

ACGME Program Requirements for Graduate Medical Education in Psychosomatic Medicine

Common Program Requirements are in BOLD

Effective: June, 2003

I. Introduction

I.A. Definition and Scope of the Specialty

Psychosomatic Medicine is the discipline encompassing the study and practice of psychiatric disorders in patients with medical, surgical, obstetrical and neurological conditions, particularly for patients with complex and/or chronic conditions. Physicians specializing in psychosomatic medicine have expertise in the diagnosis and treatment of psychiatric disorders in complex medically ill patients. The practice of psychosomatic medicine requires comprehensive knowledge of patients with acute or chronic medical, neurological, or surgical illness in which psychiatric morbidity affects their medical care and/or quality of life; patients with somatoform disorder or with psychological factors in which psychiatric morbidity affects a physical condition; and patients with a psychiatric disorder that is the direct consequence of a primary medical condition.

I.B. Duration and Scope of Education

I.B.1. An accredited residency program in psychosomatic medicine must provide 12 months of supervised graduate education.

I.B.2. To be eligible for accreditation, the subspecialty program must function as an integral part of an accredited residency program in psychiatry. There must be a reporting relationship, to ensure compliance with the ACGME accreditation standards, from the program director of the subspecialty program to the program director of the parent psychiatry residency program.

I.B.3. Prior to entry into the program, each resident must be notified in writing of the required length of training.

II. Institutions

II.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 institutions.

II.B. Participating Institutions

II.B.1. Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated

activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.

II.B.1.a) Assignment to an institution should provide resources not otherwise available to the program

II.B.2. Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:

II.B.2.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

II.B.2.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

II.B.2.c) specify the duration and content of the educational experience; and

II.B.2.d) state the policies and procedures that will govern resident education during the assignment.

II.B.3. Assignments at participating institutions must be of sufficient length to ensure a quality educational experience and should provide sufficient opportunity for continuity of care. Although the number of participating institutions may vary with the various specialties' needs, all participating institutions must demonstrate the ability to promote the program goals and educational and peer activities. Exceptions must be justified and prior-approved.

III. Program Personnel and Resources

III.A. Program Director

III.A.1. There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the Residency Review Committee (RRC) through the Web Accreditation Data System of the Accreditation Council for Graduate Medical Education (ACGME).

III.A.1.a) The program director should be a member of the staff of the sponsoring or integrated institution.

III.A.2. The program director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are

essential to maintaining such an appropriate continuity of leadership.

III.A.3. Qualifications of the Program Director are as follows:

III.A.3.a) The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities

III.A.3.a).(1) The program director must have experience in his or her field.

III.A.3.b) The program director must be certified psychosomatic medicine by the American Board of Psychiatry and Neurology, or possess qualifications judged to be acceptable by the RRC.

III.A.3.c) The program director must be appointed in good standing and based at the primary teaching site.

III.A.4. Responsibilities of the program director are as follows:

III.A.4.a) The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.

III.A.4.b) The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.

III.A.4.c) The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.

III.A.4.d) The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:

III.A.4.d).(1) the addition or deletion of a participating institution

III.A.4.d).(2) a change in the format of the educational program;

- III.A.4.d).(3) a change in the approved resident complement for those specialties that approve resident complement.
- III.A.4.d).(4) On review of a proposal for any such major change in the program, the RRC may determine that a site visit is necessary.
- III.B. Faculty
- III.B.1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program.
- III.B.1.a) In addition to the program director, there must be a minimum of one additional physician faculty member who meets the requirements in III.B.3. below.
- III.B.2. The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, and must support the goals and objectives of the educational program of which they are a member.
- III.B.3. Qualifications of the physician faculty are as follows:
- III.B.3.a) The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.
- III.B.3.b) The physician faculty must be certified in psychosomatic medicine by the American Board of Psychiatry and Neurology, or possess qualifications judged to be acceptable by the RRC.
- III.B.3.c) The physician faculty must be appointed in good standing to the staff of an institution participating in the program.
- III.B.4. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. *Scholarship* is defined as the following:
- III.B.4.a) the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;
- III.B.4.b) the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;

III.B.4.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.

III.B.4.d) Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.

III.B.5. Qualifications of the nonphysician faculty are as follows:

III.B.5.a) Nonphysician faculty must be appropriately qualified in their field.

III.B.5.b) Nonphysician faculty must possess appropriate institutional appointments.

III.C. Other Program Personnel

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

III.D. Resources

The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.

IV. Resident Appointments

IV.A. Eligibility Criteria

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

IV.A.1. Subspecialty training in psychosomatic medicine is a voluntary component in the continuum of the educational process; such training should take place on satisfactory completion of an ACGME-accredited program in psychiatry.

IV.B. Number of Residents

The RRC will approve the number of residents based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional

funding, and the quality of faculty teaching.

IV.C. Resident Transfers

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

IV.D. Appointment of Fellows and Other Students

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

IV.D.1. The appointment of other residents requires a clear statement of the areas of training, clinical responsibilities, and duration of the special education. This statement must be supplied to the Residency Review Committee at the time the program is site visited.

IV.D.2. If such residents/trainees so appointed will, in the judgment of the Residency Review Committee, detract from the education of the regularly appointed psychosomatic residents, the accreditation status of the program may be adversely affected.

V. Program Curriculum

V.A. Program Design

V.A.1. Format

The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.

V.A.1.a) The educational program must provide an intellectual environment for acquiring the knowledge, skills, clinical judgment, and attitudes that are essential for practice of the subspecialty.

V.A.2. Goals and Objectives

The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments.

V.A.3. The responsibility given to residents in patient care should depend upon each resident's knowledge, problem-solving ability, manual skills, experience, and the severity and complexity of each patient's illness.

V.B. Specialty Curriculum

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

V.B.1. Curriculum

The training program must provide opportunities for residents to acquire advanced clinical knowledge and skills in the field of psychosomatic medicine. This objective must be accomplished by a combination of supervised clinical experiences and formal didactic conferences. The curriculum must assure residents the opportunity to acquire the cognitive knowledge, interpersonal skills, professional attitudes, and practical experience required of a psychiatrist with added qualifications in psychosomatic medicine. All major dimensions of the curriculum must be structured educational experiences guided by written goals and objectives as well as by specified teaching and evaluation methods. Educational experiences must be planned and faculty must attend and meaningfully participate.

V.B.2. Didactic experiences in psychosomatic medicine must provide residents with sufficient opportunity to develop knowledge, skill and proficiency involving

V.B.2.a) the nature and extent of psychiatric morbidity in medical illness and its treatments,

V.B.2.b) the impact of comorbid psychiatric disorders on the course of medical illness,

V.B.2.c) understanding of how and why patients respond to illness,

V.B.2.d) knowledge of appropriate treatment interventions for co-existing psychiatric disorders in the medically ill

V.B.2.e) psychological and psychiatric effects of new medical or surgical therapies,

V.B.2.f) the epidemiology of psychiatric illness and its treatment in medical disease, and

V.B.2.g) knowledge of the nature and factors that influence the physician-patient relationship.

V.B.3. Clinical Components

V.B.3.a)

Patient Population

There must be an adequate number of patients representing both sexes with a wide variety of clinical problems to provide a patient population sufficient to meet the educational needs of the residents. The number of critically ill patients available for the residents at the primary clinical site should be sufficient to meet the educational goals of the program.

V.B.3.b)

Clinical experiences in psychosomatic medicine must provide residents with sufficient opportunity for the psychiatric evaluation of individuals involving

V.B.3.b).(1)

psychiatric complications of medical illnesses,

V.B.3.b).(2)

psychiatric complications of medical treatments, especially medications, new surgical or medical procedures, transplantation, and a range of experimental therapies,

V.B.3.b).(3)

typical and atypical presentations of psychiatric disorders that are due to medical, neurological, and surgical illnesses,

V.B.3.b).(4)

evaluation and management of delirium, dementia, and secondary ("organic") psychiatric disorders,

V.B.3.b).(5)

evaluation and management of somatoform disorders, and chronic pain,

V.B.3.b).(6)

assessment of capacity to give informed consent for medical and surgical procedures in the presence of cognitive impairment

V.B.3.b).(7)

provision of non-pharmacologic interventions, including cognitive-behavioral psychotherapy, interpersonal psychotherapy, as well as focused, short-term psychotherapy in patients suffering the effects of complex medical disorders or their treatments,

V.B.3.b).(8)

indications for, and use of psychotropics in specific medical, neurological, obstetrical, and surgical conditions,

V.B.3.b).(9)

interactions between psychotropic medications and the full-range of medications used for a variety of medical and surgical conditions,

V.B.3.b).(10)

collaboration with other physicians, and other members of the multidisciplinary treatment team,

V.B.3.b).(11)

teaching other physicians and other members of the multidisciplinary team how to recognize and respond to

various psychiatric disorders,

V.B.3.b).(12) leading an integrated psychosocial health care team in the medical setting.

V.B.3.c) Residents must participate in continuity of patient care.

V.B.3.d) A written statement defining the role of related disciplines must be in place outlining requirements for multidisciplinary care and resident interactions with other specialties.

V.C. Residents Scholarly Activities

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

V.D. ACGME Competencies

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

V.D.1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;

V.D.2. *Medical Knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;

V.D.3. *Practice-based learning and improvement* that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;

V.D.4. *Interpersonal and communication skills* that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;

V.D.5. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;

V.D.6. *Systems-based practice*, as manifested by actions that 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.

VI. Resident Duty Hours and the Working Environment

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

VI.A. Supervision of Residents

VI.A.1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.

VI.A.1.a) Supervision of the residents by psychosomatic faculty members must be available at all times.

VI.A.2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.

VI.A.3. Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.

VI.B. Duty Hours

VI.B.1. Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.

VI.B.2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

VI.B.3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.

VI.B.4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

VI.C. On-call Activities

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

VI.C.1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.

VI.C.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

VI.C.3. No new patients may be accepted after 24 hours of continuous duty.

VI.C.4. *At-home call* (or pager call) is defined as a call taken from outside the assigned institution.

VI.C.4.a) The frequency of at-home call is not subject to the every-third- night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

VI.C.4.b) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

VI.C.4.c) The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

VI.D. Moonlighting

VI.D.1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

VI.D.2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.

VI.D.3. Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This

refers to the practice of *internal moonlighting*.

VI.E. Oversight

VI.E.1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.

VI.E.2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

VI.F. Duty Hours Exceptions

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

VII. Evaluation

VII.A. Resident

VII.A.1. Formative Evaluation

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

VII.A.1.a) Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

VII.A.1.b) Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.

VII.A.1.c) Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.

VII.A.2. Final Evaluation

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

- VII.A.2.a) The final evaluation of each resident must document proficiency in the following outcome areas:
- VII.A.2.a).(1) knowledge of abnormal behavior and psychiatric illnesses that occur among medical, neurological, obstetrics-gynecology, and surgical patients,
 - VII.A.2.a).(2) knowledge of biological, psychological and social factors that influence the development, course and outcome of medical/surgical diseases,
 - VII.A.2.a).(3) ability to diagnose and treat psychiatric disturbances that occur among the physically ill, including the administration of psychotropic medications to seriously ill patients,
 - VII.A.2.a).(4) understanding of pharmacology, including the psychopharmacology of the medically ill, with emphasis on, and psychiatric side effects of, non-psychotropic medications and the interactions of psychotropic medications with other medications on the central nervous system,
 - VII.A.2.a).(5) ability to provide consultation in medical and surgical settings,
 - VII.A.2.a).(6) facilitative skills necessary to enhance the care of psychiatric disturbances among the physically ill through cooperative interaction with other physicians and allied health professionals,
 - VII.A.2.a).(7) ability to effectively supervise medical students and residents performing consultations and to teach medical and surgical colleagues about psychiatric complications of physical illness,
 - VII.A.2.a).(8) participation in the development of new knowledge, evaluation of research findings, and the continuing acquisition of new knowledge, through the development of good habits of inquiry,

VII.A.2.a).(9) knowledge of the organizational and administrative skills needed to finance, staff, and manage a psychosomatic medicine service.

VII.B. Faculty

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

VII.C. Program

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

VII.C.1. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.

VII.C.2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency 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 residency program.

VII.C.2.a) When averaged over any five-year period, a minimum of 80% of all program graduates must successfully complete the examinations of the American Board of Psychiatry and Neurology.

VIII. Experimentation and Innovation

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

IX. Certification

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

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