Accreditation Council for
Graduate Medical Education

ACGME Program Requirements for Graduate Medical Education in Psychiatry

ACGME Program Requirements for Graduate Medical Education in Psychiatry

Common Program Requirements are in BOLD

Introduction

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

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

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

Int.C. ~~Duration of Education~~

The educational program in psychiatry must be 48 months in length. (Core)*

I. Institutions

I.A. Sponsoring Institution

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

responsibility extends to resident assignments at all participating sites. (Core)

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. (Core)

I.A.1. The sponsoring institution must:

I.A.1.a) ~~dedicate no less than~~ provide at least 50 percent salary support and protected time of 50 percent FTE (at least 20 hours per week) for the program director ~~of his or her professional effort to the psychiatry educational program and receive institutional support for this time.~~; (Core)

I.A.1.b) provide for at least 20 hours per week for direct program administration and education for the program director; and, (Core)

I.A.1.c) provide additional dedicated time and salary support either for the program director or for associate program directors, based on program size ~~and complexity of training sites~~. (Core)

I.A.1.c).(1) At a minimum, the following ~~a~~ total ~~of 30~~ hours per week~~,~~ must be provided for the program director or combined program director and associate program director ~~time, is required for an approved complement of 24 to 40 residents, and 40 hours per week for an approved complement of 41 to 79 residents. When a program is approved for 80 or more residents, there must be additional time allocated for directing the program~~: (Core)

Residents	Hours/Week
24-40	30
41-79	40
>80	40 + additional time* allocated for directing program (*10 additional hours for every 20 residents)

I.A.2. There must be a residency coordinator who has adequate time and institutional support, based on program size and complexity, to support the ~~residency~~ program. (Core)

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. (Detail)

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and

supervisory responsibilities for residents; (Detail)

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

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

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

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

I.B.3. ~~The number and distribution of participating sites must not preclude satisfactory participation by residents in teaching and didactic exercises. Geographic proximity of participating sites will be one factor in evaluating program cohesion, continuity, and peer interaction.~~ The number of and distance between participating sites must allow for full participation by residents in all organized education aspects of the program. (Core)

II. Program Personnel and Resources

II.A. Program Director

II.A.1. **There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director.** (Core)

II.A.1.a) **The program director must submit this change to the ACGME via the ADS.** (Core)

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

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

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

II.A.3.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;** (Core)

II.A.3.b) **current certification in the specialty by the American Board of** Psychiatry and Neurology (ABPN)**, or specialty qualifications**

147 **that are acceptable to the Review Committee; and,** (Core)
148
149 II.A.3.b).(1) The Review Committee accepts only ABPN certification.
150
151 **II.A.3.c)** **current medical licensure and appropriate medical staff**
152 **appointment.** (Core)
153
154 **II.A.4.** **The program director must administer and maintain an educational**
155 **environment conducive to educating the residents in each of the**
156 **ACGME competency areas.** (Core)
157
158 **The program director must:**
159
160 **II.A.4.a)** **oversee and ensure the quality of didactic and clinical**
161 **education in all sites that participate in the program;** (Core)
162
163 **II.A.4.b)** **approve a local director at each participating site who is**
164 **accountable for resident education;** (Core)
165
166 **II.A.4.c)** **approve the selection of program faculty as appropriate;** (Core)
167
168 **II.A.4.d)** **evaluate program faculty;** (Core)
169
170 **II.A.4.e)** **approve the continued participation of program faculty based**
171 **on evaluation;** (Core)
172
173 **II.A.4.f)** **monitor resident supervision at all participating sites;** (Core)
174
175 **II.A.4.g)** **prepare and submit all information required and requested by**
176 **the ACGME.** (Core)
177
178 **II.A.4.g).(1)** **This includes but is not limited to the program**
179 **application forms and annual program resident**
180 **updates to the ADS, and ensure that the information**
181 **submitted is accurate and complete.** (Core)
182
183 **II.A.4.h)** **ensure compliance with grievance and due process**
184 **procedures as set forth in the Institutional Requirements and**
185 **implemented by the sponsoring institution;** (Detail)
186
187 **II.A.4.i)** **provide verification of residency education for all residents,**
188 **including those who leave the program prior to completion;**
189 (Core)
190
191 **II.A.4.j)** **implement policies and procedures consistent with the**
192 **institutional and program requirements for resident duty**
193 **hours and the working environment, including moonlighting,**
194 (Core)
195
196 **and, to that end, must:**
197

II.A.4.j).(1) **distribute these policies and procedures to the residents and faculty;** (Detail)

II.A.4.j).(2) **monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;** (Core)

II.A.4.j).(3) **adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,** (Detail)

II.A.4.j).(4) **if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.** (Detail)

II.A.4.k) **monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;** (Detail)

II.A.4.l) **comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;** (Detail)

II.A.4.m) **be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;** (Detail)

II.A.4.n) **obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including:** (Core)

II.A.4.n).(1) **all applications for ACGME accreditation of new programs;** (Detail)

II.A.4.n).(2) **changes in resident complement;** (Detail)

II.A.4.n).(3) **major changes in program structure or length of training;** (Detail)

II.A.4.n).(4) **progress reports requested by the Review Committee;** (Detail)

II.A.4.n).(5) **responses to all proposed adverse actions;** (Detail)

II.A.4.n).(6) **requests for increases or any change to resident duty hours;** (Detail)

II.A.4.n).(7) **voluntary withdrawals of ACGME-accredited programs;** (Detail)

249 **II.A.4.n).(8)** **requests for appeal of an adverse action;** (Detail)
250
251 **II.A.4.n).(9)** **appeal presentations to a Board of Appeal or the**
252 **ACGME; and,** (Detail)
253
254 **II.A.4.n).(10)** **proposals to ACGME for approval of innovative**
255 **educational approaches.** (Detail)
256
257 **II.A.4.o)** **obtain DIO review and co-signature on all program**
258 **application forms, as well as any correspondence or**
259 **document submitted to the ACGME that addresses:** (Detail)
260
261 **II.A.4.o).(1)** **program citations, and/or,** (Detail)
262
263 **II.A.4.o).(2)** **request for changes in the program that would have**
264 **significant impact, including financial, on the program**
265 **or institution.** (Detail)
266
267 II.A.4.p) monitor performance and maintain personal contact with residents
268 during the first post-graduate year while they are on services other
269 than psychiatry; (Detail)
270
271 II.A.4.q) ~~make resident appointments and assignments in accordance with~~
272 ~~institutional and departmental policies and procedures; (Detail)~~
273
274 II.A.4.r) monitor residents~~'~~ stress, including physical or emotional
275 conditions which inhibit performance or learning, as well as drug-
276 or alcohol-related dysfunction; and, (Detail)
277
278 II.A.4.s) ~~Program directors and teaching staff members should be sensitive~~
279 ~~to the need~~ provide for timely ~~provision of~~ confidential counseling
280 and psychological support services to residents. (Detail)
281
282 ~~II.A.4.s).(1)~~ ~~Educational situations that consistently produce~~
283 ~~undesirable stress on residents must be evaluated and~~
284 ~~modified. (Detail)~~
285
286 II.A.4.t) ~~dedicate no less than 50 percent (at least 20 hours per week) of~~
287 ~~his or her professional effort to the psychiatry educational program~~
288 ~~and receive institutional support for this time. (Core)~~
289
290 ~~II.A.4.t).(1)~~ ~~This effort must be devoted to administrative and~~
291 ~~educational activities of the psychiatry educational~~
292 ~~program. (Core)~~
293
294 **II.B.** **Faculty**
295
296 **II.B.1.** **At each participating site, there must be a sufficient number of**
297 **faculty with documented qualifications to instruct and supervise all**
298 **residents at that location.** (Core)
299

The faculty must:

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

II.B.1.b) **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.** (Core)

II.B.2. **The physician faculty must have current certification in the specialty by the American Board of** Psychiatry and Neurology**, or possess qualifications judged acceptable to the Review Committee.** (Core)

II.B.3. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.** (Core)

II.B.4. **The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.** (Core)

II.B.5. **The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.** (Core)

II.B.5.a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.** (Detail)

II.B.5.b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**

II.B.5.b).(1) **peer-reviewed funding;** (Detail)

II.B.5.b).(2) **publication of original research or review articles in peer reviewed journals, or chapters in textbooks;** (Detail)

II.B.5.b).(3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,** (Detail)

II.B.5.b).(4) **participation in national committees or educational organizations.** (Detail)

II.B.5.c) **Faculty should encourage and support residents in scholarly activities.** (Core)

~~II.B.6. Faculty members must participate regularly and systematically in the educational program, and must be readily available for consultation whenever a resident is faced with a major therapeutic or diagnostic problem. (Detail)~~

~~II.B.7. Faculty members should actively participate in the planning, organization,~~

~~and presentation of conferences, as well as in clinical teaching and supervision. (Detail)~~

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

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. (Core)

II.C.1. Associate Program Director

An associate program director is a member of the physician teaching faculty who assists the program director in the administrative and clinical oversight of the educational program. (Core)

II.C.1.a) The associate program director must report directly to the program director. (Core)

II.C.2. Chair of Psychiatry

The chair of psychiatry must be:

II.C.2.a) a physician who is appointed to and in good standing with the medial staff of a site participating in the program; (Detail)

II.C.2.b) qualified and have at least three years' experience as a clinician, administrator, and educator in psychiatry; (Core)

II.C.2.c) certified in psychiatry by the ABPN~~American Board of Psychiatry and Neurology~~, or must possess appropriate qualifications judged to be acceptable by the Review Committee; (Core)

II.C.2.d) actively involved in psychiatry through continuing medical education, professional societies, and scholarly activities; and, (Detail)

II.C.2.e) capable of mentoring medical faculty members, residents, administrators, and other health care professionals, and possess medical leadership qualifications consistent with other physician chairs within the sponsoring institution. (Detail)

II.D. Resources

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

II.D.1. ~~These patients~~ There should be patients of different ages and genders from across the life cycle and from a variety of ethnic, racial, sociocultural, and economic backgrounds. (Detail)

II.D.2. There should be an inpatient population ~~must have adequate patients for each mode of required education and, minimally, must include~~ that is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and genders. (Detail)

II.D.3. Organized clinical services in inpatient, outpatient, emergency, consultation/liaison, and child and adolescent psychiatry must be available. (Core)

II.D.4. Patient services that are comprehensive and continuous should be available. (Detail)

II.D.5. ~~and~~ Allied medical and ancillary staff members ~~are~~ should be available for back-up support ~~at all times~~. (Detail)

II.D.6. ~~Programs must have available adequate inpatient and outpatient facilities and other suitable clinical placements at which the residents can meet the educational objectives of the program. (Core)~~

II.D.6.a) ~~The program should specify the facilities in which the goals and objectives are to be implemented. (Core)~~

II.D.7. ~~All residents~~ There must be ~~have available to them~~ offices designated for residents to use ~~adequate in size and decor to allow them~~ to interview patients and accomplish their clinical duties in a professional manner. (Core)

II.D.8. There ~~facility~~ must be ~~also provide adequate and~~ specifically-designated areas for ~~in which~~ residents~~'~~ to use to ~~can~~ perform basic physical examinations and other necessary diagnostic procedures and treatment interventions. (Core)

II.D.9. There must be ~~adequate~~ educational space and equipment, ~~including equipment~~ with the capability to record and playback ~~session~~, specifically designated for seminars, lectures, and other educational activities. (Core)

II.D.10. There must be available to residents equipment with the capacity for recording and viewing clinical encounters. (Core)

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. (Detail)

III. Resident Appointments

III.A. Eligibility Criteria

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

III.A.1. Prior to appointment in the program, ~~director must accept only those~~ applicants ~~whose qualifications of residency include~~ must demonstrate sufficient command of English to permit accurate and unimpeded communication. (Core)

III.A.2. Prior to entry in the program, each resident must be notified, in writing, of the required length of education for which the program is accredited. (Core)

III.A.2.a) ~~The required length of education for a particular resident must not be changed during his or her program without mutual agreement, unless there is a break in education or the resident requires remedial education. (Core)~~

III.B. Number of Residents

The program's educational resources must be adequate to support the number of residents appointed to the program. (Core)

III.B.1. The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. (Core)

III.B.2. Programs ~~must~~ should have at least three residents at each level of education. (Detail)

III.B.2.a) ~~Programs that fall below this prescribed critical mass will be reviewed, and if this deficiency is not corrected, they may be cited for non-compliance, except when the number of fourth-year residents is fewer than three because residents have entered child and adolescent psychiatry education. (Detail)~~

III.C. Resident Transfers

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

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

III.C.2.a) ~~Verification must include evaluation of professional integrity of~~

~~residents transferring from one program to another, including from a general psychiatry to a child and adolescent psychiatry program. (Detail)~~

~~III.C.3. A transferring resident's educational program must be sufficiently individualized so that he or she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation. (Detail)~~

III.C.4. If previous ACGME-accredited ~~training~~ education was not in a psychiatry program, residents may receive up to but no more than 12 months' credit for prior ~~training~~ education as part of the expected 48 months of the educational program. (Core)

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. (Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. (Detail)

IV. Educational Program

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

IV.A.1. Overall educational goals for the program, which the program must make available to residents and faculty; (Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form; (Core)

IV.A.3. Regularly scheduled didactic sessions; (Core)

IV.A.3.a) ~~The program must ensure the participation of~~ Residents and faculty members should participate in journal clubs, research conferences, didactics, and/or other activities that address critical appraisal of the literature and understanding of the research process. (Detail)

IV.A.3.b) Didactic instruction should ~~must be systematically organized, thoughtfully integrated, based on sound educational principles, and~~ include regularly scheduled lectures, seminars, and assigned readings that are coordinated with concurrent clinical experiences and are specific to the resident's level of education. (Detail)

IV.A.3.c) ~~The didactic sessions must be scheduled to ensure~~ Each resident must attend a minimum of 70 percent of ~~residents attendance while adhering to program duty hour policies~~ regularly scheduled didactic sessions. ~~Didactic and clinical education must have priority in the allotment of residents' time and energy.~~ (Core)

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

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents: (Outcome)

IV.A.5.a).(1).(a) must demonstrate competence in the evaluation and treatment of patients of different ages and genders from diverse backgrounds~~across the life cycle~~, and from a variety of ethnic, racial, sociocultural, and economic backgrounds; and; (Outcome)

IV.A.5.a).(1).(b) must demonstrate competence in:

IV.A.5.a).(1).(b).(i) forging a therapeutic alliance with patients and their families of all ages, genders, from diverse backgrounds, and from a variety of ethnic, racial, sociocultural, and economic backgrounds; (Outcome)

IV.A.5.a).(1).(b).(ii) formulating a clinical diagnosis for patients by conducting patient interviews, (Outcome)

IV.A.5.a).(1).(b).(iii) eliciting a clear and accurate history; (Outcome)

IV.A.5.a).(1).(b).(iv) performing a physical, neurological, and mental status examination, including use of appropriate diagnostic studies; (Outcome)

IV.A.5.a).(1).(b).(v) completing a systematic recording of findings in the medical record; (Outcome)

IV.A.5.a).(1).(b).(vi) ~~relating history and clinical findings to the relevant~~ formulating an understanding of a

patient's biological, psychological, behavioral, and sociocultural issues associated with etiology and treatment; (Outcome)

IV.A.5.a).(1).(b).(vii) developing a differential diagnosis and treatment plan for patients with ~~all~~ psychiatric disorders ~~in the current standard nomenclature, i.e., diagnostic and DSM, taking into consideration all relevant data~~; (Outcome)

IV.A.5.a).(1).(b).(viii) managing and treating patients using pharmacological regimens, including concurrent use of medications and psychotherapy; (Outcome)

IV.A.5.a).(1).(b).(ix) ~~applying~~ managing and treating patients using both brief and long-term supportive, psychodynamic, and cognitive-behavioral psychotherapies ~~to both brief and long-term patient encounters, as well as to ensuring exposure to family, couples, group, and other individual evidence-based psychotherapies~~; (Outcome)

IV.A.5.a).(1).(b).(x) providing psychiatric consultation in a variety of medical and surgical settings; (Outcome)

IV.A.5.a).(1).(b).(xi) managing and treating ~~the~~ chronically-mentally ill patients with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions; (Outcome)

IV.A.5.a).(1).(b).(xii) providing psychiatric care to patients ~~who are~~ receiving treatment from non-medical therapists and coordinating such treatment; and, (Outcome)

IV.A.5.a).(1).(b).(xiii) recognizing and appropriately responding to family violence (e.g., child, partner, and elder physical, emotional, and sexual abuse and neglect) and its effect on both victims and perpetrators. (Outcome)

IV.A.5.a).(2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Outcome)

IV.A.5.b) Medical Knowledge

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

must demonstrate competence in their ~~proficiency in their~~ knowledge of:

IV.A.5.b).(1) ~~the~~ major theoretical approaches to understanding the patient-doctor relationship; (Outcome)

IV.A.5.b).(2) ~~the~~ biological, genetic, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle; (Outcome)

IV.A.5.b).(3) ~~the~~ fundamental principles of the epidemiology, etiologies, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, family, sociocultural, and iatrogenic factors that affect the prevention, incidence, prevalence, and long-term course and treatment of psychiatric disorders and conditions; (Outcome)

IV.A.5.b).(4) ~~the~~ diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, ~~such as~~ including neoplasm, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders,~~ multiple sclerosis~~ neurocognitive disorders, seizure disorders, stroke, intractable pain, and other related disorders; (Outcome)

IV.A.5.b).(5) ~~the use,~~ reliability and validity of the generally-accepted diagnostic techniques, including physical examination of the patient, laboratory testing, imaging, neurophysiologic and neuropsychological testing, and psychological testing; (Outcome)

IV.A.5.b).(6) ~~the~~ indications for and uses of electroconvulsive and neuromodulation therap~~y~~ies; (Outcome)

IV.A.5.b).(7) ~~the use and interpretation of psychological testing~~;

~~IV.A.5.b).(7).(a) Under the supervision and guidance of a qualified clinical psychologist, residents should have experience with the interpretation of the psychological tests most commonly used, and some of this experience should be with their own~~

708 ~~patients.~~ ~~(Outcome)~~
709
710 IV.A.5.b).(8) ~~the~~ history of psychiatry and its relationship to the evolution
711 of medicine; (Outcome)
712
713 IV.A.5.b).(9) ~~the~~ legal aspects of psychiatric practice~~, and when and~~
714 ~~how to refer~~; (Outcome)
715
716 IV.A.5.b).(10) aspects of American culture and subcultures, including
717 immigrant populations, particularly those found in the
718 patient community associated with the educational
719 program, with specific focus on the cultural elements of the
720 relationship between the resident and the patient, including
721 the dynamics of differences in cultural identity, values and
722 preferences, and power ~~for residents with cultural~~
723 ~~backgrounds different from those of their patients~~; and,
724 (Outcome)
725
726 IV.A.5.b).(11) ~~Axis III~~ medical conditions that can affect evaluation and
727 care of patients~~(e.g., CNS lesions, HIV/AIDS, and other~~
728 ~~medical conditions)~~. (Outcome)
729
730 **IV.A.5.c) Practice-based Learning and Improvement**
731
732 **Residents must demonstrate the ability to investigate and**
733 **evaluate their care of patients, to appraise and assimilate**
734 **scientific evidence, and to continuously improve patient care**
735 **based on constant self-evaluation and life-long learning.**
736 (Outcome)
737
738 **Residents are expected to develop skills and habits to be able**
739 **to meet the following goals:**
740
741 **IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's**
742 **knowledge and expertise;** (Outcome)
743
744 **IV.A.5.c).(2) set learning and improvement goals;** (Outcome)
745
746 **IV.A.5.c).(3) identify and perform appropriate learning activities;**
747 (Outcome)
748
749 **IV.A.5.c).(4) systematically analyze practice using quality**
750 **improvement methods, and implement changes with**
751 **the goal of practice improvement;** (Outcome)
752
753 **IV.A.5.c).(5) incorporate formative evaluation feedback into daily**
754 **practice;** (Outcome)
755
756 **IV.A.5.c).(6) locate, appraise, and assimilate evidence from**
757 **scientific studies related to their patients' health**
758 **problems;** (Outcome)

759
760 **IV.A.5.c).(7)** **use information technology to optimize learning; and,** (Outcome)
761
762
763 **IV.A.5.c).(8)** **participate in the education of patients, families,**
764 **students, residents and other health professionals.**
765 (Outcome)
766
767 ~~IV.A.5.c).(9) take primary responsibility for lifelong learning to improve~~
768 ~~knowledge, skills, and practice performance through~~
769 ~~familiarity with general and rotation-specific goals and~~
770 ~~objectives, as well as attendance at conferences. (Outcome)~~
771
772 **IV.A.5.d)** **Interpersonal and Communication Skills**
773
774 **Residents must demonstrate interpersonal and**
775 **communication skills that result in the effective exchange of**
776 **information and collaboration with patients, their families,**
777 **and health professionals.** (Outcome)
778
779 **Residents are expected to:**
780
781 **IV.A.5.d).(1)** **communicate effectively with patients, families, and**
782 **the public, as appropriate, across a broad range of**
783 **socioeconomic and cultural backgrounds;** (Outcome)
784
785 **IV.A.5.d).(2)** **communicate effectively with physicians, other health**
786 **professionals, and health related agencies;** (Outcome)
787
788 **IV.A.5.d).(3)** **work effectively as a member or leader of a health care**
789 **team or other professional group;** (Outcome)
790
791 **IV.A.5.d).(4)** **act in a consultative role to other physicians and**
792 **health professionals; and,** (Outcome)
793
794 **IV.A.5.d).(5)** **maintain comprehensive, timely, and legible medical**
795 **records, if applicable.** (Outcome)
796
797 ~~IV.A.5.d).(6) interview patients and family in an effective manner to~~
798 ~~facilitate accurate diagnosis and biological, psychological,~~
799 ~~and social formulation. (Outcome)~~
800
801 **IV.A.5.e)** **Professionalism**
802
803 **Residents must demonstrate a commitment to carrying out**
804 **professional responsibilities and an adherence to ethical**
805 **principles.** (Outcome)
806
807 **Residents are expected to demonstrate:**
808
809 **IV.A.5.e).(1)** **compassion, integrity, and respect for others;** (Outcome)

810
811 **IV.A.5.e).(2)** **responsiveness to patient needs that supersedes self-**
812 **interest;** (Outcome)
813
814 **IV.A.5.e).(3)** **respect for patient privacy and autonomy;** (Outcome)
815
816 **IV.A.5.e).(4)** **accountability to patients, society and the profession;**
817 (Outcome)
818
819 **IV.A.5.e).(5)** **sensitivity and responsiveness to a diverse patient**
820 **population, including but not limited to diversity in**
821 **gender, age, culture, race, religion, disabilities, and**
822 **sexual orientation; and,** (Outcome)
823
824 IV.A.5.e).(6) high standards of ethical behavior which include respect
825 for patient privacy and autonomy, ability to maintaining
826 appropriate professional boundaries, including those and
827 understanding the nuances specific to psychiatric practice.
828 Programs are expected to distribute to residents and must
829 operate in accordance with the AMA Principles of Ethics
830 with "Special Annotations for Psychiatry," as developed by
831 the American Psychiatric Association, to ensure that the
832 application and teaching of these principles are an integral
833 part of the educational process. (Outcome)
834
835 **IV.A.5.f)** **Systems-based Practice**
836
837 **Residents must demonstrate an awareness of and**
838 **responsiveness to the larger context and system of health**
839 **care, as well as the ability to call effectively on other**
840 **resources in the system to provide optimal health care.** (Outcome)
841
842 **Residents are expected to:**
843
844 **IV.A.5.f).(1)** **work effectively in various health care delivery**
845 **settings and systems relevant to their clinical**
846 **specialty;** (Outcome)
847
848 **IV.A.5.f).(2)** **coordinate patient care within the health care system**
849 **relevant to their clinical specialty;** (Outcome)
850
851 **IV.A.5.f).(3)** **incorporate considerations of cost awareness and**
852 **risk-benefit analysis in patient and/or population-**
853 **based care as appropriate;** (Outcome)
854
855 **IV.A.5.f).(4)** **advocate for quality patient care and optimal patient**
856 **care systems;** (Outcome)
857
858 **IV.A.5.f).(5)** **work in interprofessional teams to enhance patient**
859 **safety and improve patient care quality;** (Outcome)
860

IV.A.5.f).(6) **participate in identifying system errors and implementing potential systems solutions;** (Outcome)

IV.A.5.f).(7) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources; (Outcome)

IV.A.5.f).(8) practice cost-effective health care and resource allocation that ~~does not compromise~~ is aligned with high quality of care, including an understanding of the financing and regulation of psychiatric practice, as well as information about the structure of public and private organizations that influence mental health care; (Outcome)

IV.A.5.f).(9) ~~advocate for quality patient care and~~ assisti~~ng~~ patients in dealing with system complexities and disparities in mental health care resources~~, including disparity in mental health care~~; and, (Outcome)

~~IV.A.5.f).(10) work with health care managers and health care providers to assess, coordinate, and improve health care, particularly as it relates to access to mental health care; (Outcome)~~

IV.A.5.f).(11) ~~know how to~~ advocate for the promotion of mental health and the prevention of mental disorders~~disease;~~. (Outcome)

~~IV.A.5.f).(12) maintain a mechanism to ensure that charts are appropriately maintained and readily accessible for patient care and regular review for supervisory and educational purposes; (Outcome)~~

~~IV.A.5.f).(13) collaborate with psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel in the treatment of patients; and, (Outcome)~~

IV.A.6. Curriculum Organization and Resident Experiences

IV.A.6.a) ~~Residency education in psychiatry requires 48 months, of which 12 months may be completed in an ACGME-accredited child and adolescent psychiatry program. Although residency is best completed on a full-time basis; part-time training at no less than half time is permissible to accommodate residents with personal commitments (e.g., child care) and the stated full-time equivalent experience is met. (Core)~~

~~IV.A.6.a).(1) A program may petition the residency review committee to alter the length of education beyond these minimum requirements by presenting a clear educational rationale consistent with the program requirements. The program~~

~~director must obtain the approval of the sponsoring institution and the Review Committee prior to implementation and at each subsequent review of the program. (Detail)~~

~~IV.A.6.a).(2)~~ ~~Programs should meet all of the Program Requirements for Graduate Medical Education in Psychiatry. Under rare and unusual circumstances, one- or two-year programs may be approved, even though they do not meet the above requirements for psychiatry. Such one- or two-year programs will be approved only if they provide some highly specialized educational and/or research program. These programs may provide an alternative specialized year or two of training, but do not provide complete residency education in psychiatry. The traditional program time and the specialized program must ensure that residents will complete the didactic and clinical requirements outlined in the program requirements. (Detail)~~

IV.A.6.b) Required Clinical ~~e~~Experiences ~~for residents must include:~~

IV.A.6.b).(1) ~~will have~~ Residents must have major responsibility for the care of a ~~significant~~ sufficient number of patients to demonstrate competence with acute and chronic psychiatric illnesses~~;~~. (Core)

IV.A.6.b).(2) There must be patient care assignments that permit residents to practice appropriate treatment, and to have sufficient time for other aspects of their educational program.

IV.A.6.b).(2).(a) These clinical responsibilities must be coordinated with and not impinge on the non-patient care aspects of the educational program. (Core)

IV.A.6.b).(3) There must be structured clinical experiences that are organized to provide opportunities to conduct initial evaluations, to participate in the subsequent diagnostic process, and to follow patients during the treatment phase and/or evolution of their psychiatric disorders/conditions; (Core)

IV.A.6.b).(4) ~~First Year of Education A~~ The first year in psychiatry ~~should~~ must include:

IV.A.6.b).(4).(a) a minimum of four months ~~in a primary care clinical setting~~ that provides comprehensive and continuous patient care in a primary care specialty setting~~specialties such as internal medicine, family medicine, and/or pediatrics. Neurology rotations may not be used to fulfill this four-month~~

~~requirement. One month of this requirement may be fulfilled by either an emergency medicine or intensive care rotation, provided the experience is predominantly with medical evaluation and treatment and not surgical procedures~~; and, (Core)

IV.A.6.b).(4).(b) no more than eight months FTE in psychiatry. (Core)

IV.A.6.b).(5) Resident experience in neurology must include two months FTE ~~months~~ of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions; (Core)

IV.A.6.b).(5).(a) At least one month of this experience should occur in the first or second year of the program. (~~Core~~Detail)

IV.A.6.b).(6) Resident experience in inpatient psychiatry must include at least six months, but no more than 16 months FTE, of inpatient psychiatry. ~~of which there~~

IV.A.6.b).(6).(a) This must ~~be~~ include a minimum of six months of significant responsibility for the assessment, diagnosis, and treatment of general psychiatric patients who are admitted to traditional psychiatry units.~~, day hospital programs, research units, residential treatment programs, and other settings where:~~ (Core)

IV.A.6.b).(6).(b) Resident experience in outpatient psychiatry must include 12 months FTE of organized, continuous, and supervised clinical experience ~~in the assessment, diagnosis, and treatment of outpatients with a wide variety of disorders and treatment modalities, with experience in both brief and long-term care of patients~~. (Core)

IV.A.6.b).(6).(c) Each resident must have significant experience treating outpatients longitudinally for at least one year~~. This longitudinal experience should~~ to include: (Core)

IV.A.6.b).(6).(c).(i) initial evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly ~~under supervision~~; (~~Detail~~Core)

IV.A.6.b).(6).(c).(ii) ~~exposure to~~ participation in multiple treatment modalities that emphasize developmental, biological, psychological and social approaches to outpatient treatment; (~~Detail~~Core)

IV.A.6.b).(6).(c).(iii) ~~opportunities to apply~~ application of psychosocial rehabilitation techniques~~, and to evaluate~~ for the evaluation and treatment of differing disorders in a chronically-ill patient population; and, (~~Detail~~Core)

IV.A.6.b).(6).(c).(iv) no more than 20 percent of children and adolescent patients. ~~This portion of education may be used to fulfill the two - month Child and Adolescent Psychiatry requirements, so long as this component meets the requirement for child and adolescent psychiatry as set forth in in (8)(a) and (8)(b) below.~~ (~~Detail~~Core)

IV.A.6.b).(7) Resident experience in child and adolescent psychiatry~~:~~ must include two months FTE of organized clinical experience.~~ in which the residents are:~~ (Core)

IV.A.6.b).(7).(a) Supervis~~ed~~ing faculty members must have current ABPN certification in ~~by~~ child and adolescent psychiatry~~ists. who are certified by the ABPN or who are judged by the Review Committee to have equivalent qualifications; and,~~. (Core)

IV.A.6.b).(7).(b) ~~provided opportunities~~ Residents must participate in ~~to~~ assessing, ~~development and to~~ evaluating, and treating a variety of diagnoses in male and female children and adolescents and their families, using a variety of interventional modalities. (Core)

IV.A.6.b).(8) Resident experience in geriatric psychiatry must include one month FTE of organized experience focused on ~~the specific competencies in~~ areas ~~that are~~ unique to the care of the elderly. (Core)

IV.A.6.b).(8).(a) ~~These~~ Each resident's geriatric psychiatry experience must include ~~the~~:

IV.A.6.b).(8).(a).(i) diagnosis and management of mental disorders in geriatric patients with ~~multiple comorbid~~ coexistent medical disorders; (Core)

IV.A.6.b).(8).(a).(ii) ~~familiarity with the differential~~ diagnosis and management (including management of the cognitive component) of ~~the~~ degenerative disorders; (Core)

IV.A.6.b).(8).(a).(iii) ~~an understanding of~~ basic neuropsychological testing ~~as it relates to~~ of

1065 cognitive functioning in the elderly; and, ~~the~~
1066 (Core)
1067
1068 IV.A.6.b).(8).(a).(iv) ~~unique pharmacokinetic and~~
1069 ~~pharmacodynamic considerations~~
1070 ~~encountered in the elderly, including; and,~~
1071 management of drug interactions. (Core)
1072
1073 IV.A.6.b).(9) Resident experience in addiction psychiatry must include
1074 one month FTE of organized experience focused on the
1075 evaluation and clinical management of patients with
1076 substance abuse/dependence problems, including dual
1077 diagnosis.~~;~~ (Core)
1078
1079 IV.A.6.b).(9).(a) Residents must have experiences with treatment
1080 modalities that ~~should~~ include:
1081
1082 IV.A.6.b).(9).(a).(i) detoxification, ~~management of~~ overdose
1083 management, and maintenance
1084 pharmacotherapy; (Core)
1085
1086 IV.A.6.b).(9).(a).(ii) ~~the use of~~ therapeutic techniques that
1087 address the psychological and social
1088 consequences of addiction in confronting
1089 and intervening in chronic addiction
1090 rehabilitation used in recovery stages from
1091 pre-contemplation to maintenance; and, (Core)
1092
1093 IV.A.6.b).(9).(a).(iii) ~~the use of~~ self-help groups. (Core)
1094
1095 IV.A.6.b).(10) Resident experience in consultation~~/~~ -liaison must include
1096 two months FTE in which residents consult under
1097 supervision on other medical and surgical services. (Core)
1098
1099 IV.A.6.b).(11) Resident experience in forensic psychiatry~~: This~~ must
1100 include experiences ~~must expose residents to the~~
1101 evaluati~~o~~ng ~~of forensic issues such as with~~ patients who
1102 have significant forensic issues~~.~~, such as those facing
1103 criminal charges~~,~~; establishing competency to stand trial,
1104 criminal responsibility, and commitment~~,~~; and ~~an~~
1105 assessing~~ment of~~ ~~their~~patients' potential to harm
1106 themselves or others. (Core)
1107
1108 IV.A.6.b).(11).(a) This experience should include writing a forensic
1109 report. (Detail)
1110
1111 IV.A.6.b).(11).(b) ~~Where feasible,~~ Experience should include giving
1112 testimony in court. ~~is highly desirable;~~ (Detail)
1113
1114 IV.A.6.b).(12) Resident experience in emergency psychiatry ~~This~~
1115 ~~experience~~ must be conducted in an organized, supervised

~~24-hour~~ psychiatric emergency service, ~~a portion of which may occur in ambulatory urgent-care settings, but~~ and must not be counted as part of the 12-month outpatient requirement. (Core)

IV.A.6.b).(12).(a) Resident~~s must be provided~~ experiences must ~~in evaluation,~~ include crisis evaluation and management, and triage of psychiatric patients.~~;~~ (Core)

IV.A.6.b).(12).(b) On-call experiences ~~may be a part of this experience, but~~ alone must not fulfill this requirement ~~no more than 50 percent~~. (Detail)

IV.A.6.b).(13) Resident experience in community psychiatry~~: This experience~~ must provide ~~expose~~ residents ~~to~~ with a cohort of persistently and chronically-ill patients in the public sector, ~~(e.g.~~such as in~~,~~ community mental health centers, public hospitals and agencies, and other community-based settings~~)~~. (Core)

IV.A.6.b).(13).(a) ~~The program should provide residents the opportunity to consult with,~~ This experience must include learning about, and using community resources and services in planning patient care, as well as ~~to~~ consulting and working collaboratively with case managers, crisis teams, and other mental health professionals. (Core)

~~IV.A.6.b).(14) Addiction, Community, Forensic, and Geriatric psychiatry requirements can be met as part of the inpatient requirements above the minimum six months, and/or as part of the outpatient requirement (Core)~~

~~IV.A.6.b).(15) Residents must receive a minimum of two hours of direct supervision per week, at least one of which is individual. (Core)~~

IV.A.6.b).(16) ~~Electives should enrich the educational experience of residents in conformity to their needs, interest, and/or future professional plans.~~ Electives must have written goals and objectives, and must be well constructed, and supervised~~purposeful,~~ and lead to effective learning experiences. (~~Detail~~Core)

IV.A.6.b).(16).(a) The choice of electives must be made with the advice and approval of the program director and the appropriate preceptor. (~~Detail~~Core)

~~IV.A.6.b).(16).(b) All such electives must demonstrate compliance with the requirements in general psychiatry, and~~ be

~~submitted to the committee prior to implementation for review and approval. Submissions must also outline the educational curriculum necessary to meet the requirements of general psychiatry and how elective education will be structured to prepare the resident for subspecialty education. Prior to entry into the program, residents must be informed in writing that all general psychiatry requirements must be met prior to graduation. (Detail)~~

~~IV.A.6.b).(16).(c) The Review Committee encourages programs to identify residents who may be interested in academic psychiatry by introducing subspecialty education and research electives early in the residency program. This will provide an opportunity for education in general psychiatry, and exposure to a psychiatry fellowship (e.g., geriatric psychiatry) through electives. (Detail)~~

IV.A.6.c) Residents at all levels must be provided at least two hours of ~~individual~~ faculty preceptorship ~~supervision per~~ weekly, one hour of which must be individual. (Core)

IV.A.6.d) Experience must be provided for residents in participating in psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance, and performance improvement. (Core)

IV.A.6.e) For residents who ~~plan to~~ enter subspecialty education in child and adolescent psychiatry prior to completing general psychiatry requirements, certain clinical experiences with children, adolescents, and families taken during the period when the resident is designated as a child and adolescent psychiatry resident may be counted toward general psychiatry requirements as well as child and adolescent requirements, thereby fulfilling program requirements in both general and child and adolescent psychiatry. The following guidelines must be met for these experiences: (Core)

IV.A.6.e).(1) experience is limited to child and adolescent psychiatry patients; (Core)

IV.A.6.e).(2) no more than 12 months may be double-counted; (Core)

IV.A.6.e).(3) there ~~should~~ must be documentation from the child and adolescent psychiatry program director for all areas for which credit is given in both programs; (Core)

IV.A.6.e).(4) there will be no reduction in total length of time devoted to education in child and adolescent psychiatry; and, (Core)

1218 IV.A.6.e).(5) only the following experiences can be used to meet
1219 requirements in both general and child and adolescent
1220 psychiatry:
1221
1222 IV.A.6.e).(5).(a) one month FTE of child neurology; (Core)
1223
1224 IV.A.6.e).(5).(b) one month FTE of pediatric consultation; (Core)
1225
1226 IV.A.6.e).(5).(c) one month FTE of addiction psychiatry; (Core)
1227
1228 IV.A.6.e).(5).(d) forensic psychiatry experience; (Core)
1229
1230 IV.A.6.e).(5).(e) community psychiatry experience; and, (Core)
1231
1232 IV.A.6.e).(5).(f) no more than 20 percent of the resident's
1233 psychiatry_outpatient experience. (Core)
1234
1235 **IV.B. Residents' Scholarly Activities**
1236
1237 **IV.B.1. The curriculum must advance residents' knowledge of the basic**
1238 **principles of research, including how research is conducted,**
1239 **evaluated, explained to patients, and applied to patient care.** (Core)
1240
1241 **IV.B.2. Residents should participate in scholarly activity.** (Core)
1242
1243 IV.B.2.a) ~~Residents must have instruction in research methods in the~~
1244 ~~clinical, biological, and behavioral sciences related to psychiatry,~~
1245 ~~including techniques to appraise the professional and scientific~~
1246 ~~literature and to apply evidence based findings to patient care.~~
1247 ~~(Core)~~
1248
1249 IV.B.2.b) The program must provide residents with research opportunities
1250 and the opportunity for development of research skills for
1251 residents interested in conducting research in psychiatry or related
1252 fields.
1253
1254 IV.B.2.c) The program must provide interested residents access to and the
1255 opportunity to participate actively in ongoing research under a
1256 mentor. ~~If unavailable in the local program, efforts to establish~~
1257 ~~such mentoring programs are encouraged.~~ (~~Detail~~Core)
1258
1259 IV.B.2.d) All residents must be educated in research literacy. Research
1260 literacy is the ability to critically appraise and understand the
1261 relevant research literature and to apply research findings
1262 appropriately to clinical practice the concepts and process of
1263 evidence-based clinical practice includinge skills development in
1264 question formulation, information searching, critical appraisal, and
1265 medical decision-making. (Core), thus providing the structure for
1266 teaching research literacy to psychiatry residents. The program
1267 must promote an atmosphere of scholarly inquiry, including the
1268 access to ongoing research activity in psychiatry Residents must

1269 be taught the design and interpretation of data. (Core)
1270
1271 **IV.B.3. The sponsoring institution and program should allocate adequate**
1272 **educational resources to facilitate resident involvement in scholarly**
1273 **activities.** (Detail)
1274
1275 **V. Evaluation**
1276
1277 **V.A. Resident Evaluation**
1278
1279 **V.A.1. The program director must appoint the Clinical Competency**
1280 **Committee.** (Core)
1281
1282 **V.A.1.a) At a minimum the Clinical Competency Committee must be**
1283 **composed of three members of the program faculty.** (Core)
1284
1285 **V.A.1.a).(1) Others eligible for appointment to the committee**
1286 **include faculty from other programs and non-**
1287 **physician members of the health care team.** (Detail)
1288
1289 **V.A.1.b) There must be a written description of the responsibilities of**
1290 **the Clinical Competency Committee.** (Core)
1291
1292 **V.A.1.b).(1) The Clinical Competency Committee should:**
1293
1294 **V.A.1.b).(1).(a) review all resident evaluations semi-annually;**
1295 (Core)
1296
1297 **V.A.1.b).(1).(b) prepare and assure the reporting of Milestones**
1298 **evaluations of each resident semi-annually to**
1299 **ACGME; and,** (Core)
1300
1301 **V.A.1.b).(1).(c) advise the program director regarding resident**
1302 **progress, including promotion, remediation,**
1303 **and dismissal.** (Detail)
1304
1305 **V.A.2. Formative Evaluation**
1306
1307 **V.A.2.a) The faculty must evaluate resident performance in a timely**
1308 **manner during each rotation or similar educational**
1309 **assignment, and document this evaluation at completion of**
1310 **the assignment.** **(Core)**
1311
1312 **V.A.2.b) The program must:**
1313
1314 **V.A.2.b).(1) provide objective assessments of competence in**
1315 **patient care and procedural skills, medical knowledge,**
1316 **practice-based learning and improvement,**
1317 **interpersonal and communication skills,**
1318 **professionalism, and systems-based practice based**
1319 **on the specialty-specific Milestones;** **(Core)**

V.A.2.b).(2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);** **(Detail)**

V.A.2.b).(3) **document progressive resident performance improvement appropriate to educational level; and,** **(Core)**

V.A.2.b).(4) **provide each resident with documented semiannual evaluation of performance with feedback.** **(Core)**

V.A.2.c) **The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.** **(Detail)**

V.A.2.d) ~~Regular evaluations of the knowledge, skills, and professional growth of each resident, using appropriate criteria and procedures, must be maintained, including complete records of evaluations containing explicit statements on the resident's progress toward meeting educational objectives and his or her major strengths and weaknesses. (Detail)~~

V.A.2.e) The program must conduct an annual formal evaluation of the core medical knowledge ~~formally examine the cognitive knowledge~~ of each resident ~~at least annually~~ in the second, third, and fourth years, and conduct an examination across biological, psychological, and social spheres that are defined in the program's written goals and objectives. (~~Detail~~Core)

V.A.2.f) The program must formally conduct a clinical skills examination for each resident. (Core)

V.A.2.f).(1) This examination should include~~ing~~ an annual evaluation of the resident's ~~following skills:~~ ~~(Core)~~

V.A.2.f).(1).(a) ability to interview patients and families; (Detail)

V.A.2.f).(1).(b) ability to establish an appropriate doctor/patient relationship; (Detail)

V.A.2.f).(1).(c) ability to elicit an appropriate present and past psychiatric, medical, social, and developmental history; (Detail)

V.A.2.f).(1).(d) ability to assess mental status; (Detail)

V.A.2.f).(1).(e) ability to provide a relevant formulation, differential diagnosis and provisional treatment plan; and, (Detail)

V.A.2.f).(1).(f) ability to make an organized presentation of the pertinent history, including the mental status

examination. (Detail)

V.A.2.g) ~~Performance on all evaluations must be documented and quantified, whenever possible, and provided to the resident. When necessary, remediation opportunities must be provided. Residents must not advance to the next year of education, or graduate from the program, unless the competence for their level of education in each area is documented. (Detail)~~

V.A.2.h) The program must monitor clinical records on major rotations to assess resident competence~~ies~~ to: (~~Outcome~~Core)

V.A.2.h).(1) document an adequate history and perform mental status, physical, and neurological examinations; (~~Outcome~~Core)

V.A.2.h).(2) organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues; (~~Outcome~~Core)

V.A.2.h).(3) proceed with appropriate laboratory and other diagnostic procedures; (~~Outcome~~Core)

V.A.2.h).(4) develop and implement an appropriate treatment plan followed by regular and relevant progress notes regarding both therapy and medication management; and, (~~Outcome~~Core)

V.A.2.h).(5) prepare an adequate discharge summary and plan. (~~Outcome~~Core)

V.A.2.i) Residents' teaching abilities ~~should~~ must be documented by evaluations from faculty members and/or learners. (~~Detail~~Core)

V.A.2.j) The record of evaluation must demonstrate that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. In the case of transferring residents, the records ~~should~~ must include the experiences in the prior and current program. (Core)

~~V.A.2.j).(1) The record must be reviewed periodically with the program director or a designee, and must be made available to the surveyor of the program. The record may be maintained in a number of ways and is not limited to a paper-driven patient log. (Detail)~~

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program. (Core)

V.A.3.b) **The program director must provide a summative evaluation for each resident upon completion of the program.** (Core)

This evaluation must:

V.A.3.b).(1) **become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy;** (Detail)

V.A.3.b).(2) **document the resident's performance during the final period of education;** (Detail)

V.A.3.b).(3) **verify that the resident has demonstrated sufficient competence to enter practice without direct supervision; and,** (Detail)

V.A.3.b).(4) include a summary of any documented evidence of unethical behavior, unprofessional behavior, or clinical incompetence or a statement that none such has occurred. (Core)

V.A.3.b).(4).(a) Where there is such evidence, it must be comprehensively recorded, along with the resident's response(s) to such evidence. (~~Detail~~Core)

V.A.3.c) In at least three evaluations with any patient type, in any clinical setting, and at any time during the program, residents must demonstrate satisfactory competence in: establishing an appropriate doctor/patient relationship, psychiatric interviewing, performing the mental status examination and in case presentation. (Outcome)

V.A.3.c).(1) Each of the three required evaluations must be conducted by an ABPN-certified psychiatrist, and at least two of the evaluations must be conducted by different ABPN-certified psychiatrists. (~~Detail~~Core)

V.A.3.c).(2) Satisfactory demonstration of the competencies during the three required evaluations ~~is required~~ must be documented prior to completing the program. (~~Detail~~Core)

V.B. Faculty Evaluation

V.B.1. **At least annually, the program must evaluate faculty performance as it relates to the educational program.** (Core)

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.** (Detail)

1473 **V.B.3.** **This evaluation must include at least annual written confidential evaluations by the residents.** (Detail)
1474
1475
1476 **V.C. Program Evaluation and Improvement**
1477
1478 **V.C.1.** **The program director must appoint the Program Evaluation**
1479 **Committee (PEC).** **(Core)**
1480
1481 **V.C.1.a)** **The Program Evaluation Committee:**
1482
1483 **V.C.1.a).(1)** **must be composed of at least two program faculty**
1484 **members and should include at least one resident;**
1485 **(Core)**
1486
1487 **V.C.1.a).(2)** **must have a written description of its responsibilities;**
1488 **and,** **(Core)**
1489
1490 **V.C.1.a).(3)** **should participate actively in:**
1491
1492 **V.C.1.a).(3).(a)** **planning, developing, implementing, and**
1493 **evaluating educational activities of the**
1494 **program;** **(Detail)**
1495
1496 **V.C.1.a).(3).(b)** **reviewing and making recommendations for**
1497 **revision of competency-based curriculum goals**
1498 **and objectives;** **(Detail)**
1499
1500 **V.C.1.a).(3).(c)** **addressing areas of non-compliance with**
1501 **ACGME standards; and,** **(Detail)**
1502
1503 **V.C.1.a).(3).(d)** **reviewing the program annually using**
1504 **evaluations of faculty, residents, and others, as**
1505 **specified below.** **(Detail)**
1506
1507 **V.C.2.** **The program, through the PEC, must document formal, systematic**
1508 **evaluation of the curriculum at least annually, and is responsible for**
1509 **rendering a written and Annual Program Evaluation (APE).** **(Core)**
1510
1511 **The program must monitor and track each of the following areas:**
1512
1513 **V.C.2.a)** **resident performance;** **(Core)**
1514
1515 **V.C.2.b)** **faculty development;** **(Core)**
1516
1517 **V.C.2.c)** **graduate performance, including performance of program**
1518 **graduates on the certification examination;** **(Core)**
1519
1520 V.C.2.c).(1) At least 80 percent of a program's graduates completing
1521 the program in the preceding five years must have taken
1522 the certifying examination. (Outcome)
1523

1524 V.C.2.c).(2) At least 80 percent of a program's graduates from the
1525 preceding five years who take In its evaluation of residency
1526 programs, the Review Committee will take into
1527 consideration the information provided by the
1528 ABPNAmerican Board of Psychiatry and Neurology
1529 regarding resident performance on the certifying
1530 examinations in general psychiatry for the first time must
1531 pass during the most recent five years. The expectation is
1532 that the rate of those passing the examination on their first
1533 attempt is 50% and that 70% of those who complete the
1534 program will take the certifying examination. (Outcome)
1535
1536 **V.C.2.d) program quality; and, (Core)**
1537
1538 **V.C.2.d).(1) Residents and faculty must have the opportunity to**
1539 **evaluate the program confidentially and in writing at**
1540 **least annually, and (Detail)**
1541
1542 **V.C.2.d).(2) The program must use the results of residents' and**
1543 **faculty members' assessments of the program**
1544 **together with other program evaluation results to**
1545 **improve the program. (Detail)**
1546
1547 **V.C.2.e) progress on the previous year's action plan(s). (Core)**
1548
1549 **V.C.3. The PEC must prepare a written plan of action to document**
1550 **initiatives to improve performance in one or more of the areas listed**
1551 **in section V.C.2., as well as delineate how they will be measured and**
1552 **monitored. (Core)**
1553
1554 **V.C.3.a) The action plan should be reviewed and approved by the**
1555 **teaching faculty and documented in meeting minutes. (Detail)**
1556
1557 V.C.4. Education Policy Committee
1558
1559 The program director of the residency program should have an
1560 Educational Policy Committee composed of members of the psychiatry
1561 program teaching staff. This committee should include representation
1562 from the residents as well as a member of the teaching staff from each
1563 ACGME-approved subspecialty fellowship programs that is affiliated with
1564 the psychiatry residency. There should be a written description of the
1565 committee, including its responsibility to the sponsoring department or
1566 institution and to the program director. This committee should participate
1567 actively in: (Detail)
1568
1569 V.C.4.a) planning, developing, implementing, and evaluating all significant
1570 features of the residency program, including the selection of
1571 residents (unless there is a separate residency selection
1572 committee); (Detail)
1573
1574 V.C.4.b) determining curriculum goals and objectives; and, (Detail)

V.C.4.c) ~~evaluating both the teaching staff members and the residents. (Detail)~~

VI. Resident Duty Hours in the Learning and Working Environment

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

VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. (Core)

VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment. (Core)

VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. (Core)

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, (Core)

VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations. (Core)

VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.A.6. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.6.a) assurance of the safety and welfare of patients entrusted to their care; (Outcome)

VI.A.6.b) provision of patient- and family-centered care; (Outcome)

VI.A.6.c) assurance of their fitness for duty; (Outcome)

VI.A.6.d) management of their time before, during, and after clinical assignments; (Outcome)

VI.A.6.e) recognition of impairment, including illness and fatigue, in themselves and in their peers; (Outcome)

VI.A.6.f) attention to lifelong learning; (Outcome)

1626
1627 **VI.A.6.g)** **the monitoring of their patient care performance improvement indicators; and,** (Outcome)
1628
1629
1630 **VI.A.6.h)** **honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.** (Outcome)
1631
1632
1633 **VI.A.7.** **All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They 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.** (Outcome)
1634
1635
1636
1637
1638
1639 **VI.B.** **Transitions of Care**
1640
1641 **VI.B.1.** **Programs must design clinical assignments to minimize the number of transitions in patient care.** (Core)
1642
1643
1644 **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.** (Core)
1645
1646
1647
1648 **VI.B.3.** **Programs must ensure that residents are competent in communicating with team members in the hand-over process.** (Outcome)
1649
1650
1651 **VI.B.4.** **The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.** (Detail)
1652
1653
1654
1655
1656 **VI.C.** **Alertness Management/Fatigue Mitigation**
1657
1658 **VI.C.1.** **The program must:**
1659
1660 **VI.C.1.a)** **educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;** (Core)
1661
1662
1663 **VI.C.1.b)** **educate all faculty members and residents in alertness management and fatigue mitigation processes; and,** (Core)
1664
1665
1666 **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.** (Detail)
1667
1668
1669
1670 **VI.C.2.** **Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.** (Core)
1671
1672
1673
1674 **VI.C.3.** **The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.** (Core)
1675
1676

VI.D. Supervision of Residents

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

~~Only licensed independent practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient.~~

VI.D.1.a) **This information should be available to residents, faculty members, and patients.** (Detail)

VI.D.1.b) **Residents and faculty members should inform patients of their respective roles in each patient's care.** (Detail)

VI.D.2. **The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.** (Core)

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care. (Detail)

VI.D.3. **Levels of Supervision**

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.D.3.a) **Direct Supervision – the supervising physician is physically present with the resident and patient.** (Core)

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.** (Core)

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. (Core)

VI.D.3.c) **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.** (Core)

VI.D.4. **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.** (Core)

VI.D.4.a) **The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.** (Core)

VI.D.4.b) **Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.** (Detail)

VI.D.4.c) **Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** (Detail)

VI.D.5. **Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.** (Core)

VI.D.5.a) **Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.** (Outcome)

VI.D.5.a).(1) **In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.** (Core)

VI.D.5.a).(2) PGY-1 residents ~~may~~ should progress to being supervised indirectly with direct supervision available only after demonstrating competence in: ~~(Detail)~~

VI.D.5.a).(2).(a) the ability and willingness to ask for help when indicated; (Detail)

VI.D.5.a).(2).(b) gathering an appropriate history; (Detail)

VI.D.5.a).(2).(c) the ability to perform an emergent psychiatric assessment; and, (Detail)

1779
1780 VI.D.5.a).(2).(d) presenting patient findings and data accurately to a
1781 supervisor who has not seen the patient. (Detail)
1782
1783 **VI.D.6. Faculty supervision assignments should be of sufficient duration to**
1784 **assess the knowledge and skills of each resident and delegate to**
1785 **him/her the appropriate level of patient care authority and**
1786 **responsibility.** (Detail)
1787
1788 **VI.E. Clinical Responsibilities**
1789
1790 **The clinical responsibilities for each resident must be based on PGY-level,**
1791 **patient safety, resident education, severity and complexity of patient**
1792 **illness/condition and available support services.** (Core)
1793
1794 **VI.F. Teamwork**
1795
1796 **Residents must care for patients in an environment that maximizes**
1797 **effective communication. This must include the opportunity to work as a**
1798 **member of effective interprofessional teams that are appropriate to the**
1799 **delivery of care in the specialty.** (Core)
1800
1801 VI.F.1. Contributors to effective interprofessional teams should include consulting
1802 physicians, psychologists, psychiatric nurses, social workers, and other
1803 professional and paraprofessional mental health personnel involved in the
1804 evaluation and treatment of patients. (Detail)
1805
1806 **VI.G. Resident Duty Hours**
1807
1808 **VI.G.1. Maximum Hours of Work per Week**
1809
1810 **Duty hours must be limited to 80 hours per week, averaged over a**
1811 **four-week period, inclusive of all in-house call activities and all**
1812 **moonlighting.** (Core)
1813
1814 **VI.G.1.a) Duty Hour Exceptions**
1815
1816 **A Review Committee may grant exceptions for up to 10% or a**
1817 **maximum of 88 hours to individual programs based on a**
1818 **sound educational rationale.** (Detail)
1819
1820 The Review Committee for Psychiatry will not consider requests
1821 for exceptions to the 80-hour limit to the residents' work week.
1822
1823 **VI.G.1.a).(1) In preparing a request for an exception the program**
1824 **director must follow the duty hour exception policy**
1825 **from the ACGME Manual on Policies and Procedures.**
1826 (Detail)
1827
1828 **VI.G.1.a).(2) Prior to submitting the request to the Review**
1829 **Committee, the program director must obtain approval**

1830 **of the institution's GMEC and DIO.** (Detail)
1831
1832 **VI.G.2. Moonlighting**
1833
1834 **VI.G.2.a)** **Moonlighting must not interfere with the ability of the resident**
1835 **to achieve the goals and objectives of the educational**
1836 **program.** (Core)
1837
1838 **VI.G.2.b)** **Time spent by residents in Internal and External Moonlighting**
1839 **(as defined in the ACGME Glossary of Terms) must be**
1840 **counted towards the 80-hour Maximum Weekly Hour Limit.**
1841 (Core)
1842
1843 **VI.G.2.c)** **PGY-1 residents are not permitted to moonlight.** (Core)
1844
1845 **VI.G.3. Mandatory Time Free of Duty**
1846
1847 **Residents must be scheduled for a minimum of one day free of duty**
1848 **every week (when averaged over four weeks). At-home call cannot**
1849 **be assigned on these free days.** (Core)
1850
1851 **VI.G.4. Maximum Duty Period Length**
1852
1853 **VI.G.4.a)** **Duty periods of PGY-1 residents must not exceed 16 hours in**
1854 **duration.** (Core)
1855
1856 **VI.G.4.b)** **Duty periods of PGY-2 residents and above may be**
1857 **scheduled to a maximum of 24 hours of continuous duty in**
1858 **the hospital.** (Core)
1859
1860 **VI.G.4.b).(1)** **Programs must encourage residents to use alertness**
1861 **management strategies in the context of patient care**
1862 **responsibilities. Strategic napping, especially after 16**
1863 **hours of continuous duty and between the hours of**
1864 **10:00 p.m. and 8:00 a.m., is strongly suggested.** (Detail)
1865
1866 **VI.G.4.b).(2)** **It is essential for patient safety and resident education**
1867 **that effective transitions in care occur. Residents may**
1868 **be allowed to remain on-site in order to accomplish**
1869 **these tasks; however, this period of time must be no**
1870 **longer than an additional four hours.** (Core)
1871
1872 **VI.G.4.b).(3)** **Residents must not be assigned additional clinical**
1873 **responsibilities after 24 hours of continuous in-house**
1874 **duty.** (Core)
1875
1876 **VI.G.4.b).(4)** **In unusual circumstances, residents, on their own**
1877 **initiative, may remain beyond their scheduled period**
1878 **of duty to continue to provide care to a single patient.**
1879 **Justifications for such extensions of duty are limited**
1880 **to reasons of required continuity for a severely ill or**

1881 **unstable patient, academic importance of the events**
1882 **transpiring, or humanistic attention to the needs of a**
1883 **patient or family.** (Detail)
1884
1885 **VI.G.4.b).(4).(a)** **Under those circumstances, the resident must:**
1886
1887 **VI.G.4.b).(4).(a).(i)** **appropriately hand over the care of all**
1888 **other patients to the team responsible**
1889 **for their continuing care; and,** (Detail)
1890
1891 **VI.G.4.b).(4).(a).(ii)** **document the reasons for remaining to**
1892 **care for the patient in question and**
1893 **submit that documentation in every**
1894 **circumstance to the program director.**
1895 (Detail)
1896
1897 **VI.G.4.b).(4).(b)** **The program director must review each**
1898 **submission of additional service, and track**
1899 **both individual resident and program-wide**
1900 **episodes of additional duty.** (Detail)
1901
1902 **VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**
1903
1904 **PGY-1 residents should have 10 hours, and must have eight hours,**
1905 **free of duty between scheduled duty periods.** (Core)
1906
1907 **VI.G.5.a)** **Intermediate-level residents should have 10 hours free of**
1908 **duty, and must have eight hours between scheduled duty**
1909 **periods. They must have at least 14 hours free of duty after 24**
1910 **hours of in-house duty.** (Core)
1911
1912 PGY-2 residents are considered to be at the intermediate level.
1913
1914 **VI.G.5.b)** **Residents in the final years of education must be prepared to**
1915 **enter the unsupervised practice of medicine and care for**
1916 **patients over irregular or extended periods.** (Outcome)
1917
1918 Residents at the PGY-3 level or beyond are considered to be in
1919 the final years of education.
1920
1921 **VI.G.5.b).(1)** **This preparation must occur within the context of the**
1922 **80-hour, maximum duty period length, and one-day-**
1923 **off-in-seven standards. While it is desirable that**
1924 **residents in their final years of education have eight**
1925 **hours free of duty between scheduled duty periods,**
1926 **there may be circumstances when these residents**
1927 **must stay on duty to care for their patients or return to**
1928 **the hospital with fewer than eight hours free of duty.**
1929 (Detail)
1930
1931 **VI.G.5.b).(1).(a)** **Circumstances of return-to-hospital activities**

with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. (Detail)

VI.G.5.b).(1).(b) There are no circumstances under which residents in the final years of education may stay on duty with fewer than eight hours off. (Core)

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

Residents must not be scheduled for more than six consecutive nights of night float. (Core)

VI.G.6.a) Residents should not be scheduled for more than four consecutive weeks of night float during the required one-year, full-time outpatient psychiatry experience. (Detail)

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

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

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

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

VI.G.8. At-Home Call

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

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

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

***

*__Core Requirements:__ Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.