

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Addiction Psychiatry**

3
4 **One-year Common Program Requirements are in BOLD**

5
6 Effective: July, 2003
7

8 **Introduction**

9
10 **Int.A. Residency and fellowship programs are essential dimensions of the**
11 **transformation of the medical student to the independent practitioner along**
12 **the continuum of medical education. They are physically, emotionally, and**
13 **intellectually demanding, and require longitudinally-concentrated effort on**
14 **the part of the resident or fellow.**

15
16 **The specialty education of physicians to practice independently is**
17 **experiential, and necessarily occurs within the context of the health care**
18 **delivery system. Developing the skills, knowledge, and attitudes leading to**
19 **proficiency in all the domains of clinical competency requires the resident**
20 **and fellow physician to assume personal responsibility for the care of**
21 **individual patients. For the resident and fellow, the essential learning**
22 **activity is interaction with patients under the guidance and supervision of**
23 **faculty members who give value, context, and meaning to those**
24 **interactions. As residents and fellows gain experience and demonstrate**
25 **growth in their ability to care for patients, they assume roles that permit**
26 **them to exercise those skills with greater independence. This concept—**
27 **graded and progressive responsibility—is one of the core tenets of**
28 **American graduate medical education. Supervision in the setting of**
29 **graduate medical education has the goals of assuring the provision of safe**
30 **and effective care to the individual patient; assuring each resident’s and**
31 **fellow’s development of the skills, knowledge, and attitudes required to**
32 **enter the unsupervised practice of medicine; and establishing a foundation**
33 **for continued professional growth.**

34
35 **Int.B. ~~Addiction psychiatry is the subspecialty of psychiatry that focuses on the~~**
36 **~~prevention, evaluation, and treatment of substance-related disorders as well as~~**
37 **~~related education and research. In addition, The addiction psychiatrist is~~**
38 **proficient ~~will be fully educated in techniques required in the treatment of the~~**
39 **~~larger group of patients with dual diagnoses of addictive disorders and other~~**
40 **~~psychiatric disorders.~~**

41
42 **Int.C. ~~Duration and Scope of Education~~**

43
44 **Int.C.1. ~~The length of the educational program in addiction psychiatry program must be~~**
45 **~~12 months in length. Any program that extends education beyond these minimum~~**
46 **~~requirements must present a clear educational rationale consonant with the~~**
47 **~~special requirements and objectives for a fellowship in addiction psychiatry.~~**

48
49 **Int.C.2. ~~Training in addiction psychiatry that occurred during the general~~**
50 **~~residency will not be credited toward the one-year requirement.~~**
51

- 52 **I. Institutions**
53
54 **I.A. Sponsoring Institution**
55
56 **One sponsoring institution must assume ultimate responsibility for the**
57 **program, as described in the Institutional Requirements, and this**
58 **responsibility extends to fellow assignments at all participating sites.**
59
60 **The sponsoring institution and the program must ensure that the program**
61 **director has sufficient protected time and financial support for his or her**
62 **educational and administrative responsibilities to the program.**
63
64 I.A.1. ~~The sponsoring institution must also sponsor program must be~~
65 ~~administratively attached to and sponsored by an Accreditation Council~~
66 ~~for Graduate Medical Education (ACGME)-accredited core residency~~
67 ~~program in psychiatry. The program must function in close relationship to~~
68 ~~the general psychiatry residency.~~
69
70 I.A.2. ~~The program must take place in facilities approved by the appropriate~~
71 ~~state licensing agencies and, where appropriate, by the Joint Commission~~
72 ~~on the Accreditation of Healthcare Organizations.~~
73
74 **I.B. Participating Sites**
75
76 **I.B.1. There must be a program letter of agreement (PLA) between the**
77 **program and each participating site providing a required**
78 **assignment. The PLA must be renewed at least every five years.**
79
80 **The PLA should:**
81
82 **I.B.1.a) identify the faculty who will assume both educational and**
83 **supervisory responsibilities for fellows;**
84
85 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
86 **formal evaluation of fellows, as specified later in this**
87 **document;**
88
89 **I.B.1.c) specify the duration and content of the educational**
90 **experience; and,**
91
92 **I.B.1.d) state the policies and procedures that will govern fellow**
93 **education during the assignment.**
94
95 **I.B.2. The program director must submit any additions or deletions of**
96 **participating sites routinely providing an educational experience,**
97 **required for all fellows, of one month full time equivalent (FTE) or**
98 **more through the Accreditation Council for Graduate Medical**
99 **Education (ACGME) Accreditation Data System (ADS).**
100

101 I.B.3. The number of and distance between participating sites ~~shall must not~~
102 ~~impair training and allow for full participation in conferences and other all~~
103 ~~organized educational aspects of the program.~~

104
105 I.B.4. ~~Presence of Other Programs~~

106
107 ~~The addiction psychiatry program should provide peer interaction~~
108 ~~between its fellows and those of other medical/surgical specialties. To~~
109 ~~achieve this goal, an Within the participating site there should be an~~
110 ~~ACGME-accredited program in at least one of the following non-~~
111 ~~psychiatric specialties; such as family medicine, internal medicine,~~
112 ~~neurology, or physical medicine and rehabilitation should be present~~
113 ~~within the participating sites of the program.~~

114 115 II. Program Personnel and Resources

116 117 II.A. Program Director

118
119 II.A.1. **There must be a single program director with authority and**
120 **accountability for the operation of the program. The sponsoring**
121 **institution's GMC must approve a change in program director.**
122 **After approval, the program director must submit this change to the**
123 **ACGME via the ADS.**

124
125 II.A.1.a) The program director must devote at least 15 hours per week to
126 the program. This must include activities related to administration,
127 didactic teaching, and individual supervision outside of clinical
128 activities.

129
130 II.A.2. **Qualifications of the program director must include:**

131
132 II.A.2.a) **requisite subspecialty expertise and documented educational**
133 **and administrative experience acceptable to the Review**
134 **Committee;**

135
136 II.A.2.a).(1) ~~_____ The program director must be an active clinician.~~

137
138 II.A.2.b) **current certification in the subspecialty by the American**
139 **Board of Psychiatry and Neurology (ABPN) , or subspecialty**
140 **qualifications that are acceptable to the Review Committee;**
141 **and,**

142
143 II.A.2.b).(1) The Review Committee accepts only ABPN certification in
144 the subspecialty.

145
146 II.A.2.c) **current medical licensure and appropriate medical staff**
147 **appointment.**

148
149 II.A.3. **The program director must administer and maintain an educational**
150 **environment conducive to educating the fellows in each of the**
151 **ACGME competency areas. The program director must:**

| | | |
|-----|----------------------|--|
| 152 | | |
| 153 | II.A.3.a) | prepare and submit all information required and requested by the ACGME; |
| 154 | | |
| 155 | | |
| 156 | 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; |
| 157 | | |
| 158 | | |
| 159 | | |
| 160 | II.A.3.c) | obtain review and approval of the sponsoring institution's GMC/DIO before submitting to the ACGME information or requests for the following: |
| 161 | | |
| 162 | | |
| 163 | | |
| 164 | II.A.3.c).(1) | all applications for ACGME accreditation of new programs; |
| 165 | | |
| 166 | | |
| 167 | II.A.3.c).(2) | changes in fellow complement; |
| 168 | | |
| 169 | II.A.3.c).(3) | major changes in program structure or length of training; |
| 170 | | |
| 171 | | |
| 172 | II.A.3.c).(4) | progress reports requested by the Review Committee; |
| 173 | | |
| 174 | II.A.3.c).(5) | responses to all proposed adverse actions; |
| 175 | | |
| 176 | II.A.3.c).(6) | requests for increases or any change to fellow duty hours; |
| 177 | | |
| 178 | | |
| 179 | II.A.3.c).(7) | voluntary withdrawals of ACGME-accredited programs; |
| 180 | | |
| 181 | | |
| 182 | II.A.3.c).(8) | requests for appeal of an adverse action; and, |
| 183 | | |
| 184 | II.A.3.c).(9) | appeal presentations to a Board of Appeal or the ACGME. |
| 185 | | |
| 186 | | |
| 187 | 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: |
| 188 | | |
| 189 | | |
| 190 | | |
| 191 | II.A.3.d).(1) | program citations, and/or |
| 192 | | |
| 193 | II.A.3.d).(2) | request for changes in the program that would have significant impact, including financial, on the program or institution. |
| 194 | | |
| 195 | | |
| 196 | | |
| 197 | II.A.3.e) | devote sufficient time to the program to ensure implementation and achievement of the educational goals and objectives. |
| 198 | | |
| 199 | | |
| 200 | II.A.3.f) | ensure the provision of written descriptions of departmental policies regarding salary and benefits, due process, sickness and |
| 201 | | |

- 202 other leaves, on-call responsibilities, and vacation time to all
203 fellows upon appointment to the program.
204
- 205 II.A.3.g) All fellows must be provided with written descriptions of the
206 malpractice coverage provided for each clinical assignment.
207
- 208 II.A.3.h) maintain all other records including those related to appointment,
209 departmental processes regarding due process, sickness and
210 other leaves, on-call responsibilities, and vacation time;
211
- 212 II.A.3.i) ensure the opportunity for fellows to achieve the cognitive
213 knowledge, interpersonal skills, professional attitudes, and
214 practical experience required of an addiction psychiatrist providing
215 acute and chronic care for the patient with substance-related
216 disorders.
217
- 218 II.A.3.j) develop and implement a supervision policy that specifies lines of
219 responsibility for program faculty members and fellows that is
220 consistent with the supervision policy in the general psychiatry
221 program; and,
222
- 223 II.A.3.k) participate in scholarly activities appropriate to the subspecialty,
224 including local, regional, and national specialty societies,
225 research, presentations, or publication.
226
- 227 **II.B. Faculty**
228
- 229 **II.B.1. There must be a sufficient number of faculty with documented**
230 **qualifications to instruct and supervise all fellows.**
231
- 232 II.B.1.a) In addition to the program director, there must be at least one
233 other FTE of faculty member certified by the American Board of
234 Psychiatry and Neurology (ABPN) in the subspecialty of addiction
235 psychiatry. Programs with large patient populations, multiple sites,
236 and large fellow complements will be expected to have the
237 number of physician faculty appropriate to the program's size and
238 structure.
239
- 240 II.B.1.b) Each participating site must have a designated site director who is
241 a member of the faculty and who is responsible for the day-to-day
242 activities of the program at that site, with overall coordination by
243 the program director.
244
- 245 **II.B.2. The faculty must devote sufficient time to the educational program**
246 **to fulfill their supervisory and teaching responsibilities and**
247 **demonstrate a strong interest in the education of fellows.**
248
- 249 **II.B.3. The physician faculty must have current certification in the**
250 **subspecialty by the American Board of Psychiatry and Neurology, or**
251 **possess qualifications acceptable to the Review Committee.**
252

253 **II.B.4. The physician faculty must possess current medical licensure and**
254 **appropriate medical staff appointment.**
255

256 **II.B.5. The responsibility for establishing and maintaining an environment of**
257 **inquiry and scholarship rests with the faculty, and an active research**
258 **component must be included in each program. Scholarship is defined as**
259 **the following: All faculty members must participate in scholarly activities**
260 **appropriate to the subspecialty, including local, regional, and national**
261 **specialty societies, research, presentations, or publications.**
262

263 **II.B.5.a).(1) the scholarship of *discovery*, as evidenced by peer-**
264 **reviewed funding or by publication of original research in a**
265 **peer-reviewed journal;**
266

267 **II.B.5.a).(2) the scholarship of *dissemination*, as evidenced by review**
268 **articles or chapters in textbooks; and,**
269

270 **II.B.5.a).(3) the scholarship of *application*, as evidenced by the**
271 **publication or presentation of, for example, case reports or**
272 **clinical series at local, regional, or national professional**
273 **and scientific society meetings.**
274

275 **II.B.6. Complementary to the above scholarship is the Faculty members must**
276 **regularly participation of participate the teaching staff in organized clinical**
277 **discussions, rounds, journal clubs, and research conferences. in a**
278 **manner that promotes a spirit of inquiry and scholarship (e.g., the offering**
279 **of guidance and technical support for fellows involved in research such as**
280 **research design and statistical analysis); and the provision of support for**
281 **fellows' participation, as appropriate, in scholarly activities.**
282

283 **II.C. Other Program Personnel**
284

285 **The institution and the program must jointly ensure the availability of all**
286 **necessary professional, technical, and clerical personnel for the effective**
287 **administration of the program.**
288

289 **II.C.1. Addiction psychiatry fellows must be provided with meaningful patient**
290 **care experiences as part of an interdisciplinary care team. The fellow**
291 **should work in settings that include representatives There must be**
292 **professional personnel available to the program from clinical disciplines**
293 **such as including social work, psychology, psychiatric nursing,**
294 **occupational therapy, pharmacy, and nutrition.**
295

296 **II.C.2. as well as There must be clinicians available to the program in anesthesia**
297 **(including pain management), emergency medicine, family medicine,**
298 **geriatrics, internal medicine, neurology, obstetrics and gynecology,**
299 **surgical specialties, and pediatrics/adolescent medicine as appropriate for**
300 **the care of the patient.**
301

- 302 II.C.3. ~~In addition, fellows should work with other staff such as s~~Substance
303 abuse counselors and, where appropriate, ~~with teachers, should be~~
304 ~~available to the program.~~
305
- 306 II.C.4. There must be a designated program coordinator.
307
- 308 **II.D. Resources**
309
- 310 **The institution and the program must jointly ensure the availability of**
311 **adequate resources for fellow education, as defined in the specialty**
312 **program requirements.**
313
- 314 II.D.1. ~~All elements of the program must be located in designated facilities based~~
315 ~~on written affiliation agreements between the participating sites and the~~
316 ~~administration of the program.~~
317
- 318 II.D.2. ~~Inpatient Care Facility: The sponsor of the program must be a part of, or~~
319 ~~affiliated with,~~
320
- 321 II.D.2.a) There should be at least one acute care general hospital with a full
322 range of services, including medical and surgical services,
323 intensive care units, emergency services, diagnostic laboratory,
324 and imaging services.
325
- 326 II.D.2.a).(1) If the acute care hospital is specialized and does not itself
327 have the full spectrum of services described above, the
328 program must document that it has access for education
329 purposes to other affiliated acute care facilities that have
330 the services not present at the specialized facility.
331
- 332 II.D.3. ~~Partial Hospitalization and Day Treatment: Programs must have access~~
333 ~~to a partial hospitalization and/or day treatment program (such as an~~
334 ~~intensive outpatient program).~~
335
- 336 II.D.3.a) Such programs ~~may~~should be located either in community-based
337 sites or within the sponsoring department of psychiatry in its acute
338 care hospital.
339
- 340 II.D.3.b) ~~Exposure to s~~Self-help and other community programs (such as
341 12-step programs widely used by patients with substance-related
342 disorders) must be available ~~provided.~~
343
- 344 II.D.4. ~~Ambulatory Care Service: The program must provide experience in a~~
345 There must be a multidisciplinary ambulatory care facility. ~~such as a~~
346 ~~methadone maintenance clinic, an alcohol treatment clinic, or other~~
347 ~~specialized outpatient program.~~
348
- 349 II.D.5. ~~Library: Fellows must have ready access to a major medical library either~~
350 ~~at the institution where the fellows are located or through arrangement~~
351 ~~with convenient nearby institutions.~~
352

- 353 II.D.5.a) ~~Library services should include computer support for electronic~~
354 ~~retrieval of information from medical databases.~~
- 355
- 356 II.D.5.b) ~~There must be access to an onsite library or to a collection of~~
357 ~~appropriate texts and journals in each institution participating in~~
358 ~~the training program. On-site libraries and/or collections of texts~~
359 ~~and journals must be readily available during nights and~~
360 ~~weekends.~~
- 361
- 362 II.D.6. ~~Clinical experience must include the opportunity to evaluate and follow a~~
363 ~~variety of There must be patients of both sexes, including adolescents,~~
364 ~~adults, and geriatric patients of each gender and age groups spanning a~~
365 ~~broad range of diagnoses to ensure that fellows achieve proficiency in the~~
366 ~~required patient care outcomes. as enumerated in Program Requirements~~
367 ~~IV.A.5. Fellows must provide both primary and consultative care in both~~
368 ~~inpatient (including intensive care) and outpatient settings for patients~~
369 ~~with a wide variety of types of substance-related disorders. Where the~~
370 ~~primary site is devoted to the care of patients with only a particular form of~~
371 ~~substance-related disorders, appropriate affiliations must be arranged to~~
372 ~~ensure that adequate exposure is provided to a sufficient number and~~
373 ~~variety of patients with substance-related disorders. The number and~~
374 ~~variety of new and follow-up patients spanning the life cycle from~~
375 ~~adolescence to old age must be sufficient to ensure an adequate~~
376 ~~outpatient and inpatient experience as specified in Intro.C.2.~~
- 377
- 378 II.D.6.a) ~~The spectrum of patients should include diverse socioeconomic,~~
379 ~~educational, and cultural backgrounds.~~
- 380
- 381 II.D.7. ~~Ancillary Support Services: At all participating facilities, there must be~~
382 ~~appropriate support services to ensure an adequate educational~~
383 ~~experience. This includes support personnel in all categories including~~
384 ~~clerical and laboratory and physical resources to ensure that fellows have~~
385 ~~sufficient time and space to carry out their clinical and educational~~
386 ~~functions.~~
- 387
- 388 **II.E. Medical Information Access**
- 389
- 390 **Fellows must have ready access to specialty-specific and other appropriate**
391 **reference material in print or electronic format. Electronic medical literature**
392 **databases with search capabilities should be available.**
- 393
- 394 **III. Fellow Appointments**
- 395
- 396 **III.A. Eligibility Criteria**
- 397
- 398 **Each fellow must successfully complete an ACGME-accredited specialty**
399 **program and/or meet other eligibility criteria as specified by the Review**
400 **Committee. The program must document that each fellow has met the**
401 **eligibility criteria.**
- 402

- 403 III.A.1. Prior to appointment in the program The addiction psychiatry fellow
404 fellows must have satisfactorily completed either an ACGME-accredited
405 general psychiatry program or a general psychiatry program in Canada
406 accredited by the Royal College of Physicians and Surgeons of Canada
407 residency prior to entering the program.
408
- 409 III.A.2. Prior to appointment in the program entry, each addiction psychiatry
410 fellow must be notified in writing of the required length of education. for
411 which the program is accredited The required length of education may not
412 be changed without mutual agreement unless there is a break in
413 education or the fellow requires remedial education.
414
- 415 III.A.3. supervise the recruitment, selection, and appointment process for
416 applicants, including compliance with appropriate credentialing policies
417 and procedures in accordance with institutional and departmental policies
418 and procedures. Prior to appointment to the program, the The program
419 director must receive documentation from the each fellow's prior general
420 psychiatry program in order to verifying satisfactory completion of all
421 educational and ethical requirements for graduation., before appointment
422 to the program;
423
- 424 III.A.3.a) Agreements with applicants made prior to the completion of the
425 general residency must be contingent on this requirement.
426
- 427 **III.B. Number of Fellows**
428
- 429 **The program director may not appoint more fellows than approved by the**
430 **Review Committee, unless otherwise stated in the specialty-specific**
431 **requirements. The program's educational resources must be adequate to**
432 **support the number of fellows appointed to the program.**
433
- 434 III.B.1. Any permanent changes in fellow complement will require prior approval
435 by the RRC.
436
- 437 III.B.2. At the same time, the presence of fellows in addiction psychiatry must not
438 dilute or otherwise detract from the didactic or clinical experience
439 available to general psychiatry residents.
440
- 441 III.B.3. The presence of other learners must not interfere with the appointed
442 fellows' education.
443
- 444 **IV. Educational Program**
445
- 446 **IV.A. The curriculum must contain the following educational components:**
447
- 448 **IV.A.1. Skills and competencies the fellow will be able to demonstrate at the**
449 **conclusion of the program. The program must distribute these skills**
450 **and competencies to fellows and faculty annually, in either written**
451 **or electronic form. These skills and competencies should be**
452 **reviewed by the fellow at the start of each rotation;**
453

454 IV.A.1.a) ~~The program must offer advanced education such that the~~
455 ~~knowledge, skills, clinical judgment, and attitudes essential to the~~
456 ~~practice of addiction psychiatry at the consultant level are~~
457 ~~provided.~~
458

459 **IV.A.2. ACGME Competencies**

460
461 **The program must integrate the following ACGME competencies**
462 **into the curriculum:**
463

464 **IV.A.2.a) Patient Care**

465
466 **Fellows must be able to provide patient care that is**
467 **compassionate, appropriate, and effective for the treatment of**
468 **health problems and the promotion of health. Fellows:**
469

470 ~~IV.A.2.a).(1) The program must include the following clinical~~
471 ~~components:~~
472

473 IV.A.2.a).(2) ~~must, as part of their program's clinical components,~~
474 demonstrate proficiency in evaluating and treating
475 ~~evaluate, consult with, and treat the following patients:~~
476

477 IV.A.2.a).(2).(a) patients with primary substance-related disorders,
478 and their families;
479

480 IV.A.2.a).(2).(b) medical and surgical patients in the emergency
481 department, intensive care units, and general
482 wards of the hospital with acute and chronic
483 substance-related disorders, including acute
484 intoxication and overdose;
485

486 IV.A.2.a).(2).(c) psychiatric inpatients and outpatients with chemical
487 dependencies and co-morbid psychopathology to
488 include a broad range of psychiatric diagnoses,
489 ~~such as~~ affective disorders, psychotic disorders,
490 organic disorders, personality disorders, and
491 anxiety disorders, as well as patients suffering from
492 medical conditions commonly associated with
493 substance-related disorders such as including
494 hepatitis and HIV/AIDS; and,
495

496 IV.A.2.a).(2).(d) medication-dependent patients with chronic
497 medical disorders/conditions, ~~(such as including~~
498 ~~patients with chronic pain);~~
499

500 **IV.A.2.b) Medical Knowledge**

501
502 **Fellows must demonstrate knowledge of established and**
503 **evolving biomedical, clinical, epidemiological and social-**
504 **behavioral sciences, as well as the application of this**

| | | |
|-----|-----------------------|---|
| 505 | | knowledge to patient care. Fellows: |
| 506 | | |
| 507 | IV.A.2.b).(1) | must <u>demonstrate proficiency in their knowledge of:</u> |
| 508 | | <u>acquire knowledge and skills in the following areas:</u> |
| 509 | | |
| 510 | IV.A.2.b).(1).(a) | knowledge of the signs and symptoms of the use |
| 511 | | and abuse of all of the major categories of |
| 512 | | substances, enumerated in IV.A.2.a)(2), as well as |
| 513 | | knowledge of the types of treatment required for |
| 514 | | each; |
| 515 | | |
| 516 | IV.A.2.b).(1).(a).(i) | <u>Fellows must demonstrate</u> knowledge of the |
| 517 | | signs of withdrawal from these major |
| 518 | | categories of substances, knowledge and |
| 519 | | experience with the range of options for |
| 520 | | treatment of the withdrawal syndromes, and |
| 521 | | <u>knowledge of</u> the complications commonly |
| 522 | | associated with such withdrawal. |
| 523 | | |
| 524 | IV.A.2.b).(1).(b) | knowledge of the signs and symptoms of signs and |
| 525 | | symptoms of overdose,; including the medical and |
| 526 | | psychiatric sequelae of overdose, and experience |
| 527 | | in providing proper treatment of overdose; |
| 528 | | |
| 529 | IV.A.2.b).(1).(c) | knowledge of the signs and symptoms of the social |
| 530 | | and psychological problems as well as and the |
| 531 | | medical and psychiatric disorders which often |
| 532 | | accompany the chronic use and abuse of the major |
| 533 | | categories of substances.; |
| 534 | | |
| 535 | IV.A.2.b).(1).(d) | knowledge and understanding of the special |
| 536 | | problems of the pregnant woman with substance- |
| 537 | | related disorders and of the babies born to these |
| 538 | | women; |
| 539 | | |
| 540 | IV.A.2.b).(1).(e) | knowledge of family systems and dynamics |
| 541 | | relevant to the etiology, diagnosis, and treatment of |
| 542 | | substance-related disorders; and, |
| 543 | | |
| 544 | IV.A.2.b).(1).(f) | knowledge of the genetic vulnerabilities, risk and |
| 545 | | protective factors, epidemiology, and prevention of |
| 546 | | substance-related disorders. |
| 547 | | |
| 548 | IV.A.2.c) | Practice-based Learning and Improvement |
| 549 | | |
| 550 | | Fellows are expected to develop skills and habits to be able |
| 551 | | to meet the following goals: |
| 552 | | |
| 553 | IV.A.2.c).(1) | systematically analyze practice using quality |
| 554 | | improvement methods, and implement changes with |
| 555 | | the goal of practice improvement; |

556
557 **IV.A.2.c).(2)** **locate, appraise, and assimilate evidence from**
558 **scientific studies related to their patients' health**
559 **problems;**

560
561 IV.A.2.c).(2).(a) This must include demonstrate familiarity with the
562 major medical journals and professional-scientific
563 organizations dealing with research on the
564 understanding and treatment of substance-related
565 disorders.

566
567 IV.A.2.c).(3) critically analyze research reports, as presented in journal
568 clubs and seminars; and,

569
570 IV.A.2.c).(4) ~~Fellows should develop demonstrate~~ administrative and
571 ~~As the fellows progress through the~~ teaching skills.
572 ~~they should have the opportunity to teach~~
573 ~~personnel such as other, including teaching and~~
574 ~~supervising~~ residents, medical students, and other allied
575 health professionals. ~~Fellows must have experience in~~
576 ~~teaching and supervising clinical trainees in the care of~~
577 ~~patients with substance-related disorders.~~

578
579 **IV.A.2.d)** **Interpersonal and Communication Skills**

580
581 **Fellows must demonstrate interpersonal and communication**
582 **skills that result in the effective exchange of information and**
583 **collaboration with patients, their families, and health**
584 **professionals.**

585
586 IV.A.2.d).(1) ~~Fellows must acquire knowledge and skills in the~~
587 ~~management of detoxification and inpatient management~~
588 ~~of Substance-related Disorders, as well as have~~
589 ~~experience in working must work~~ collaboratively with
590 specialists in the emergency department and intensive
591 care units in the diagnosis and management of acute
592 overdose symptoms.

593
594 IV.A.2.d).(2) ~~Fellows must work must have experience working~~
595 ~~collaboratively with other mental health providers and allied~~
596 ~~health professionals, including nurses, social workers,~~
597 ~~psychologists, nurse practitioners, counselors,~~
598 ~~pharmacists, and others who participate in the care of~~
599 ~~patients with substance-related disorders.~~

600
601 IV.A.2.d).(3) ~~Fellows must have experience in working work effectively~~
602 ~~with multidisciplinary teams as a consultant and as a team~~
603 ~~leader, including the integratieng of recommendations and~~
604 ~~decisions from consulting medical specialists and other~~
605 ~~professionals in related health disciplines.~~

606

| | | |
|-----|-------------------|--|
| 607 | IV.A.2.e) | Professionalism |
| 608 | | |
| 609 | | Fellows must demonstrate a commitment to carrying out |
| 610 | | professional responsibilities and an adherence to ethical |
| 611 | | principles. |
| 612 | | |
| 613 | IV.A.2.f) | Systems-based Practice |
| 614 | | |
| 615 | | Fellows must demonstrate an awareness of and |
| 616 | | responsiveness to the larger context and system of health |
| 617 | | care, as well as the ability to call effectively on other |
| 618 | | resources in the system to provide optimal health care. |
| 619 | | |
| 620 | IV.A.2.f).(1) | <u>Fellows must demonstrate an understanding of the must</u> |
| 621 | | <u>incorporate considerations of cost awareness and risk-</u> |
| 622 | | <u>benefit analysis in current economic aspects of providing</u> |
| 623 | | <u>psychiatric and other health care services to the addicted</u> |
| 624 | | <u>patients with substance-related disorder.</u> |
| 625 | | |
| 626 | IV.A.2.f).(2) | <u>Fellows must demonstrate knowledge of must incorporate</u> |
| 627 | | <u>quality assurance measures and cost effectiveness of</u> |
| 628 | | <u>various treatment modalities for <u>when treating</u> substance-</u> |
| 629 | | <u>related disorders.</u> |
| 630 | | |
| 631 | IV.A.3. | <u>Curriculum Organization and Fellow Experiences</u> |
| 632 | | |
| 633 | IV.A.3.a) | Completion of the program is best accomplished on a full-time |
| 634 | | basis. If it is undertaken on a part-time basis, The 12-month |
| 635 | | program must be completed within a two-year period. |
| 636 | | |
| 637 | IV.A.3.b) | Programs must be based on a structured written curriculum with |
| 638 | | well-defined goals and objectives. Clinical, basic science, and |
| 639 | | research conferences, as well as seminars and critical literature |
| 640 | | review activities pertaining to substance-related disorders must be |
| 641 | | conducted regularly and as scheduled. |
| 642 | | |
| 643 | IV.A.3.b).(1) | <u>Conferences in addiction psychiatry, such as including</u> |
| 644 | | <u>grand rounds, case conferences, reading seminars, and</u> |
| 645 | | <u>journal clubs, should be specifically designed to</u> |
| 646 | | <u>complement the clinical experiences.</u> |
| 647 | | |
| 648 | IV.A.3.b).(2) | <u>Fellows must attend at least 70% of all required didactic</u> |
| 649 | | <u>components of the program. Regular aAttendance by</u> |
| 650 | | <u>fellows and faculty <u>members</u> should be documented.</u> |
| 651 | | |
| 652 | IV.A.3.b).(3) | <u>Didactic topics must include: The curriculum must include</u> |
| 653 | | <u>sufficient didactic content so that the graduates will have a</u> |
| 654 | | <u>comprehensive understanding of</u> |
| 655 | | |
| 656 | IV.A.3.b).(3).(a) | <u>the pharmacology of all commonly abused</u> |
| 657 | | <u>substances, as well as <u>and</u> the actions of</u> |

658 pharmacological agents used to treat these
659 conditions;

660
661 IV.A.3.b).(3).(b) ~~Fellowship education must focus on the~~
662 biopsychosocial and functional concepts of
663 diagnosis and treatment as applied ~~in~~ to inpatient,
664 outpatient, and other treatment settings;

665
666 IV.A.3.b).(3).(c) iatrogenic aspects of illness, as well as cultural,
667 ethnic, racial, socioeconomic, ethical, and legal
668 considerations that may affect or interact with the
669 psychiatric care of ~~these patients must be included~~
670 ~~in the program~~;

671
672 IV.A.3.b).(3).(d) ~~The program should present the~~ epidemiology of
673 substance-related disorders, ~~such as~~ including
674 cultural, ethnic, racial, gender, sexual orientation,
675 socioeconomic, and familial factors affecting the
676 availability and use of addicting substances; and,
677

678 IV.A.3.b).(3).(e) functional assessment, signs, and symptoms of
679 neuropsychiatric impairment associated with
680 substance-related disorders, and the identification
681 of physical illnesses and iatrogenic factors that can
682 alter mental status, and behavior.

683
684 IV.A.3.b).(4) Clinical experience and didactics should be integrated to
685 provide appropriate progressive learning.

686
687 IV.A.3.c) ~~The field of addiction psychiatry requires knowledge of~~
688 ~~pharmacology, psychiatry, general medicine, as well as an~~
689 ~~understanding of the interaction of these disciplines. Programs~~
690 ~~must include both direct experiences in clinical care as well as~~
691 ~~formal didactic conferences. Instruction and experience~~ Fellow
692 experiences must include:
693

694 IV.A.3.c).(1) ~~should evaluate~~ evaluating acute and chronic patients in
695 inpatient and outpatient settings. ~~There should be an~~
696 ~~identifiable structured educational experience in~~
697 ~~neuropsychiatry relevant to the practice of addiction~~
698 ~~psychiatry that includes both didactic and clinical training~~
699 ~~methods. The curriculum should emphasize functional~~
700 ~~assessment, signs and symptoms of neuropsychiatric~~
701 ~~impairment associated with Substance-related Disorders,~~
702 ~~and the identification of physical illnesses and iatrogenic~~
703 ~~factors that can alter mental status, and behavior.~~

704
705 IV.A.3.c).(1).(a) Fellows must treat a minimum of five ~~addicted~~
706 outpatients with addictive disorders that include a
707 variety of diagnoses requiring individual treatment
708 for at least six months.

| | | |
|-----|-------------------|--|
| 709 | | |
| 710 | IV.A.3.c).(2) | the performance of performing assessments, including the |
| 711 | | mental status examination, a neuropsychiatric evaluation |
| 712 | | instrument such as the Mini-Mental Status Examination, |
| 713 | | community and environmental assessments, family and |
| 714 | | care giver assessments, medical assessments, and |
| 715 | | physical and psychological functional assessments; These |
| 716 | | skills comprise the basis for the formal assessment of the |
| 717 | | addicted patient using a synthesis of clinical findings, |
| 718 | | historical and current information, as well as data from |
| 719 | | laboratory and other special studies. |
| 720 | | |
| 721 | IV.A.3.c).(3) | must have experience with managing opiate replacement |
| 722 | | therapy; |
| 723 | | |
| 724 | IV.A.3.c).(4) | experience in the use of using psychoactive medications in |
| 725 | | the treatment of psychiatric disorders often accompanying |
| 726 | | the major categories of substance-related disorders; |
| 727 | | |
| 728 | IV.A.3.c).(5) | experience in the use of using techniques required for |
| 729 | | confrontation of and intervention with a chronic substance |
| 730 | | abuser, and in dealing with the defense mechanisms that |
| 731 | | cause the such a patient to resist entry into treatment; |
| 732 | | |
| 733 | IV.A.3.c).(6) | experience in the use of using the various |
| 734 | | psychotherapeutic modalities involved in the ongoing |
| 735 | | management of the chronic substance abusing patient, |
| 736 | | including individual psychotherapies, (e.g., cognitive- |
| 737 | | behavioral therapy), couples therapy, family therapy, group |
| 738 | | therapy, motivational enhancement therapy, and relapse |
| 739 | | prevention therapy; |
| 740 | | |
| 741 | IV.A.3.c).(7) | must work working with patients who are participating in |
| 742 | | self-help programs; |
| 743 | | |
| 744 | IV.A.3.c).(8) | must, as part of their program's clinical components, be |
| 745 | | exposed to assessing and treating patients with |
| 746 | | substance-related disorders related to the following |
| 747 | | substances: |
| 748 | | |
| 749 | IV.A.3.c).(8).(a) | alcohol; |
| 750 | | |
| 751 | IV.A.3.c).(8).(b) | benzodiazepines; |
| 752 | | |
| 753 | IV.A.3.c).(8).(c) | cannabis and hallucinogens; |
| 754 | | |
| 755 | IV.A.3.c).(8).(d) | cocaine and other stimulants; |
| 756 | | |
| 757 | IV.A.3.c).(8).(e) | opioids; |
| 758 | | |

759 IV.A.3.c).(8).(f) other substances of abuse, including sedatives,
760 hypnotics or anxiolytics; and,
761
762 ~~IV.A.3.c).(8).(g)~~ miscellaneous or unusual substances, e.g.,
763 designer drugs, organic solvents/inhalants
764
765 IV.A.3.c).(9) ~~The program must provide specific experiences in~~
766 providing consultation to acute and chronic medically ill
767 patients with substance-related disorders who are being
768 treated on emergency, intensive care, medical and/or
769 surgical services of a general hospital. ~~Supervision of~~
770 ~~addiction psychiatry fellows in their clinical evaluation of~~
771 ~~such patients, as well as in their consultative role, is~~
772 ~~essential. The program should provide fellows with the~~
773 ~~opportunity to~~
774
775 **IV.A.3.c).(9).(a)** Fellows should function at the level of a specialist
776 consultant to primary care physicians and to
777 intensive care specialists.
778
779 IV.A.3.d) Each fellow must have a minimum of two hours of individual
780 supervision faculty preceptorship weekly, of which one hour may
781 be group preceptorship supervision.
782
783 IV.A.3.e) Each fellow must maintain a patient log documenting all clinical
784 experiences.
785
786 IV.A.3.f) ~~peer interaction among the fellows should occur in the course of~~
787 ~~clinical and/or didactic work, but is most satisfactory when~~
788 ~~organized around joint patient evaluation and/or care.~~
789
790 **IV.B. Fellows' Scholarly Activities**
791
792 IV.B.1. ~~Each program must provide an opportunity for fellows to participate in~~
793 ~~research or other scholarly activities, and fellows must participate in such~~
794 ~~scholarly activities. Fellows must participate in developing new knowledge~~
795 ~~or evaluating research findings.~~
796
797 **V. Evaluation**
798
799 **V.A. Fellow Evaluation**
800
801 **V.A.1. Formative Evaluation**
802
803 V.A.1.a) **The faculty must evaluate fellow performance in a timely**
804 **manner.**
805
806 ~~V.A.1.a).(1)~~ ~~Supervision must include observation, assessment, and~~
807 ~~demonstration of the fellows' knowledge and skills in~~
808 ~~clinical evaluation, technical proficiency, and professional~~
809 ~~attitudes.~~

- 810
- 811 **V.A.1.b) The program must:**
- 812
- 813 **V.A.1.b).(1) provide objective assessments of competence in**
- 814 **patient care, medical knowledge, practice-based**
- 815 **learning and improvement, interpersonal and**
- 816 **communication skills, professionalism, and systems-**
- 817 **based practice;**
- 818
- 819 **V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients,**
- 820 **self, and other professional staff); and,**
- 821
- 822 **V.A.1.b).(3) provide each fellow with documented semiannual**
- 823 **evaluation of performance with feedback.**
- 824
- 825 **~~V.A.1.b).(3)-(a)~~ The evaluation must include review and discussion**
- 826 **with each fellow of his or her monitor the progress**
- 827 **of each addiction psychiatry fellow, including the**
- 828 **maintenance of an educational record that**
- 829 **documents documenting completion of all required**
- 830 **components of the program, as well as evaluations**
- 831 **of fellows'his or her clinical and didactic work by**
- 832 **supervisors and teachers.** ~~This record shall include~~
- 833 **a and his or her patient log which shall document**
- 834 **for each addiction psychiatry fellow that he/she has**
- 835 **completed documenting all clinical experiences.**
- 836 **required by the Program Requirements and the**
- 837 **educational objectives of the program.**
- 838
- 839 **V.A.1.c) The evaluations of fellow performance must be accessible for**
- 840 **review by the fellow, in accordance with institutional policy.**
- 841
- 842 **V.A.1.d) Assessment should include ~~the regular and timely performance~~**
- 843 **~~feedback to fellows that includes at least semiannual written~~**
- 844 **~~evaluations and written quarterly~~ written evaluations of the ~~all~~**
- 845 **fellows by all supervisors and ~~the~~ directors of clinical components**
- 846 **of the program.**
- 847
- 848 **V.A.2. Summative Evaluation**
- 849
- 850 **The program director must provide a summative evaluation for each**
- 851 **fellow upon completion of the program. This evaluation must**
- 852 **become part of the fellow's permanent record maintained by the**
- 853 **institution, and must be accessible for review by the fellow in**
- 854 **accordance with institutional policy. This evaluation must:**
- 855
- 856 **V.A.2.a) document the fellow's performance during their education,**
- 857 **and**
- 858
- 859 **V.A.2.b) verify that the fellow has demonstrated sufficient competence**
- 860 **to enter practice without direct supervision.**

- 861
862 V.A.3. The final evaluation of each fellow must document proficiency in all
863 required competency-based outcomes.
864
- 865 **V.B. Faculty Evaluation**
866
- 867 **V.B.1. At least annually, the program must evaluate faculty performance as**
868 **it relates to the educational program.**
869
- 870 **V.B.2. These evaluations should include a review of the faculty’s clinical**
871 **teaching abilities, commitment to the educational program, clinical**
872 **knowledge, professionalism, and scholarly activities.**
873
- 874 **V.C. Program Evaluation and Improvement**
875
- 876 **V.C.1. The program must document formal, systematic evaluation of the**
877 **curriculum at least annually. The program must monitor and track**
878 **each of the following areas:**
879
- 880 **V.C.1.a) fellow performance,**
881
- 882 **V.C.1.b) faculty development, and,**
883
- 884 **V.C.1.c) program goals and objectives, as well as program effectiveness in**
885 **achieving them.**
886
- 887 **V.C.1.c).(1) At least one fellow representative and all faculty members**
888 **should participate in these reviews.**
889
- 890 **V.C.2. If deficiencies are found, the program should prepare a written plan**
891 **of action to document initiatives to improve performance in the**
892 **areas listed in section V.C.1. The action plan should be reviewed**
893 **and approved by the teaching faculty and documented in meeting**
894 **minutes.**
895
- 896 **V.C.3. At least 80% of the program’s graduates from the preceding five years**
897 **should have taken the ABPN certifying examination in addiction**
898 **psychiatry.**
899
- 900 **V.C.4. At least 80% of the program’s graduates from the preceding five years**
901 **taking the ABPN examination for addiction psychiatry for the first time**
902 **must pass.**
903
- 904 **VI. Fellow Duty Hours in the Learning and Working Environment**
905
- 906 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
907
- 908 **VI.A.1. Programs and sponsoring institutions must educate fellows and**
909 **faculty members concerning the professional responsibilities of**
910 **physicians to appear for duty appropriately rested and fit to provide**
911 **the services required by their patients.**

- 912
913 **VI.A.2.** **The program must be committed to and responsible for promoting**
914 **patient safety and fellow well-being in a supportive educational**
915 **environment.**
916
- 917 **VI.A.3.** **The program director must ensure that fellows are integrated and**
918 **actively participate in interdisciplinary clinical quality improvement**
919 **and patient safety programs.**
920
- 921 **VI.A.4.** **The learning objectives of the program must:**
922
- 923 **VI.A.4.a)** **be accomplished through an appropriate blend of supervised**
924 **patient care responsibilities, clinical teaching, and didactic**
925 **educational events; and,**
926
- 927 **VI.A.4.b)** **not be compromised by excessive reliance on fellows to fulfill**
928 **non-physician service obligations.**
929
- 930 **VI.A.5.** **The program director and sponsoring institution must ensure a**
931 **culture of professionalism that supports patient safety and personal**
932 **responsibility. Fellows and faculty members must demonstrate an**
933 **understanding and acceptance of their personal role in the**
934 **following:**
935
- 936 **VI.A.5.a)** **assurance of the safety and welfare of patients entrusted to**
937 **their care;**
938
- 939 **VI.A.5.b)** **provision of patient- and family-centered care;**
940
- 941 **VI.A.5.c)** **assurance of their fitness for duty;**
942
- 943 **VI.A.5.d)** **management of their time before, during, and after clinical**
944 **assignments;**
945
- 946 **VI.A.5.e)** **recognition of impairment, including illness and fatigue, in**
947 **themselves and in their peers;**
948
- 949 **VI.A.5.f)** **attention to lifelong learning;**
950
- 951 **VI.A.5.g)** **the monitoring of their patient care performance improvement**
952 **indicators; and,**
953
- 954 **VI.A.5.h)** **honest and accurate reporting of duty hours, patient**
955 **outcomes, and clinical experience data.**
956
- 957 **VI.A.6.** **All fellows and faculty members must demonstrate responsiveness**
958 **to patient needs that supersedes self-interest. Physicians must**
959 **recognize that under certain circumstances, the best interests of the**
960 **patient may be served by transitioning that patient's care to another**
961 **qualified and rested provider.**
962

| | | |
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| 963 | VI.B. | Transitions of Care |
| 964 | | |
| 965 | VI.B.1. | Programs must design clinical assignments to minimize the number of transitions in patient care. |
| 966 | | |
| 967 | | |
| 968 | 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. |
| 969 | | |
| 970 | | |
| 971 | | |
| 972 | VI.B.3. | Programs must ensure that fellows are competent in communicating with team members in the hand-over process. |
| 973 | | |
| 974 | | |
| 975 | 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. |
| 976 | | |
| 977 | | |
| 978 | | |
| 979 | VI.C. | Alertness Management/Fatigue Mitigation |
| 980 | | |
| 981 | VI.C.1. | The program must: |
| 982 | | |
| 983 | VI.C.1.a) | educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; |
| 984 | | |
| 985 | | |
| 986 | VI.C.1.b) | educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, |
| 987 | | |
| 988 | | |
| 989 | 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. |
| 990 | | |
| 991 | | |
| 992 | | |
| 993 | 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. |
| 994 | | |
| 995 | | |
| 996 | | |
| 997 | 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. |
| 998 | | |
| 999 | | |
| 1000 | | |
| 1001 | VI.D. | Supervision of Fellows |
| 1002 | | |
| 1003 | 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. |
| 1004 | | |
| 1005 | | |
| 1006 | | |
| 1007 | | |
| 1008 | | |
| 1009 | | Only licensed independent practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient. |
| 1010 | | |
| 1011 | | |
| 1012 | | |
| 1013 | VI.D.1.a) | This information should be available to fellows, faculty |

| | | |
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| 1014 | | members, and patients. |
| 1015 | | |
| 1016 | VI.D.1.b) | Fellows and faculty members should inform patients of their respective roles in each patient’s care. |
| 1017 | | |
| 1018 | | |
| 1019 | VI.D.2. | The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients. |
| 1020 | | |
| 1021 | | |
| 1022 | | 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. |
| 1023 | | |
| 1024 | | |
| 1025 | | |
| 1026 | | |
| 1027 | | |
| 1028 | | |
| 1029 | | |
| 1030 | | |
| 1031 | | |
| 1032 | | |
| 1033 | VI.D.3. | Levels of Supervision |
| 1034 | | |
| 1035 | | To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision: |
| 1036 | | |
| 1037 | | |
| 1038 | | |
| 1039 | VI.D.3.a) | Direct Supervision – the supervising physician is physically present with the fellow and patient. |
| 1040 | | |
| 1041 | | |
| 1042 | VI.D.3.b) | Indirect Supervision: |
| 1043 | | |
| 1044 | 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. |
| 1045 | | |
| 1046 | | |
| 1047 | | |
| 1048 | | |
| 1049 | 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. |
| 1050 | | |
| 1051 | | |
| 1052 | | |
| 1053 | | |
| 1054 | | |
| 1055 | | |
| 1056 | VI.D.3.c) | Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. |
| 1057 | | |
| 1058 | | |
| 1059 | | |
| 1060 | 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. |
| 1061 | | |
| 1062 | | |
| 1063 | | |
| 1064 | | |

- 1065 VI.D.4.a) **The program director must evaluate each fellow’s abilities**
 1066 **based on specific criteria. When available, evaluation should**
 1067 **be guided by specific national standards-based criteria.**
 1068
- 1069 VI.D.4.b) **Faculty members functioning as supervising physicians**
 1070 **should delegate portions of care to fellows, based on the**
 1071 **needs of the patient and the skills of the fellows.**
 1072
- 1073 VI.D.4.c) **Fellows should serve in a supervisory role of residents or**
 1074 **junior fellows in recognition of their progress toward**
 1075 **independence, based on the needs of each patient and the**
 1076 **skills of the individual fellow.**
 1077
- 1078 VI.D.5. **Programs must set guidelines for circumstances and events in**
 1079 **which fellows must communicate with appropriate supervising**
 1080 **faculty members, such as the transfer of a patient to an intensive**
 1081 **care unit, or end-of-life decisions.**
 1082
- 1083 VI.D.5.a) **Each fellow must know the limits of his/her scope of**
 1084 **authority, and the circumstances under which he/she is**
 1085 **permitted to act with conditional independence.**
 1086
- 1087 VI.D.6. **Faculty supervision assignments should be of sufficient duration to**
 1088 **assess the knowledge and skills of each fellow and delegate to**
 1089 **him/her the appropriate level of patient care authority and**
 1090 **responsibility.**
 1091
- 1092 VI.E. **Clinical Responsibilities**
 1093
 1094 **The clinical responsibilities for each fellow must be based on PGY-level,**
 1095 **patient safety, fellow education, severity and complexity of patient**
 1096 **illness/condition and available support services.**
 1097
- 1098 VI.F. **Teamwork**
 1099
 1100 **Fellows must care for patients in an environment that maximizes effective**
 1101 **communication. This must include the opportunity to work as a member of**
 1102 **effective interprofessional teams that are appropriate to the delivery of care**
 1103 **in the specialty.**
 1104
- 1105 VI.F.1. **Contributors to effective interprofessional teams include consulting**
 1106 **physicians, psychologists, psychiatric nurses, social workers and other**
 1107 **professional and paraprofessional mental health personnel involved in the**
 1108 **evaluation and treatment of patients.**
 1109
- 1110 VI.G. **Fellow Duty Hours**
 1111
- 1112 VI.G.1. **Maximum Hours of Work per Week**
 1113
 1114 **Duty hours must be limited to 80 hours per week, averaged over a**
 1115 **four-week period, inclusive of all in-house call activities and all**

| | | |
|------|----------------------|--|
| 1116 | | moonlighting. |
| 1117 | | |
| 1118 | VI.G.1.a) | Duty Hour Exceptions |
| 1119 | | |
| 1120 | | A Review Committee may grant exceptions for up to 10% or a |
| 1121 | | maximum of 88 hours to individual programs based on a |
| 1122 | | sound educational rationale. |
| 1123 | | |
| 1124 | VI.G.1.a).(1) | In preparing a request for an exception the program |
| 1125 | | director must follow the duty hour exception policy |
| 1126 | | from the ACGME Manual on Policies and Procedures. |
| 1127 | | |
| 1128 | VI.G.1.a).(2) | Prior to submitting the request to the Review |
| 1129 | | Committee, the program director must obtain approval |
| 1130 | | of the institution's GMEC and DIO. |
| 1131 | | |
| 1132 | VI.G.2. | Moonlighting |
| 1133 | | |
| 1134 | VI.G.2.a) | Moonlighting must not interfere with the ability of the fellow |
| 1135 | | to achieve the goals and objectives of the educational |
| 1136 | | program. |
| 1137 | | |
| 1138 | VI.G.2.b) | Time spent by fellows in Internal and External Moonlighting |
| 1139 | | (as defined in the ACGME Glossary of Terms) must be |
| 1140 | | counted towards the 80-hour Maximum Weekly Hour Limit. |
| 1141 | | |
| 1142 | VI.G.3. | Mandatory Time Free of Duty |
| 1143 | | |
| 1144 | | Fellows must be scheduled for a minimum of one day free of duty |
| 1145 | | every week (when averaged over four weeks). At-home call cannot |
| 1146 | | be assigned on these free days. |
| 1147 | | |
| 1148 | VI.G.4. | Maximum Duty Period Length |
| 1149 | | |
| 1150 | | Duty periods of fellows may be scheduled to a maximum of 24 hours |
| 1151 | | of continuous duty in the hospital. Programs must encourage |
| 1152 | | fellows to use alertness management strategies in the context of |
| 1153 | | patient care responsibilities. Strategic napping, especially after 16 |
| 1154 | | hours of continuous duty and between the hours of 10:00 p.m. and |
| 1155 | | 8:00 a.m., is strongly suggested. |
| 1156 | | |
| 1157 | VI.G.4.a) | It is essential for patient safety and fellow education that |
| 1158 | | effective transitions in care occur. Fellows may be allowed to |
| 1159 | | remain on-site in order to accomplish these tasks; however, |
| 1160 | | this period of time must be no longer than an additional four |
| 1161 | | hours. |
| 1162 | | |
| 1163 | VI.G.4.b) | Fellows must not be assigned additional clinical |
| 1164 | | responsibilities after 24 hours of continuous in-house duty. |
| 1165 | | |
| 1166 | VI.G.4.c) | In unusual circumstances, fellows, on their own initiative, |

1167 may remain beyond their scheduled period of duty to
1168 continue to provide care to a single patient. Justifications for
1169 such extensions of duty are limited to reasons of required
1170 continuity for a severely ill or unstable patient, academic
1171 importance of the events transpiring, or humanistic attention
1172 to the needs of a patient or family.
1173

1174 **VI.G.4.c).(1)** Under those circumstances, the fellow must:

1175
1176 **VI.G.4.c).(1).(a)** appropriately hand over the care of all other
1177 patients to the team responsible for their
1178 continuing care; and,

1179
1180 **VI.G.4.c).(1).(b)** document the reasons for remaining to care for
1181 the patient in question and submit that
1182 documentation in every circumstance to the
1183 program director.
1184

1185 **VI.G.4.c).(2)** The program director must review each submission of
1186 additional service, and track both individual fellow and
1187 program-wide episodes of additional duty.
1188

1189 **VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**

1190
1191 **VI.G.5.a)** **Fellows must be prepared to enter the unsupervised practice**
1192 **of medicine and care for patients over irregular or extended**
1193 **periods.**

1194
1195 Addiction psychiatry fellows are considered to be in the final years
1196 of education.
1197

1198 **VI.G.5.a).(1)** **This preparation must occur within the context of the**
1199 **80-hour, maximum duty period length, and one-day-**
1200 **off-in-seven standards. While it is desirable that**
1201 **fellows have eight hours free of duty between**
1202 **scheduled duty periods, there may be circumstances**
1203 **when these fellows must stay on duty to care for their**
1204 **patients or return to the hospital with fewer than eight**
1205 **hours free of duty.**
1206

1207 **VI.G.5.a).(1).(a)** **Circumstances of return-to-hospital activities**
1208 **with fewer than eight hours away from the**
1209 **hospital by fellows must be monitored by the**
1210 **program director.**

1211
1212 **VI.G.5.a).(1).(b)** **There are no circumstances under which fellows**
1213 **may stay on duty with fewer than eight hours off.**
1214

1215 **VI.G.6.** **Maximum Frequency of In-House Night Float**

1216
1217 **Fellows must not be scheduled for more than six consecutive nights**

| | | |
|------|----------------------|--|
| 1218 | | of night float. |
| 1219 | | |
| 1220 | VI.G.7. | Maximum In-House On-Call Frequency |
| 1221 | | |
| 1222 | | Fellows must be scheduled for in-house call no more frequently than |
| 1223 | | every-third-night (when averaged over a four-week period). |
| 1224 | | |
| 1225 | VI.G.8. | At-Home Call |
| 1226 | | |
| 1227 | VI.G.8.a) | Time spent in the hospital by fellows on at-home call must |
| 1228 | | count towards the 80-hour maximum weekly hour limit. The |
| 1229 | | frequency of at-home call is not subject to the every-third- |
| 1230 | | night limitation, but must satisfy the requirement for one-day- |
| 1231 | | in-seven free of duty, when averaged over four weeks. |
| 1232 | | |
| 1233 | VI.G.8.a).(1) | At-home call must not be so frequent or taxing as to |
| 1234 | | preclude rest or reasonable personal time for each |
| 1235 | | fellow. |
| 1236 | | |
| 1237 | VI.G.8.b) | Fellows are permitted to return to the hospital while on at- |
| 1238 | | home call to care for new or established patients. Each |
| 1239 | | episode of this type of care, while it must be included in the |
| 1240 | | 80-hour weekly maximum, will not initiate a new “off-duty |
| 1241 | | period” |
| 1242 | | |
| 1243 | | *** |