary to meet the requirements of general psychiatry and how elective education will be structured to prepare the resident for subspecialty education. Prior to entry into the program, residents must be informed in writing that all general psychiatry requirements must be met prior to graduation.

Int.C.3. First Year of Education

The program director of the psychiatry residency program must monitor performance and maintain personal contact with residents during the first postgraduate-year while they are on services other than psychiatry. A first postgraduate-year in psychiatry should include:

Int.C.3.a) a minimum of four-months in a primary care clinical setting that provides comprehensive and continuous patient care in specialties such as internal medicine, family medicine, and/or pediatrics. Neurology rotations may not be used to fulfill this four-month requirement. One month of this requirement may be fulfilled by either an emergency medicine or intensive care rotation, provided the experience is predominantly with medical evaluation and treatment and not surgical procedures, and

Int.C.3.b) no more than eight months in psychiatry.

## I. Institutions

### I.A. Sponsoring Institution

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

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

## **I.B. Participating Sites**

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

**The PLA should:**

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

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

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

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

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

**I.B.3. The number and distribution of participating sites must not preclude satisfactory participation by residents in teaching and didactic exercises. Geographic proximity of participating sites will be one factor in evaluating program cohesion, continuity, and peer interaction.**

## **II. Program Personnel and Resources**

### **II.A. Program Director**

**II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**

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

**II.A.2.a) In general, the minimum term of appointment must be at least the duration of the program plus one year.**

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

- II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
- II.A.3.b) current certification in the specialty by the American Board of Psychiatry and Neurology, or specialty qualifications that are acceptable to the Review Committee; and,**
- II.A.3.c) current medical licensure and appropriate medical staff appointment.**
- II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**
  - II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
  - II.A.4.b) approve a local director at each participating site who is accountable for resident education;**
  - II.A.4.c) approve the selection of program faculty as appropriate;**
  - II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
  - II.A.4.e) monitor resident supervision at all participating sites;**
  - II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
  - II.A.4.g) provide each resident with documented semiannual evaluation of performance with feedback;**
  - II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
  - II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;**
  - II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:**
    - II.A.4.j).(1) distribute these policies and procedures to the residents and faculty;**

- II.A.4.j).(2)** monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
- II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
- II.A.4.j).(4)** if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
- II.A.4.k)** monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
- II.A.4.l)** comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
- II.A.4.m)** be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMCC/DIO before submitting to the ACGME information or requests for the following:
  - II.A.4.n).(1)** all applications for ACGME accreditation of new programs;
  - II.A.4.n).(2)** changes in resident complement;
  - II.A.4.n).(3)** major changes in program structure or length of training;
  - II.A.4.n).(4)** progress reports requested by the Review Committee;
  - II.A.4.n).(5)** responses to all proposed adverse actions;
  - II.A.4.n).(6)** requests for increases or any change to resident duty hours;
  - II.A.4.n).(7)** voluntary withdrawals of ACGME-accredited programs;
  - II.A.4.n).(8)** requests for appeal of an adverse action;
  - II.A.4.n).(9)** appeal presentations to a Board of Appeal or the ACGME; and,

- II.A.4.n).(10) **proposals to ACGME for approval of innovative educational approaches.**
- II.A.4.o) **obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
  - II.A.4.o).(1) **program citations, and/or**
  - II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**
- II.A.4.p) make resident appointments and assignments in accordance with institutional and departmental policies and procedures.
- II.A.4.q) supervise residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff.
- II.A.4.r) regularly evaluate residents' knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician.
- II.A.4.s) monitor residents' stress, including physical or emotional conditions which inhibit performance or learning, as well as drug- or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Educational situations that consistently produce undesirable stress on residents must be evaluated and modified.
- II.A.4.t) dedicate no less than 50% (at least 20 hours per week) of his or her professional effort to the psychiatry educational program and receive institutional support for this time. This effort must be devoted to administrative and educational activities of the psychiatry educational program.

**II.B. Faculty**

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

**The faculty must:**

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

and

- II.B.1.b) **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**
- II.B.2. **The physician faculty must have current certification in the specialty by the American Board of Psychiatry and Neurology, or possess qualifications acceptable to the Review Committee.**
- II.B.2.a) A physician faculty member may be appointed to the School of Medicine as a voluntary faculty member.
- II.B.3. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
- II.B.4. **The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
- II.B.5. **The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
- II.B.5.a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
- II.B.5.b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**
  - II.B.5.b).(1) **peer-reviewed funding;**
  - II.B.5.b).(2) **publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
  - II.B.5.b).(3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**
  - II.B.5.b).(4) **participation in national committees or educational organizations.**
- II.B.5.c) **Faculty should encourage and support residents in scholarly activities.**
- II.B.6. The faculty must participate regularly and systematically in the educational program, and must be readily available for consultation whenever a resident is faced with a major therapeutic or diagnostic problem.
- II.B.7. The faculty should actively participate in the planning, organization, and presentation of conferences as well as in clinical teaching and supervision.

II.B.8. A member of the teaching staff in each participating site must be designated to assume responsibility for the day-to-day activities of the program at that site, with overall coordination by the program director.

**II.C. Other Program Personnel**

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

II.C.1. Associate Program Director

An associate program director is a member of the physician teaching faculty who assists the program director in the administrative and clinical oversight of the educational program. The sponsoring institution must provide additional dedicated time either for the program director or for associate program directors based on program size and complexity of training sites. At a minimum, a total of 30 hours per week, program director or combined program director and associate program director time, is required for an approved complement of 24 to 40 residents, and 40 hours per week for an approved complement of 41 to 79 residents. When a program is approved for 80 or more residents, there must be additional time allocated for directing the program

II.C.2. There must be a residency coordinator who has adequate time, based on program size and complexity, to support the residency program.

II.C.3. Chair of Psychiatry

The chair of psychiatry must be:

II.C.3.a) a physician who is appointed to and in good standing with the medical staff of a site participating in the program;

II.C.3.b) qualified and have at least three years' experience as a clinician, administrator, and educator in psychiatry;

II.C.3.c) certified in psychiatry by the American Board of Psychiatry and Neurology or possess appropriate qualifications judged to be acceptable by the Review Committee;

II.C.3.d) actively involved in psychiatry through continuing medical education, professional societies, and scholarly activities; and,

II.C.3.e) capable of mentoring medical faculty, residents, administrators and other health care professionals, and possess medical leadership qualifications consistent with other physician chairs within the sponsoring institution.

II.C.4. Education Policy Committee

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

- II.C.4.a) planning, developing, implementing, and evaluating all significant features of the residency program, including the selection of residents (unless there is a separate residency selection committee);
- II.C.4.b) determining curriculum goals and objectives; and
- II.C.4.c) evaluating both the teaching staff and the residents.

## **II.D. Resources**

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

- II.D.1. All programs must have adequate patient populations for each mode of required education and, minimally, must include organized clinical services in inpatient, outpatient, emergency, consultation/liaison, and child and adolescent psychiatry.
- II.D.2. Residency 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.
- II.D.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.
- II.D.4. There must be adequate space and equipment, including equipment with the capability to record and playback session, specifically designated for seminars, lectures, and other educational activities.

## **II.E. Medical Information Access**

**Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic**

**medical literature databases with search capabilities should be available.**

### **III. Resident Appointments**

#### **III.A. Eligibility Criteria**

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

- III.A.1. The program director must accept only those applicants whose qualifications of residency include sufficient command of English to permit accurate and unimpeded communication.

#### **III.B. Number of Residents**

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

- III.B.1. In order to promote an educationally-sound, intellectually-stimulating atmosphere of effective and graded responsibility, programs must have at least three residents at each level of education. Programs that fall below this prescribed critical mass will be reviewed, and if this deficiency is not corrected, they may be cited for noncompliance, except when the number of PG-4 residents is fewer than three because residents have entered child and adolescent psychiatry training.

- III.B.2. Any permanent change in the number of approved positions requires prior approval by the Review Committee. Programs seeking interim approval of a permanent increase in the number of approved resident positions should contact the Executive Director of the Review Committee. Prior approval is not required for temporary changes in resident numbers owing to makeup or remedial time for currently-enrolled residents, or to fill vacancies. Approval of permanent increases above the approved range of residents will require documentation that didactic and clinical education, including supervision, will not be compromised.

#### **III.C. Resident Transfers**

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

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

- III.C.3. Verification must include evaluation of professional integrity of residents

transferring from one program to another, including from a general psychiatry to a child and adolescent psychiatry program.

- III.C.4. A transferring resident's educational program must be sufficiently individualized so that he/she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation.

**III.D. Appointment of Fellows and Other Learners**

**The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.**

**IV. Educational Program**

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

**IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;**

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

**IV.A.3. Regularly scheduled didactic sessions;**

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

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

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

**IV.A.5.a) Patient Care**

**Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:**

**IV.A.5.a).(1) must have supervised experience in the evaluation and treatment of patients. These patients should be of different ages and gender from across the life cycle, and from a variety of ethnic, racial, sociocultural, and economic backgrounds;**

- IV.A.5.a).(2) should be familiar with Axis III conditions that can affect evaluation and care (e.g., CNS lesions, HIV/AIDS, and other medical conditions).
- IV.A.5.a).(3) should develop competence in:
- IV.A.5.a).(3).(a) formulating a clinical diagnosis for patients by conducting patient interviews, eliciting a clear and accurate history; performing physical, neurological, and mental status examination, including appropriate diagnostic studies; 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;
- IV.A.5.a).(3).(b) developing a differential diagnosis and treatment plan for all psychiatric disorders in the current standard nomenclature, i.e., DSM, taking into consideration all relevant data;
- IV.A.5.a).(3).(c) using pharmacological regimens, including concurrent use of medications and psychotherapy;
- IV.A.5.a).(3).(d) understanding the indications and uses of electroconvulsive therapy;
- IV.A.5.a).(3).(e) applying supportive, psychodynamic, and cognitive-behavioral psychotherapies to both brief and long-term individual practice, as well as to assuring exposure to family, couples, group and other individual evidence-based psychotherapies;
- IV.A.5.a).(3).(f) providing psychiatric consultation in a variety of medical and surgical settings;
- IV.A.5.a).(3).(g) providing care and treatment for the chronically-mentally ill with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions;
- IV.A.5.a).(3).(h) participating in psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance and performance improvement;
- IV.A.5.a).(3).(i) providing psychiatric care to patients who are receiving treatment from nonmedical therapists and coordinating such treatment; and,

- IV.A.5.a).(3).(j) recognizing and appropriately responding to family violence (e.g., child, partner, and elder physical, emotional, and sexual abuse and neglect) and its effect on both victims and perpetrators.
- IV.A.5.a).(4) will have major responsibility for the care of a significant number of patients with acute and chronic psychiatric illnesses;
- IV.A.5.a).(4).(a) Patient care assignments must permit residents to practice appropriate treatment, and to have sufficient time for other aspects of their educational program.
- IV.A.5.a).(4).(b) Residents must be provided structured clinical experiences that are organized to provide opportunities to conduct initial evaluations, to participate in the subsequent diagnostic process, and to follow patients during the treatment phase and/or evolution of their psychiatric disorders/conditions.
- IV.A.5.a).(4).(c) Experiences may be completed on a full or part-time basis so long as the stated full-time equivalent experience is met. For residents who plan to enter subspecialty education in child and adolescent psychiatry prior to completing general psychiatry requirements, certain clinical experiences with children, adolescents and families taken during the period when the resident is designated as a child and adolescent psychiatry resident may be counted toward general psychiatry requirements as well as child and adolescent requirements, thereby fulfilling program requirements in both general and child and adolescent psychiatry. The following guidelines must be met for these experiences:
- IV.A.5.a).(4).(c).(i) limited to child and adolescent psychiatry patients;
- IV.A.5.a).(4).(c).(ii) no more than 12 months may be double counted;
- IV.A.5.a).(4).(c).(iii) there should be documentation from the child and adolescent psychiatry program director for all areas for which credit is given in both programs;
- IV.A.5.a).(4).(c).(iv) there will be no reduction in total length of time devoted to education in child and adolescent psychiatry; this must remain at

two years; and,

- IV.A.5.a).(4).(c).(v) only the following experiences can be used to meet requirements in both general and child and adolescent psychiatry:
- IV.A.5.a).(4).(c).(v).(a) one month full-time equivalent of child neurology;
- IV.A.5.a).(4).(c).(v).(b) one month full-time equivalent of pediatric consultation;
- IV.A.5.a).(4).(c).(v).(c) one month full-time equivalent of addiction psychiatry;
- IV.A.5.a).(4).(c).(v).(d) forensic psychiatry experience;
- IV.A.5.a).(4).(c).(v).(e) community psychiatry experience; and
- IV.A.5.a).(4).(c).(v).(f) no more than 20% of outpatient experience of the Program Requirements for Psychiatry.
- IV.A.5.a).(5) will have the required clinical experiences which include the following:
- IV.A.5.a).(5).(a) Neurology: two full-time equivalent months of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions. At least one month should occur in the first or second year of the program;
- IV.A.5.a).(5).(b) Inpatient Psychiatry: six but no more than 16 months full-time equivalent 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:
- IV.A.5.a).(5).(b).(i) The patient population is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and gender, and
- IV.A.5.a).(5).(b).(ii) Patient services are comprehensive and continuous and allied medical and ancillary staff are available for backup support at all times.

- IV.A.5.a).(5).(c) Outpatient Psychiatry: 12 month full-time equivalent organized, continuous, and supervised clinical experience in the assessment, diagnosis, and treatment of outpatients with a wide variety of disorders and treatment modalities, with experience in both brief and long-term care of patients. Each resident must have significant experience treating outpatients longitudinally for at least one year. This longitudinal experience should include:
- IV.A.5.a).(5).(c).(i) evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly under supervision;
- IV.A.5.a).(5).(c).(ii) exposure to multiple treatment modalities that emphasize developmental, biological, psychological and social approaches to outpatient treatment;
- IV.A.5.a).(5).(c).(iii) opportunities to apply psychosocial rehabilitation techniques, and to evaluate and treat differing disorders in a chronically ill patient population; and,
- IV.A.5.a).(5).(c).(iv) no more than 20% of the patients seen may be children and adolescents. This portion of education may be used to fulfill the two - month Child and Adolescent Psychiatry requirements, so long as this component meets the requirement for child and adolescent psychiatry as set forth in d.i and d.ii below.
- IV.A.5.a).(5).(d) Child and Adolescent Psychiatry: two month full-time equivalent organized clinical experience in which the residents are:
- IV.A.5.a).(5).(d).(i) supervised by child and adolescent psychiatrists who are certified by ABPN or judged by the Review Committee to have equivalent qualifications; and
- IV.A.5.a).(5).(d).(ii) provided opportunities to assess development and to evaluate and treat a variety of diagnoses in male and female children and adolescents and their families, using a variety of interventional modalities.
- IV.A.5.a).(5).(e) Geriatric Psychiatry: one month full-time equivalent

organized experience focused on the specific competencies in areas that are unique to the care of the elderly. These include the diagnosis and management of mental disorders in patients with multiple comorbid medical disorders, familiarity with the differential diagnosis and management (including management of the cognitive component) of the degenerative disorders, an understanding of neuropsychological testing as it relates to cognitive functioning in the elderly, and the unique pharmacokinetic and pharmacodynamic considerations encountered in the elderly, including drug interactions.

IV.A.5.a).(5).(f)

Addiction Psychiatry: one month full-time equivalent organized experience focused on the evaluation and clinical management of patients with substance abuse/dependence problems, including dual diagnosis. Treatment modalities should include detoxification, management of overdose, maintenance pharmacotherapy, the use of psychological and social consequences of addiction in confronting and intervening in chronic addiction rehabilitation used in recovery stages from pre-contemplation to maintenance, and the use of self-help groups.

IV.A.5.a).(5).(g)

Consultation/Liaison: two month full-time equivalent in which residents consult under supervision on other medical and surgical services.

IV.A.5.a).(5).(h)

Forensic Psychiatry: This experience must expose residents to the evaluation of forensic issues such as patients facing criminal charges, establishing competency to stand trial, criminal responsibility, commitment, and an assessment of their potential to harm themselves or others. This experience should include writing a forensic report. Where feasible, giving testimony in court is highly desirable.

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

Emergency Psychiatry: This experience must be conducted in an organized, 24-hour psychiatric emergency service, a portion of which may occur in ambulatory urgent-care settings, but not as part of the 12-month outpatient requirement. Residents must be provided experiences in evaluation, crisis evaluation and management, and triage of psychiatric patients. On-call experiences may be a part of this experience, but no more than 50%.

IV.A.5.a).(5).(j) Community Psychiatry: This experience must expose residents to persistently and chronically-ill patients in the public sector, (e.g., community mental health centers, public hospitals and agencies, and other community-based settings). The program should provide residents the opportunity to consult with, learn about, and use community resources and services in planning patient care, as well as to consult and work collaboratively with case managers, crisis teams, and other mental health professionals.

IV.A.5.a).(5).(k) Addiction, Community, Forensic, and Geriatric psychiatry requirements can be met as part of the inpatient requirements above the minimum six months, and/or as part of the outpatient requirement

IV.A.5.a).(6) receive a minimum of two hours of direct supervision per week, at least one of which is individual.

**IV.A.5.b) Medical Knowledge**

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

must meet the following requirements:

IV.A.5.b).(1) Didactic instruction must be systematically organized, thoughtfully integrated, based on sound educational principles, and include regularly scheduled lectures, seminars, and assigned readings.

IV.A.5.b).(2) The didactic sessions must be scheduled to ensure a minimum of 70% of resident attendance while adhering to program duty hour policy. Didactic and clinical education must have priority in the allotment of residents' time and energy.

IV.A.5.b).(3) The didactic curriculum must include the following specific components:

IV.A.5.b).(3).(a) the major theoretical approaches to understanding the patient-doctor relationship;

IV.A.5.b).(3).(b) the biological, genetic, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development

- throughout the life cycle;
- IV.A.5.b).(3).(c) the fundamental principles of the epidemiology, etiologies, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, sociocultural, and iatrogenic factors that affect the prevention, incidence, prevalence and long-term course and treatment of psychiatric disorders and conditions;
- IV.A.5.b).(3).(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;
- IV.A.5.b).(3).(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;
- IV.A.5.b).(3).(f) 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);
- IV.A.5.b).(3).(g) the history of psychiatry and its relationship to the evolution of medicine;
- IV.A.5.b).(3).(h) the legal aspects of psychiatric practice, and when and how to refer;
- IV.A.5.b).(3).(i) an understanding of American culture and subcultures, particularly those found in the patient community associated with the educational program, with specific focus for residents with cultural backgrounds that are different from those of their patients; and,
- IV.A.5.b).(3).(i).(i) use of case formulation that includes neurobiological, phenomenological, psychological, and sociocultural issues involved in the diagnosis and management of cases. Each program must provide the

following:

IV.A.5.b).(3).(i).(ii)

All residents must be educated in 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 the structure for teaching research literacy to psychiatry residents. The program must promote an atmosphere of scholarly inquiry, including the access to ongoing research activity in psychiatry. Residents must be taught the design and interpretation of data.

IV.A.5.b).(3).(i).(iii)

The program must provide residents with research opportunities and the opportunity for 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. If unavailable in the local program, efforts to establish such mentoring programs are encouraged.

IV.A.5.b).(3).(i).(iv)

The program must ensure the participation of residents and faculty in journal clubs, research conferences, didactics, and/or other activities that address critical appraisal of the literature and understanding of the research process.

**IV.A.5.c)**

**Practice-based Learning and Improvement**

**Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:**

**IV.A.5.c).(1)**

**identify strengths, deficiencies, and limits in one's knowledge and expertise;**

**IV.A.5.c).(2)**

**set learning and improvement goals;**

- IV.A.5.c).(3)** identify and perform appropriate learning activities;
- IV.A.5.c).(4)** systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- IV.A.5.c).(5)** incorporate formative evaluation feedback into daily practice;
- IV.A.5.c).(6)** locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- IV.A.5.c).(7)** use information technology to optimize learning; and,
- IV.A.5.c).(8)** participate in the education of patients, families, students, residents and other health professionals.
- IV.A.5.c).(9)** take primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and rotation-specific goals and objectives, as well as attendance at conferences;
- IV.A.5.c).(9).(a)** Resident's teaching abilities should be documented by evaluations from faculty and/or learners.
- IV.A.5.c).(9).(a).(i)** 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 and current program.
- IV.A.5.c).(9).(a).(ii)** The 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.
- IV.A.5.d)** **Interpersonal and Communication Skills**
- Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:**
- IV.A.5.d).(1)** communicate effectively with patients, families, and

- the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;**
- IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies;**
- IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group;**
- IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and,**
- IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable.**
- IV.A.5.d).(6) interview patients and family in an effective manner to facilitate accurate diagnosis and biological, psychological and social formulation.**

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

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

- IV.A.5.e).(1) compassion, integrity, and respect for others;**
- IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest;**
- IV.A.5.e).(3) respect for patient privacy and autonomy;**
- IV.A.5.e).(4) accountability to patients, society and the profession; and,**
- IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.**
- IV.A.5.e).(6) high standards of ethical behavior which include respect for patient privacy and autonomy, maintaining appropriate professional boundaries, and understanding the nuances specific to psychiatric practice. Programs are expected to distribute to residents and 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.**

**IV.A.5.f)**

**Systems-based Practice**

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

**IV.A.5.f).(1)**

**work effectively in various health care delivery settings and systems relevant to their clinical specialty;**

**IV.A.5.f).(2)**

**coordinate patient care within the health care system relevant to their clinical specialty;**

**IV.A.5.f).(3)**

**incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;**

**IV.A.5.f).(4)**

**advocate for quality patient care and optimal patient care systems;**

**IV.A.5.f).(5)**

**work in interprofessional teams to enhance patient safety and improve patient care quality; and,**

**IV.A.5.f).(6)**

**participate in identifying system errors and implementing potential systems solutions.**

**IV.A.5.f).(7)**

know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;

**IV.A.5.f).(8)**

practice 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, as well as information about the structure of public and private organizations that influence mental health care;

**IV.A.5.f).(9)**

advocate for quality patient care and assisting patients in dealing with system complexities, including disparity in mental health care;

**IV.A.5.f).(10)**

work with health care managers and health care providers to assess, coordinate, and improve health care, particularly as it relates to access to mental health care;

**IV.A.5.f).(11)**

know how to advocate for the promotion of mental health and the prevention of disease;

- IV.A.5.f).(12) maintain a mechanism to ensure that charts are appropriately maintained and readily accessible for patient care and regular review for supervisory and educational purposes;
- IV.A.5.f).(13) collaborate with psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel in the treatment of patients; and
- IV.A.5.f).(14) monitor clinical records on major rotations to assess resident competencies to:
  - IV.A.5.f).(14).(a) document an adequate history and perform mental status, physical, and neurological examinations;
  - IV.A.5.f).(14).(b) organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues;
  - IV.A.5.f).(14).(c) proceed with appropriate laboratory and other diagnostic procedures;
  - IV.A.5.f).(14).(d) develop and implement an appropriate treatment plan followed by regular and relevant progress notes regarding both therapy and medication management; and,
  - IV.A.5.f).(14).(e) prepare an adequate discharge summary and plan.

#### **IV.B. Residents' Scholarly Activities**

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

**IV.B.2. Residents should participate in scholarly activity.**

IV.B.2.a) Residents will have instruction in research methods in the clinical, biological, and behavioral sciences related to psychiatry, including techniques to appraise the professional and scientific literature and to apply evidence based findings to patient care.

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

#### **V. Evaluation**

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

##### **V.A.1. Formative Evaluation**

- V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.**
- V.A.1.b) The program must:**
- V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**
  - V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**
  - V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,**
  - V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.**
- V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.**
- V.A.1.d) Regular evaluations 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.**
- V.A.1.e) The program must formally examine the cognitive knowledge of each resident at least annually in the PG-2, PG-3 and PG-4 years, and conduct an examination across biological, psychological and social spheres that are defined in the program's written goals and objectives.**
- V.A.1.f) The program must formally conduct a clinical skills examination. A required component of this assessment is an annual evaluation of the following skills:**
- V.A.1.f).(1) ability to interview patients and families;**
  - V.A.1.f).(2) ability to establish an appropriate doctor/patient relationship;**
  - V.A.1.f).(3) ability to elicit an appropriate present and past psychiatric, medical, social, and developmental history;**

- V.A.1.f).(4) ability to assess mental status;
- V.A.1.f).(5) ability to provide a relevant formulation, differential diagnosis and provisional treatment plan; and,
- V.A.1.f).(6) ability to make an organized presentation of the pertinent history, including the mental status examination.
- V.A.1.g) Performance on all evaluations must be documented and quantified, whenever possible, and provided to the resident. When necessary, remediation opportunities must be provided. Residents must not advance to the next year of education, or graduate from the program, unless the competence for their level of education in each area is documented.
- V.A.1.h) In at least three evaluations with any patient type, in any clinical setting, and at any time during the program, residents must demonstrate satisfactory competence in: establishing an appropriate doctor/patient relationship, psychiatric interviewing, performing the mental status examination and in case presentation. Each of the three required evaluations must be conducted by an ABPN-certified psychiatrist, and at least two of the evaluations must be conducted by different ABPN-certified psychiatrists. Satisfactory demonstration of the competencies during the three required evaluations is required prior to completing the program.

**V.A.2. Summative Evaluation**

**The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:**

- V.A.2.a) **document the resident's performance during the final period of education, and**
- V.A.2.b) **verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.**
- V.A.2.c) include a summary of any documented evidence of unethical behavior, unprofessional behavior, or clinical incompetence or a statement that none such has occurred. Where there is such evidence, it must be comprehensively recorded, along with the resident's response(s) to such evidence.

**V.B. Faculty Evaluation**

- V.B.1. **At least annually, the program must evaluate faculty performance as**

it relates to the educational program.

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

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

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

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

**V.C.1.a)** resident performance;

**V.C.1.b)** faculty development;

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

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

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

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

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

**V.C.3.** In its evaluation of residency programs, the Review Committee 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 five 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

**VI.** Resident Duty Hours in the Learning and Working Environment

**VI.A.** Professionalism, Personal Responsibility, and Patient Safety

**VI.A.1.** Programs and sponsoring institutions must educate residents and

**faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**

- VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.**
- VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.**
- VI.A.4. The learning objectives of the program must:**
  - VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**
  - VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations.**
- VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**
  - VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;**
  - VI.A.5.b) provision of patient- and family-centered care;**
  - VI.A.5.c) assurance of their fitness for duty;**
  - VI.A.5.d) management of their time before, during, and after clinical assignments;**
  - VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;**
  - VI.A.5.f) attention to lifelong learning;**
  - VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,**
  - VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.**
- VI.A.6. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the**

**best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.**

**VI.B. Transitions of Care**

- VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.**
- VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.**
- VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.**
- VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.**

**VI.C. Alertness Management/Fatigue Mitigation**

- VI.C.1. The program must:**
  - VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;**
  - VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,**
  - VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.**
- VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.**
- VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.**

**VI.D. Supervision of Residents**

- VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.**

Only licensed independent practitioners as consistent with state

regulations and medical staff bylaws may have primary responsibility for a patient.

- VI.D.1.a)** This information should be available to residents, faculty members, and patients.
- VI.D.1.b)** Residents and faculty members should inform patients of their respective roles in each patient's care.
- VI.D.2.** The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.
- Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.
- VI.D.3.** Levels of Supervision
- To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:
- VI.D.3.a)** Direct Supervision – the supervising physician is physically present with the resident and patient.
- VI.D.3.b)** Indirect Supervision:
- VI.D.3.b).(1)** with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
- VI.D.3.b).(2)** with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
- VI.D.3.c)** Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
- VI.D.4.** The privilege of progressive authority and responsibility, conditional

**independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.**

- VI.D.4.a)                    The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
- VI.D.4.b)                    Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.**
- VI.D.4.c)                    Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.**
- VI.D.5.                      Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**
- VI.D.5.a)                    Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**
- VI.D.5.a).(1)                In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.**
- VI.D.5.a).(2)                PGY-1 residents may progress to being supervised indirectly with direct supervision available only after demonstrating competence in:**
  - VI.D.5.a).(2).(a)                    the ability and willingness to ask for help when indicated;**
  - VI.D.5.a).(2).(b)                    gathering an appropriate history;**
  - VI.D.5.a).(2).(c)                    the ability to perform an emergent psychiatric assessment; and,**
  - VI.D.5.a).(2).(d)                    presenting patient findings and data accurately to a supervisor who has not seen the patient.**
- VI.D.6.                      Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.**

**VI.E.                      Clinical Responsibilities**

**The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.**

**VI.F. Teamwork**

**Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.**

VI.F.1. Contributors to effective interprofessional teams include consulting physicians, psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients.

**VI.G. Resident Duty Hours**

**VI.G.1. Maximum Hours of Work per Week**

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

**VI.G.1.a) Duty Hour Exceptions**

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

The Review Committee for Psychiatry will not consider requests for exceptions to the 80-hour limit to the residents' work week.

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

VI.G.1.a).(2) **Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.**

**VI.G.2. Moonlighting**

VI.G.2.a) **Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**

VI.G.2.b) **Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.**

- VI.G.2.c) PGY-1 residents are not permitted to moonlight.**
- VI.G.3. Mandatory Time Free of Duty**
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.**
- VI.G.4. Maximum Duty Period Length**
- VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.**
- VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.**
- VI.G.4.b).(1) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.**
- VI.G.4.b).(2) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.**
- VI.G.4.b).(3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.**
- VI.G.4.b).(3).(a) Under those circumstances, the resident must:**
- VI.G.4.b).(3).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,**
- VI.G.4.b).(3).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.**

**VI.G.4.b).(3).(b)**

**The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.**

**VI.G.5.**

**Minimum Time Off between Scheduled Duty Periods**

**VI.G.5.a)**

**PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.**

**VI.G.5.b)**

**Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.**

PGY-2 residents are considered to be at the intermediate level.

**VI.G.5.c)**

**Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.**

Residents at the PGY-3 level or beyond are considered to be in the final years of education.

**VI.G.5.c).(1)**

**This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.**

**VI.G.5.c).(1).(a)**

**Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.**

**VI.G.5.c).(1).(b)**

There are no circumstances under which residents in the final years of education may stay on duty with fewer than eight hours off.

**VI.G.6.**

**Maximum Frequency of In-House Night Float**

**Residents must not be scheduled for more than six consecutive nights of night float.**

**VI.G.6.a)**

Residents should not be scheduled for more than four consecutive weeks of night float during the required one-year, full-time

outpatient psychiatry experience.

VI.G.6.b) Residents should not be scheduled for more than a total of eight weeks of night float during the one-year of consecutive outpatient experience.

**VI.G.7. Maximum In-House On-Call Frequency**

**PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).**

VI.G.7.a) On psychiatry rotations, in-house call must occur no more frequently than every fourth night, averaged over a four-week period.

**VI.G.8. At-Home Call**

**VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.**

**VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.**

**VI.G.8.b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.**

**VII. Innovative Projects**

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

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