

ACGME Program Requirements for Graduate Medical Education in Forensic Psychiatry

One-year Common Program Requirements are in BOLD

Effective: June, 2003

Introduction

Int.A. Residency and fellowship programs are essential dimensions of the transformation of the medical student to the independent practitioner along the continuum of medical education. They are physically, emotionally, and intellectually demanding, and require longitudinally-concentrated effort on the part of the resident or fellow.

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 and fellow physician to assume personal responsibility for the care of individual patients. For the resident and fellow, 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 and fellows 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 and fellow’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. Forensic psychiatry is the psychiatry subspecialty that focuses on interrelationships between psychiatry and the law (civil, criminal, and administrative law), that include:

Int.B.1. the psychiatric evaluation of individuals involved with the legal system, or consultations on behalf of the third parties such as employers or insurance companies;

Int.B.2. the specialized psychiatric treatment required by those who have been incarcerated in jails, prisons, or special forensic psychiatric hospitals;

Int.B.3. active involvement in the area of legal regulation of general psychiatric practice; and,

Int.B.4. related education and research efforts.

Int.C. Duration and Scope of Education

- Int.C.1. The training period in forensic psychiatry must be 12 months.
- Int.C.2. Training in forensic psychiatry that occurs during the general residency training will not be credited toward the one-year requirement.
- Int.C.3. Training is best accomplished on a full-time basis. If it is undertaken on a part-time basis, the 12-month program must be completed within a two-year period.
- Int.C.4. Prior to entry, each fellow must be notified in writing of the required length of training for which the program is accredited and the requirements for satisfactory completion of the program. Neither the required length of training for a particular individual nor the graduation requirements may be changed without mutual agreement during his or her program unless there is a break in his or her training or the individual requires remedial training.
- Int.D. Educational Goals and Objectives
- Int.D.1. The program must offer advanced training that affords sufficient opportunities for the fellow to develop the knowledge, skills, clinical judgment, and attitudes essential to the practice of forensic psychiatry.
- Int.D.2. Clinical experience must include experiences in the following three areas:
- Int.D.2.a) forensic evaluation of a variety of subjects of both genders, including adolescent, adult, and geriatric age groups, who represent a broad range of mental disorders and circumstances, in both civil and criminal contexts;
- Int.D.2.b) consultation to general psychiatric services on issues related to the legal regulation of psychiatric practice, such as civil commitment, confidentiality, refusal of treatment, decision-making competence, guardianship, etc.; and,
- Int.D.2.c) treatment of persons involved in the criminal justice system. Appropriate affiliations must be arranged to ensure that adequate exposure to a sufficient number and variety of experiences is provided.
- Int.D.3. Programs must be based on a structured written curriculum with well-defined goals and objectives. Clinical case conferences and seminars dealing with topics such as law, ethics, the relevant basic and social sciences, and research must be conducted regularly and as scheduled. The curriculum must include sufficient didactic content so that graduates will be knowledgeable about the content outlined in IV.A.3.a-e.
- Int.D.4. Training must focus on the social and legal context for forensic work, both civil and criminal. Instruction should take into account the sociocultural, ethnic, economic, and ethical considerations that affect mentally ill

persons who come into contact with the legal system.

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 fellow assignments at all participating sites.

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

I.A.1. The program must be administratively attached to and sponsored by a core residency program in psychiatry that holds full accreditation from the Accreditation Council for Graduate Medical Education (ACGME).

I.A.2. The program must take place in facilities approved by state licensing agencies and, where appropriate, The Joint Commission.

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 fellows;

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, 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 fellow education during the assignment.

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an education experience, required for all fellows, 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 of and distance between participating sites should not be so great as to interfere with training and participation in conferences and other organized educational aspects of the program.

I.B.4. Presence of Other Training Programs

The program should provide peer interaction between its fellows and those of other specialties. To achieve this goal, an accredited training program in at least one nonpsychiatric medical specialty should be present within the program's participating institutions. Peer interaction among the fellows should occur in the course of clinical and/or didactic work, but it is most satisfactory when organized around joint patient evaluation and/or care. In addition, peer interaction with students in related fields, such as law, psychology, and social work, is highly desirable.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director responsible with authority and accountability for the operation of the program. The sponsoring institution's GMCEC 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. Qualifications of the program director must include:

II.A.2.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

II.A.2.b) current certification in the subspecialty by the American Board of Psychiatry and Neurology (ABPN), or subspecialty qualifications that are acceptable to the Review Committee;

II.A.2.c) current medical licensure and appropriate medical staff appointment;

II.A.3. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. The program director must:

II.A.3.a) prepare and submit all information required and requested by the ACGME;

II.A.3.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

II.A.3.c) obtain review and approval of the sponsoring institution's GMCEC/DIO before submitting to the ACGME information or requests for the following:

- II.A.3.c).(1) **all applications for ACGME accreditation of new programs;**
- II.A.3.c).(2) **changes in fellow complement;**
- II.A.3.c).(3) **major changes in program structure or length of training;**
- II.A.3.c).(4) **progress reports requested by the Review Committee;**
- II.A.3.c).(5) **responses to all proposed adverse actions;**
- II.A.3.c).(6) **requests for increases or any change to fellow duty hours;**
- II.A.3.c).(7) **voluntary withdrawals of ACGME-accredited programs;**
- II.A.3.c).(8) **requests for appeal of an adverse action; and,**
- II.A.3.c).(9) **appeal presentations to a Board of Appeal or the ACGME.**

- II.A.3.d) **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.3.d).(1) **program citations, and/or**
 - II.A.3.d).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**

- II.A.3.e) select fellows for appointment to the program in accordance with institutional and departmental policies and procedures. The director must receive documentation from the general psychiatry program completed by an applicant to verify satisfactory completion of all educational and ethical requirements for graduation before the applicant is appointed to the program. Agreements with applicants made prior to the completion of the general residency must be contingent on this requirement;

- II.A.3.f) monitor the progress of each fellow, including the maintenance of a training record that documents completion of all required components of the program as well as evaluations of fellows' clinical and didactic work by supervisors and teachers. This record shall include a patient log that shall document that each fellow has completed all clinical experiences required by the Program Requirements and the educational objectives of the program;

- II.A.3.g) ensure the provision of written descriptions of departmental

policies regarding salary and benefits, due process, sickness and other leaves, on-call responsibilities, and vacation time to all fellows on their appointment to the program. All fellows must be provided with written descriptions of the malpractice coverage provided for each clinical assignment;

II.A.3.h) be an active clinician and must devote sufficient time to the program to ensure implementation of the educational goals and objectives; and,

II.A.3.i) participate in scholarly activities appropriate to the subspecialty such as local, regional, and national specialty societies; research; presentations; and publication.

II.B. Faculty

II.B.1. There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.

II.B.1.a) The faculty must include at least one certified child and adolescent psychiatrist.

II.B.1.b) In addition to the faculty psychiatrists, the faculty must include a lawyer and a forensic psychologist.

II.B.2. The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.

II.B.3. The physician faculty must have current certification in the subspecialty by the American Board of Psychiatry and Neurology, or possess qualifications acceptable to the Review Committee.

II.B.4. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

II.B.5. 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:

II.B.5.a) the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;

II.B.5.b) the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks; and,

II.B.5.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.

- II.B.6. 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 fellows involved in research such as research design and statistical analysis); and the provision of support for fellows' participation, as appropriate, in scholarly activities.
- II.B.7. Physician faculty members must be additionally qualified by experience in forensic psychiatry to provide the expertise needed to fulfill the didactic, clinical, and research goals of the program.
- II.B.8. Programs with large patient populations, multiple participating sites, and large fellow complements will be expected to have additional faculty members appropriate to their program's size and structure.
- II.B.9. A member of the teaching staff of each participating site 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. The director of forensic psychiatry training at each participating site shall be appointed by or with the concurrence of the forensic psychiatry program director.
- II.B.10. 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 fellow representative should participate in these reviews.
- II.B.11. The teaching staff should periodically evaluate the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the teaching staff, and the quality of supervision of fellows.

II.C. Other Program Personnel

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

II.D. Resources

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

- II.D.1. All elements of the program must be located in designated facilities based on written affiliation agreements and must include experiences in the

following three venues:

- II.D.1.a) Facilities in which forensic psychiatric evaluations are performed on subjects with a broad variety of psychiatric disorders, where fellows can learn evaluation techniques. These may include court clinics, inpatient forensic units, outpatient forensic clinics, and private practices.
- II.D.1.b) Facilities that provide general psychiatric services to patients with a broad variety of psychiatric disorders, where fellows can learn consultation regarding legal issues in psychiatric practice. These may include inpatient and outpatient facilities or may be specialized facilities that provide psychiatric care to correctional populations.
- II.D.1.c) Facilities that treat persons in the correctional system, where fellows can learn about the specialized treatment issues raised by these populations and settings. These may include prisons, jails, hospital-based correctional units, halfway facilities, rehabilitation programs, community probation programs, forensic clinics, juvenile detention facilities, and maximum-security forensic hospital facilities. Appropriate support services to ensure an adequate educational experience at all participating sites must be available, including support personnel and a physically safe environment in which fellows may carry out their clinical and educational functions.
- II.D.2. Library
- II.D.2.a) Fellows must have ready access to a major medical library or online access to relevant medical and legal materials at the institution where the fellows are located or through arrangement with convenient nearby institutions.
- II.D.2.b) Library services should include the electronic retrieval of information from medical databases.

II.E. Medical Information Access

Fellows 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. Fellow Appointments

III.A. Eligibility Criteria

Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. The program must document that each fellow has met the eligibility criteria.

III.A.1. Each fellow must have satisfactorily completed an ACGME-accredited general psychiatry residency prior to entering the program.

III.B. Number of Fellows

The program director may not appoint more fellows 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 fellows appointed to the program.

IV. Educational Program

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

IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty annually, in either written or electronic form. These skills and competencies should be reviewed by the fellow at the start of each rotation;

IV.A.2. ACGME Competencies

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

IV.A.2.a) Patient Care

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

IV.A.2.b) Medical Knowledge

Fellows 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.

IV.A.2.c) Practice-based Learning and Improvement

Fellows are expected to develop skills and habits to be able to meet the following goals:

IV.A.2.c).(1) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and,

IV.A.2.c).(2) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.

IV.A.2.d)

Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

IV.A.2.e)

Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

IV.A.2.f)

Systems-based Practice

Fellows 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.

IV.A.3.

Didactic Curriculum

The didactic curriculum must include the following components:

IV.A.3.a)

a psychiatric curriculum that includes the:

IV.A.3.a).(1)

history of forensic psychiatry;

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

roles and responsibilities of forensic psychiatrists;

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

assessment of competency to stand trial, criminal responsibility, amnesia, testamentary capacity, and civil competency;

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

issues involved in the assessment of dangerousness;

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

assessment of the accused sexual offender;

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

evaluation and treatment of incarcerated individuals;

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

ethical, administrative, and legal issues in forensic psychiatry;

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

legal regulation of psychiatric practice;

IV.A.3.a).(9)

writing of a forensic report; and,

IV.A.3.a).(10)

eyewitness testimony.

IV.A.3.b)

a law curriculum that covers issues in the legal system related to

forensic psychiatry, such as:

- IV.A.3.b).(1) fundamentals of law, statutes, and administrative regulations;
- IV.A.3.b).(2) the structure of federal and state court systems;
- IV.A.3.b).(3) use of a law library or on-line legal reference services;
- IV.A.3.b).(4) theory and practice of sentencing of the convicted offender;
- IV.A.3.b).(5) basic civil procedure;
- IV.A.3.b).(6) basic criminal procedure;
- IV.A.3.b).(7) jurisdiction;
- IV.A.3.b).(8) responsibility;
- IV.A.3.b).(9) tort law:
- IV.A.3.b).(10) children's rights;
- IV.A.3.b).(11) family law;
- IV.A.3.b).(12) confessions;
- IV.A.3.b).(13) structure and function of juvenile systems; and,
- IV.A.3.b).(14) structure and function of correctional systems.
- IV.A.3.c) a civil law curriculum that includes issues such as:
 - IV.A.3.c).(1) conservators and guardianships;
 - IV.A.3.c).(2) child custody determinations;
 - IV.A.3.c).(3) parental competence and termination of parental rights;
 - IV.A.3.c).(4) child abuse/neglect
 - IV.A.3.c).(5) psychiatric disability determinations;
 - IV.A.3.c).(6) testamentary capacity;
 - IV.A.3.c).(7) psychiatric malpractice;
 - IV.A.3.c).(8) personal injury litigation; and,
 - IV.A.3.c).(9) developmental disability law, i.e., individualized

educational needs and the right to the least restrictive environment for education.

- IV.A.3.d) a criminal law curriculum that includes issues such as:
 - IV.A.3.d).(1) competence to stand trial;
 - IV.A.3.d).(2) competence to enter a plea;
 - IV.A.3.d).(3) testimonial capacity;
 - IV.A.3.d).(4) voluntariness of confessions;
 - IV.A.3.d).(5) insanity defense(s);
 - IV.A.3.d).(6) diminished capacity;
 - IV.A.3.d).(7) evaluations in aid of sentencing;
 - IV.A.3.d).(8) safe release of persons acquitted by reason of insanity; and,
 - IV.A.3.d).(9) competence to be executed.
- IV.A.3.e) conferences in forensic psychiatry, such as grand rounds, case conferences, readings seminars, and journal clubs, that should be specifically designed to augment the clinical experiences. Regular attendance by the fellows and the faculty should be documented.
- IV.A.4. Forensic experiences
 - IV.A.4.a) Forensic experiences must provide fellows with sufficient opportunity for the psychiatric evaluation of individuals involving:
 - IV.A.4.a).(1) criminal behavior;
 - IV.A.4.a).(2) criminal responsibility and competency to stand trial;
 - IV.A.4.a).(3) sexual misconduct;
 - IV.A.4.a).(4) dangerousness; and,
 - IV.A.4.a).(5) civil law and regulation of psychiatry issues.
 - IV.A.4.b) Fellows also must have experience in the review of written records, including clinical and legal documents, and in the preparation of written reports and/or testimony in a diversity of cases, for example:
 - IV.A.4.b).(1) aiding the court in the sentencing of criminal offenders;

- IV.A.4.b).(2) domestic relations cases;
- IV.A.4.b).(3) personal injury cases;
- IV.A.4.b).(4) allegations of sexual abuse; and,
- IV.A.4.b).(5) other cases involving ethical issues and legal regulation, such as involuntary hospitalization, confidentiality, right to treatment, right to refuse treatment, informed consent, and professional liability.
- IV.A.4.c) Fellows must have supervised experience in testifying in court or in mock trial simulations.
- IV.A.4.d) Fellows must have supervised training in the relevance of legal documents, such as police reports, court testimony, polygraphs, hypnosis, narcoanalysis, psychological and neuropsychological testing, brain-imaging techniques, and other procedures relevant to assessments and treatment in forensic psychiatry.
- IV.A.4.e) Consultative experiences must provide fellows with an opportunity to interact with clinicians regarding legal issues that arise in psychiatric practice. This can occur in inpatient or outpatient settings and should include patients from diverse socioeconomic, educational, ethnic, and cultural backgrounds, with a variety of diagnoses. Fellows should have the opportunity to consult with clinicians regarding civil commitment and dangerousness, confidentiality, decision-making competence, guardianship, and refusal of treatment.
- IV.A.4.f) Clinical placement must provide fellows with experience in the evaluation and management of acutely and chronically ill patients in correctional systems such as prisons, jails, community programs, and secure forensic facilities. There also must be experience in working with other professionals and personnel in both forensic and community settings. A sufficient number and variety of patients, ranging from adolescence to old age and of diverse backgrounds, should be provided to ensure an adequate experience. Fellows must have at least six months' experience in the management of patients in correctional systems.
- IV.A.4.g) Direct clinical work with children under the age of 14 years should be limited to fellows who have previously completed ACGME-approved training in child and adolescent psychiatry or to fellows who are under the supervision of a board certified child and adolescent psychiatrist or an individual who possesses qualifications judged to be acceptable by the Review Committee.
- IV.A.4.h) Each fellow must have a minimum of two hours of individual supervision weekly, of which one hour must be individual and one hour may be group supervision.

IV.A.5. Fellow Administrative and Teaching Experiences

The program should provide appropriate experience designed to develop the administrative and teaching skills of forensic psychiatry fellows. As fellows progress through the program, they should have the opportunity to teach personnel such as other fellows, mental health professionals, and students.

IV.B. Fellow Scholarly Activity

Each program must provide an opportunity for fellows to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate fellow performance in a timely manner.

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); and,

V.A.1.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback.

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

V.A.1.d) Assessment should include quarterly written evaluations of the fellows by all supervisors and the directors of clinical components of training.

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in

accordance with institutional policy. This evaluation must:

- V.A.2.a) document the fellow's performance during their education, and**
- V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.**

V.B. Faculty Evaluation

- V.B.1. At least annually, the program must evaluate faculty performance as it pertains 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.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) fellow performance, and**
 - V.C.1.b) faculty development**
- 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. The program should use fellow performance and outcome assessment in its evaluation of the educational effectiveness of the fellowship program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the fellowship program.**

VI. Fellow 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 fellows 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 fellow well-being in a supportive educational**

environment.

VI.A.3. The program director must ensure that fellows 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 fellows to fulfill non-physician service obligations.

VI.A.5. The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows 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 fellows 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 fellows 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 fellows 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 fellows to recognize the signs of fatigue and sleep deprivation;**
- VI.C.1.b) **educate all faculty members and fellows 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 fellow 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 fellows who may be too fatigued to safely return home.

VI.D. Supervision of Fellows

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 fellows, faculty members, and patients.

VI.D.1.b) Fellows 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 fellows 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 fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care.

VI.D.3. Levels of Supervision

To ensure oversight of fellow 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 fellow 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 fellow must be assigned by the program director and faculty members.

VI.D.4.a) The program director must evaluate each fellow'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 fellows, based on the needs of the patient and the skills of the fellows.**
- VI.D.4.c) Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.**
- VI.D.5. Programs must set guidelines for circumstances and events in which fellows 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 fellow 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.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.**
- VI.E. Clinical Responsibilities**
- The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.**
- VI.F. Teamwork**
- Fellows 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. Fellow 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.

- 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 fellow to achieve the goals and objectives of the educational program.
- VI.G.2.b)** Time spent by fellows 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.3. Mandatory Time Free of Duty**
- Fellows 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**
- Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage fellows 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.a)** It is essential for patient safety and fellow education that effective transitions in care occur. Fellows 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)** Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
- VI.G.4.c)** In unusual circumstances, fellows, 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.c).(1)** Under those circumstances, the fellow must:
- VI.G.4.c).(1).(a)** appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
- VI.G.4.c).(1).(b)** 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.c).(2)** The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.

VI.G.5. Minimum Time Off between Scheduled Duty Periods

- VI.G.5.a)** Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

Forensic psychiatry fellows are considered to be in the final years of education.

- VI.G.5.a).(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 fellows have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows 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.a).(1).(a)** Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.

- VI.G.5.a).(1).(b)** There are no circumstances under which fellows may stay on duty with fewer than eight hours off.

VI.G.6. Maximum Frequency of In-House Night Float

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

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

Fellows must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by fellows 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 fellow.

VI.G.8.b) Fellows 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”.

ACGME: February 2003 Effective: June 2003
Editorial Revision, July 1, 2009
Revised Common Program Requirements Effective: July 1, 2011