ACGME Program Requirements for Graduate Medical Education in Psychosomatic Medicine

One-year Common Program Requirements are in BOLD

Effective: June, 2003

Introduction

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

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

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

Int.C. ~~Duration and Scope of Education An accredited~~ The educational program in psychosomatic medicine must ~~provide~~ be 12 months in length ~~of supervised graduate education~~.

I. Institutions

I.A. Sponsoring Institution

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

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

I.A.1. ~~To be eligible for accreditation, the subspecialty program must function as an integral part of an accredited residency program in psychiatry. There must be a reporting relationship, to ensure compliance with the Accreditation Council for Graduate Medical Education (ACGME) accreditation standards, from the program director of the subspecialty program to the program director of the parent psychiatry residency program.~~ The sponsoring institution must also sponsor an Accreditation Council for Graduate Medical Education (ACGME)-accredited program in psychiatry.

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.

I.B.1.a) ~~Participating sites should provide resources not otherwise available to the program.~~

The PLA should:

I.B.1.b) identify the faculty who will assume both educational and supervisory responsibilities for fellows;

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

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

I.B.1.e) state the policies and procedures that will govern fellow education during the assignment.

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

I.B.3. The number of and distance between participating sites must allow for full participation in all organized educational aspects of the program.

I.B.4. ~~Assignments at participating sites must be of sufficient length to ensure a quality educational experience and should provide sufficient opportunity for continuity of care. Although the number of participating sites may vary with the various specialties' needs, all participating sites must demonstrate the ability to promote the program goals and educational and peer activities. Exceptions must be justified and prior-approved.~~ Within the participating sites there should be an ACGME-accredited program in at least one of the following non-psychiatric specialties: family medicine, internal medicine, neurology, or physical medicine and rehabilitation.

II. Program Personnel and Resources

II.A. Program Director

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

II.A.1.a) ~~The program director should be a member of the staff of the sponsoring or integrated institution.~~ The program director must devote at least 15 hours per week to the program to include activities related to administration, didactic teaching and individual supervision outside of clinical activities.

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

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

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

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

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

II.A.2.d) ~~experience in his or her field.~~

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

ACGME competency areas. The program director must:

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

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

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

II.A.3.c).(1) **all applications for ACGME accreditation of new programs;**

II.A.3.c).(2) **changes in fellow complement;**

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

II.A.3.c).(4) **progress reports requested by the Review Committee;**

II.A.3.c).(5) **responses to all proposed adverse actions;**

II.A.3.c).(6) **requests for increases or any change to fellow duty hours;**

II.A.3.c).(7) **voluntary withdrawals of ACGME-accredited programs;**

II.A.3.c).(8) **requests for appeal of an adverse action; and,**

II.A.3.c).(9) **appeal presentations to a Board of Appeal or the ACGME.**

II.A.3.d) **obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**

II.A.3.d).(1) **program citations, and/or**

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

II.A.3.e) ~~There must be a reporting relationship from the program director of the subspecialty program to the program director of the parent psychiatry residency program to ensure compliance with the ACGME accreditation standards.~~

II.A.3.f) ~~A written statement defining the role of related disciplines must be in place outlining requirements for multidisciplinary care and fellow interactions with other specialties.~~

~~II.A.3.f).(1) The responsibility given to fellows in patient care should depend upon each fellow's knowledge, problem-solving ability, manual skills, experience, and the severity and complexity of each patient's illness.~~

II.A.3.g) develop and implement a supervision policy that specifies lines of responsibility for program faculty members and fellows that is consistent with the supervision policy in the general psychiatry program; and,

II.A.3.h) participate in scholarly activities appropriate to the subspecialty, including local, regional, and national specialty societies, research, presentations, or publication.

II.B. Faculty

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

II.B.1.a) In addition to the program director, there must be at least ~~a minimum of~~ one ~~additional~~ other FTE ~~physician~~ faculty member ~~who~~ certified by the ABPN in the subspecialty. ~~meets the requirements in II.B. above.~~

II.B.1.b) Each participating site must have a designated site director who is a member of the faculty and who is responsible for the day-to-day activities of the program at that site with overall coordination by the program director.

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

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

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

II.B.5. All faculty members must participate in scholarly activities appropriate to the subspecialty, including local, regional, and national specialty societies, research, presentations, or publications.

II.B.6. Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

II.C. Other Program Personnel

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

II.C.1. There must be a designated program coordinator.

II.D. Resources

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

II.D.1. There must be ~~an adequate number of~~ patients ~~representing~~ of each gender with a ~~wide~~ variety of clinical problems, ~~to provide a patient population sufficient to meet the educational needs of the fellows. The number of~~ including critically-ill patients ~~available for the fellows at the primary clinical site should be sufficient to meet the educational goals of the program~~.

II.D.2. At least one acute general hospital and one ambulatory care facility must be available.

II.E. Medical Information Access

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

III. Fellow Appointments

III.A. Eligibility Criteria

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

III.A.1. Prior to appointment in the program, fellows must have satisfactorily completed either an ACGME-accredited program in psychiatry or a general psychiatry program in Canada accredited by the Royal College of Physicians and Surgeons of Canada.

III.A.2. Prior to appointment in ~~entry into~~ the program, each fellow must be notified in writing of the required length of education.

III.A.3. Prior to appointment in the program, the program director must receive documentation from each fellow's prior general psychiatry program verifying satisfactory completion of all educational and ethical requirements for graduation.

III.A.3.a) Agreements with applicants made prior to the completion of the general residency must be contingent on this requirement.

III.B. Number of Fellows

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

~~III.B.1. The appointment of other learners requires a clear statement of the areas and duration of education and clinical responsibilities. This statement must be supplied to the Review Committee at the time the program is site visited.~~

III.B.2. The presence of other learners must not interfere with the appointed fellows' education. ~~If such residents so appointed will, in the judgment of the Review Committee, detract from the education of the regularly appointed psychosomatic fellows, the accreditation status of the program may be adversely affected.~~

IV. Educational Program

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

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

IV.A.2. ACGME Competencies

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

IV.A.2.a) Patient Care

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

IV.A.2.a).(1) must demonstrate proficiency in establishing rapport with all medical patients;

IV.A.2.a).(2) must demonstrate proficiency in diagnosing and treating ~~ability to diagnose and treat~~ psychiatric disturbances that occur among the physically ill ~~Including the administration of psychotropic medications to seriously ill patients~~;

Line	Section	Text
358	IV.A.2.a).(3)	must demonstrate proficiency in conducting ~~conduct~~
359		psychiatric evaluations of individuals involving:
360		
361	IV.A.2.a).(3).(a)	psychiatric complications of medical illnesses;
362		
363	IV.A.2.a).(3).(b)	psychiatric complications of medical treatments
364		~~especially~~, including medications, traditional and
365		new surgical or medical procedures,
366		transplantation, and ~~a range of~~ experimental
367		therapies; and,
368		
369	IV.A.2.a).(3).(c)	typical and atypical presentations of psychiatric
370		disorders ~~that are~~ due to medical, neurological, and
371		surgical illnesses~~;~~.
372		
373	IV.A.2.a).(4)	must demonstrate proficiency in evaluating and managing
374		individuals with:
375		
376	IV.A.2.a).(4).(a)	acute and chronic pain;
377		
378	IV.A.2.a).(4).(b)	~~evaluation and management of~~ delirium, dementia,
379		and ~~secondary ("organic")~~ psychiatric disorders due
380		to medical illness ~~disorders~~;
381		
382	IV.A.2.a).(4).(c)	~~evaluation and management of~~ somatoform
383		disorders~~, and~~;
384		
385	IV.A.2.a).(4).(d)	palliative care and end-of-life issues; and,
386		
387	IV.A.2.a).(4).(e)	issues in adjusting to the emotional stresses of
388		medical illness.
389		
390	IV.A.2.a).(5)	must demonstrate proficiency in assessing the ~~assessment~~
391		~~of~~ capacity of individuals to give informed consent for
392		medical and surgical procedures in the presence of
393		cognitive impairment;
394		
395	IV.A.2.a).(6)	must demonstrate proficiency in providing ~~provision of non-~~
396		~~pharmacologic~~ psychosocial interventions, including
397		psychotherapeutic interventions appropriate for the
398		medically ill ~~cognitive-behavioral psychotherapy,~~
399		~~interpersonal psychotherapy, as well as focused, short-~~
400		~~term psychotherapy in patients suffering the effects of~~
401		~~complex medical disorders or their treatments~~;
402		
403	IV.A.2.a).(7)	must demonstrate proficiency in the appropriate ~~indications~~
404		~~for and~~ use of ~~psychotropics~~ psychoactive medication in
405		~~specific~~ medical, neurological, obstetrical, and surgical
406		conditions; and,
407		

408 IV.A.2.a).(8) must demonstrate competency in assessing and managing
409 suicidality and other high risk behavior in the medical
410 setting.
411
412 **IV.A.2.b) Medical Knowledge**
413
414 **Fellows must demonstrate knowledge of established and**
415 **evolving biomedical, clinical, epidemiological and social-**
416 **behavioral sciences, as well as the application of this**
417 **knowledge to patient care. Fellows:**
418
419 IV.A.2.b).(1) must develop demonstrate competence in their knowledge
420 of skill, and proficiency involving:
421
422 IV.A.2.b).(1).(a) knowledge of abnormal behavior and psychiatric
423 illnesses that occur among medical, neurological,
424 obstetrics-and gynecologicaly, and surgical
425 patients;
426
427 IV.A.2.b).(1).(b) knowledge of biological, psychological, and social
428 factors that influence the development, course, and
429 outcome of medical and /surgical diseases;
430
431 IV.A.2.b).(1).(c) substance use and its impact on the assessment
432 and treatment of patients in the medical setting;
433
434 IV.A.2.b).(1).(d) understanding of pharmacology, including the
435 psychopharmacology of the medically ill, with
436 emphasis on, and psychiatric medication side
437 effects of, non-psychotropic medications and the
438 drug-to-drug interactions of psychotropic
439 medications with other medications on that affect
440 the central nervous system;
441
442 IV.A.2.b).(1).(e) the nature and extent of psychiatric morbidity in
443 medical illness and its treatments;
444
445 IV.A.2.b).(1).(f) the impact of co-morbid psychiatric disorders on the
446 course of medical illness;
447
448 IV.A.2.b).(1).(g) understanding of how and why patients' responses
449 respond to medical illness;
450
451 IV.A.2.b).(1).(h) knowledge of appropriate treatment interventions
452 for co-existing psychiatric disorders in the medically
453 ill;
454
455 IV.A.2.b).(1).(i) psychological and psychiatric effects of new
456 medical or surgical therapies;
457

~~IV.A.2.b).(1).(j) interactions between psychotropic medications and the full-range of medications used for a variety of medical and surgical conditions;~~

IV.A.2.b).(1).(k) ~~the~~ epidemiology of psychiatric illness and its treatment in medical disease;

IV.A.2.b).(1).(l) ~~knowledge of the~~ nature and factors that influence the physician-patient relationship in the medical setting; and,

IV.A.2.b).(1).(m) ~~knowledge of the~~ organizational and administrative skills needed to finance, staff, and manage a psychosomatic medicine service.

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

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

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

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

~~IV.A.2.c).(3) teaching other physicians and other members of the multidisciplinary team how to recognize and respond to various psychiatric disorders;~~

IV.A.2.c).(4) ~~ability to effectively supervise medical students and fellows performing consultations, and to teach medical and surgical colleagues about psychiatric complications of physical illness;~~ demonstrate administrative and teaching skills.

IV.A.2.d) Interpersonal and Communication Skills

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

IV.A.2.d).(1) Fellows must demonstrate competence in collaborating ~~collaboration~~ with ~~other~~ physicians, and members of the multidisciplinary treatment team.

IV.A.2.d).(2) Fellows must demonstrate competence in leading an integrated psychosocial health care team in the medical setting.

IV.A.2.d).(3) Fellows must demonstrate the ability to provide consultation in medical and surgical settings.

IV.A.2.d).(4) Fellows must demonstrate the ability to effectively supervise medical students, ~~and~~ residents, and other health professionals ~~fellows~~ performing consultations ~~and to teach medical and surgical colleagues about psychiatric complications of physical illness;~~.

IV.A.2.d).(5) Fellows must demonstrate competence in effectively communicating patients' psychiatric issues and treatments to the patients, their family members, and the medical team.

IV.A.2.e) Professionalism

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

IV.A.2.f) Systems-based Practice

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

IV.A.2.f).(1) Fellows must demonstrate facilitative skills necessary to enhance the care of psychiatric disturbances among the physically ill through cooperative interaction with other physicians and allied health professionals.

IV.A.2.f).(2) Fellows must demonstrate competence in effectively working with discharge planning personnel and personnel in aftercare facilities.

IV.A.3. Curriculum Organization and Fellow Experiences

IV.A.3.a) The 12-month program must be completed with a two-year period.

IV.A.3.b) ~~The training program must provide opportunities for fellows to acquire advanced clinical knowledge and skills in the field of psychosomatic medicine. This objective must be accomplished by a combination of supervised clinical experiences and formal didactic conferences. The curriculum must assure fellows the opportunity to acquire the cognitive knowledge, interpersonal skills, professional attitudes, and practical experience required of~~

~~a psychiatrist with added qualifications in psychosomatic medicine.~~ All major dimensions of the curriculum must be structured educational experiences guided by written competency-based goals and objectives ~~as well as by~~ linked to specific teaching and evaluation methods.

IV.A.3.c) Educational sessions should include journal club, critical incident conferences, weekly didactic seminars, and teaching patient rounds.

IV.A.3.c).(1) Fellows must attend at least 70% of all required didactic components of the programs. Attendance by fellows and faculty members should be documented.

IV.A.3.d) ~~Educational experiences must be planned and faculty must attend and meaningfully participate.~~

IV.A.3.e) Fellows must participate in continuity of patient care.

IV.A.3.e).(1) This experience must include care for patients in an acute general hospital and an ambulatory care facility.

IV.A.3.f) ~~Supervision of the fellows by psychosomatic faculty members must be available at all times.~~

IV.A.3.g) Each fellow must have a minimum of two hours of individual faculty preceptorship weekly, of which one hour may be group preceptorship.

IV.A.3.h) Each fellow must maintain a patient log documenting all clinical experiences.

IV.B. Fellows' Scholarly Activities

I.A.2. ~~Each program must provide an opportunity for fellows to participate in research or other scholarly activities, and fellows must participate actively in such scholarly activities.~~ Fellows must participate in developing new knowledge or evaluating research findings.

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Formative Evaluation

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

V.A.1.b) The program must:

V.A.1.b).(1) provide objective assessments of competence in

609 patient care, medical knowledge, practice-based
610 learning and improvement, interpersonal and
611 communication skills, professionalism, and systems-
612 based practice;
613
614 **V.A.1.b).(2)** **use multiple evaluators (e.g., faculty, peers, patients,**
615 **self, and other professional staff); and,**
616
617 **V.A.1.b).(3)** **provide each fellow with documented semiannual**
618 **evaluation of performance with feedback.**
619
620 V.A.1.b).(3).(a) The evaluation must include review and discussion
621 with each fellow of his or her completion of all
622 required components of the program, evaluations of
623 his or her clinical and didactic work by supervisors
624 and teachers, and his or her patient log
625 documenting all clinical experiences.
626
627 **V.A.1.c)** **The evaluations of fellow performance must be accessible for**
628 **review by the fellow, in accordance with institutional policy.**
629
630 V.A.1.d) Assessment should include quarterly written evaluations of all
631 fellows by all supervisors and the directors of clinical components
632 of the program.
633
634 **V.A.2.** **Summative Evaluation**
635
636 **The program director must provide a summative evaluation for each**
637 **fellow upon completion of the program. This evaluation must**
638 **become part of the fellow's permanent record maintained by the**
639 **institution, and must be accessible for review by the fellow in**
640 **accordance with institutional policy. This evaluation must:**
641
642 **V.A.2.a)** **document the fellow's performance during their education,**
643 **and**
644
645 **V.A.2.b)** **verify that the fellow has demonstrated sufficient competence**
646 **to enter practice without direct supervision.**
647
648 V.A.3. The final evaluation of each fellow must document proficiency in all
649 required competency-based outcomes.
650
651 **V.B.** **Faculty Evaluation**
652
653 **V.B.1.** **At least annually, the program must evaluate faculty performance as**
654 **it relates to the educational program.**
655
656 **V.B.2.** **These evaluations should include a review of the faculty's clinical**
657 **teaching abilities, commitment to the educational program, clinical**
658 **knowledge, professionalism, and scholarly activities.**
659

V.C. Program Evaluation and Improvement

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

V.C.1.a) fellow performance,

V.C.1.b) faculty development, and,

V.C.1.c) program goals and objectives as well as program effectiveness in achieving them.

V.C.1.c).(1) At least one fellow representative and all faculty members should participate in these reviews.

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

V.C.3. At least 80% of the program's graduates from the preceding five years should have taken the ABPN certifying examination in psychosomatic medicine.

V.C.4. At least ~~When averaged over any five year period, a minimum of~~ 80% of the program's graduates from the preceding five years who have taken the ABPN examination for psychosomatic medicine for the first time must pass. ~~all program graduates must successfully complete the examinations of the American Board of Psychiatry and Neurology.~~

VI. Fellow Duty Hours in the Learning and Working Environment

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

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

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

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

VI.A.4. The learning objectives of the program must:

711 **VI.A.4.a)** **be accomplished through an appropriate blend of supervised**
712 **patient care responsibilities, clinical teaching, and didactic**
713 **educational events; and,**
714
715 **VI.A.4.b)** **not be compromised by excessive reliance on fellows to fulfill**
716 **non-physician service obligations.**
717
718 **VI.A.5.** **The program director and sponsoring institution must ensure a**
719 **culture of professionalism that supports patient safety and personal**
720 **responsibility. Fellows and faculty members must demonstrate an**
721 **understanding and acceptance of their personal role in the**
722 **following:**
723
724 **VI.A.5.a)** **assurance of the safety and welfare of patients entrusted to**
725 **their care;**
726
727 **VI.A.5.b)** **provision of patient- and family-centered care;**
728
729 **VI.A.5.c)** **assurance of their fitness for duty;**
730
731 **VI.A.5.d)** **management of their time before, during, and after clinical**
732 **assignments;**
733
734 **VI.A.5.e)** **recognition of impairment, including illness and fatigue, in**
735 **themselves and in their peers;**
736
737 **VI.A.5.f)** **attention to lifelong learning;**
738
739 **VI.A.5.g)** **the monitoring of their patient care performance improvement**
740 **indicators; and,**
741
742 **VI.A.5.h)** **honest and accurate reporting of duty hours, patient**
743 **outcomes, and clinical experience data.**
744
745 **VI.A.6.** **All fellows and faculty members must demonstrate responsiveness**
746 **to patient needs that supersedes self-interest. Physicians must**
747 **recognize that under certain circumstances, the best interests of the**
748 **patient may be served by transitioning that patient's care to another**
749 **qualified and rested provider.**
750
751 **VI.B.** **Transitions of Care**
752
753 **VI.B.1.** **Programs must design clinical assignments to minimize the number**
754 **of transitions in patient care.**
755
756 **VI.B.2.** **Sponsoring institutions and programs must ensure and monitor**
757 **effective, structured hand-over processes to facilitate both**
758 **continuity of care and patient safety.**
759
760 **VI.B.3.** **Programs must ensure that fellows are competent in communicating**
761 **with team members in the hand-over process.**

762
763 **VI.B.4.** **The sponsoring institution must ensure the availability of schedules**
764 **that inform all members of the health care team of attending**
765 **physicians and fellows currently responsible for each patient's care.**
766
767 **VI.C. Alertness Management/Fatigue Mitigation**
768
769 **VI.C.1.** **The program must:**
770
771 **VI.C.1.a)** **educate all faculty members and fellows to recognize the**
772 **signs of fatigue and sleep deprivation;**
773
774 **VI.C.1.b)** **educate all faculty members and fellows in alertness**
775 **management and fatigue mitigation processes; and,**
776
777 **VI.C.1.c)** **adopt fatigue mitigation processes to manage the potential**
778 **negative effects of fatigue on patient care and learning, such**
779 **as naps or back-up call schedules.**
780
781 **VI.C.2.** **Each program must have a process to ensure continuity of patient**
782 **care in the event that a fellow may be unable to perform his/her**
783 **patient care duties.**
784
785 **VI.C.3.** **The sponsoring institution must provide adequate sleep facilities**
786 **and/or safe transportation options for fellows who may be too**
787 **fatigued to safely return home.**
788
789 **VI.D. Supervision of Fellows**
790
791 **VI.D.1.** **In the clinical learning environment, each patient must have an**
792 **identifiable, appropriately-credentialed and privileged attending**
793 **physician (or licensed independent practitioner as approved by each**
794 **Review Committee) who is ultimately responsible for that patient's**
795 **care.**
796
797 Only licensed independent practitioners as consistent with state
798 regulations and medical staff bylaws may have primary responsibility for a
799 patient.
800
801 **VI.D.1.a)** **This information should be available to fellows, faculty**
802 **members, and patients.**
803
804 **VI.D.1.b)** **Fellows and faculty members should inform patients of their**
805 **respective roles in each patient's care.**
806
807 **VI.D.2.** **The program must demonstrate that the appropriate level of**
808 **supervision is in place for all fellows who care for patients.**
809
810 **Supervision may be exercised through a variety of methods. Some**
811 **activities require the physical presence of the supervising faculty**
812 **member. For many aspects of patient care, the supervising**

813 physician may be a more advanced fellow. Other portions of care
814 provided by the fellow can be adequately supervised by the
815 immediate availability of the supervising faculty member or fellow
816 physician, either in the institution, or by means of telephonic and/or
817 electronic modalities. In some circumstances, supervision may
818 include post-hoc review of fellow-delivered care with feedback as to
819 the appropriateness of that care.
820
821 **VI.D.3. Levels of Supervision**
822
823 **To ensure oversight of fellow supervision and graded authority and**
824 **responsibility, the program must use the following classification of**
825 **supervision:**
826
827 **VI.D.3.a) Direct Supervision – the supervising physician is physically**
828 **present with the fellow and patient.**
829
830 **VI.D.3.b) Indirect Supervision:**
831
832 **VI.D.3.b).(1) with direct supervision immediately available – the**
833 **supervising physician is physically within the hospital**
834 **or other site of patient care, and is immediately**
835 **available to provide Direct Supervision.**
836
837 **VI.D.3.b).(2) with direct supervision available – the supervising**
838 **physician is not physically present within the hospital**
839 **or other site of patient care, but is immediately**
840 **available by means of telephonic and/or electronic**
841 **modalities, and is available to provide Direct**
842 **Supervision.**
843
844 **VI.D.3.c) Oversight – The supervising physician is available to provide**
845 **review of procedures/encounters with feedback provided**
846 **after care is delivered.**
847
848 **VI.D.4. The privilege of progressive authority and responsibility, conditional**
849 **independence, and a supervisory role in patient care delegated to**
850 **each fellow must be assigned by the program director and faculty**
851 **members.**
852
853 **VI.D.4.a) The program director must evaluate each fellow's abilities**
854 **based on specific criteria. When available, evaluation should**
855 **be guided by specific national standards-based criteria.**
856
857 **VI.D.4.b) Faculty members functioning as supervising physicians**
858 **should delegate portions of care to fellows, based on the**
859 **needs of the patient and the skills of the fellows.**
860
861 **VI.D.4.c) Fellows should serve in a supervisory role of residents or**
862 **junior fellows in recognition of their progress toward**
863 **independence, based on the needs of each patient and the**

864 **skills of the individual fellow.**
865
866 **VI.D.5.** **Programs must set guidelines for circumstances and events in**
867 **which fellows must communicate with appropriate supervising**
868 **faculty members, such as the transfer of a patient to an intensive**
869 **care unit, or end-of-life decisions.**
870
871 **VI.D.5.a)** **Each fellow must know the limits of his/her scope of**
872 **authority, and the circumstances under which he/she is**
873 **permitted to act with conditional independence.**
874
875 **VI.D.6.** **Faculty supervision assignments should be of sufficient duration to**
876 **assess the knowledge and skills of each fellow and delegate to**
877 **him/her the appropriate level of patient care authority and**
878 **responsibility.**
879
880 **VI.E.** **Clinical Responsibilities**
881
882 **The clinical responsibilities for each fellow must be based on PGY-level,**
883 **patient safety, fellow education, severity and complexity of patient**
884 **illness/condition and available support services.**
885
886 **VI.F.** **Teamwork**
887
888 **Fellows must care for patients in an environment that maximizes effective**
889 **communication. This must include the opportunity to work as a member of**
890 **effective interprofessional teams that are appropriate to the delivery of care**
891 **in the specialty.**
892
893 VI.F.1. Contributors to effective interprofessional teams include consulting
894 physicians, psychologists, psychiatric nurses, social workers and other
895 professional and paraprofessional mental health personnel involved in the
896 evaluation and treatment of patients.
897
898 **VI.G.** **Fellow Duty Hours**
899
900 **VI.G.1.** **Maximum Hours of Work per Week**
901
902 **Duty hours must be limited to 80 hours per week, averaged over a**
903 **four-week period, inclusive of all in-house call activities and all**
904 **moonlighting.**
905
906 **VI.G.1.a)** **Duty Hour Exceptions**
907
908 **A Review Committee may grant exceptions for up to 10% or a**
909 **maximum of 88 hours to individual programs based on a**
910 **sound educational rationale.**
911
912 **VI.G.1.a).(1)** **In preparing a request for an exception the program**
913 **director must follow the duty hour exception policy**
914 **from the ACGME Manual on Policies and Procedures.**

915
916 **VI.G.1.a).(2)** **Prior to submitting the request to the Review**
917 **Committee, the program director must obtain approval**
918 **of the institution's GMEC and DIO.**
919
920 **VI.G.2.** **Moonlighting**
921
922 **VI.G.2.a)** **Moonlighting must not interfere with the ability of the fellow**
923 **to achieve the goals and objectives of the educational**
924 **program.**
925
926 **VI.G.2.b)** **Time spent by fellows in Internal and External Moonlighting**
927 **(as defined in the ACGME Glossary of Terms) must be**
928 **counted towards the 80-hour Maximum Weekly Hour Limit.**
929
930 **VI.G.3.** **Mandatory Time Free of Duty**
931
932 **Fellows must be scheduled for a minimum of one day free of duty**
933 **every week (when averaged over four weeks). At-home call cannot**
934 **be assigned on these free days.**
935
936 **VI.G.4.** **Maximum Duty Period Length**
937
938 **Duty periods of fellows may be scheduled to a maximum of 24 hours**
939 **of continuous duty in the hospital. Programs must encourage**
940 **fellows to use alertness management strategies in the context of**
941 **patient care responsibilities. Strategic napping, especially after 16**
942 **hours of continuous duty and between the hours of 10:00 p.m. and**
943 **8:00 a.m., is strongly suggested.**
944
945 **VI.G.4.a)** **It is essential for patient safety and fellow education that**
946 **effective transitions in care occur. Fellows may be allowed to**
947 **remain on-site in order to accomplish these tasks; however,**
948 **this period of time must be no longer than an additional four**
949 **hours.**
950
951 **VI.G.4.b)** **Fellows must not be assigned additional clinical**
952 **responsibilities after 24 hours of continuous in-house duty.**
953
954 **VI.G.4.c)** **In unusual circumstances, fellows, on their own initiative,**
955 **may remain beyond their scheduled period of duty to**
956 **continue to provide care to a single patient. Justifications for**
957 **such extensions of duty are limited to reasons of required**
958 **continuity for a severely ill or unstable patient, academic**
959 **importance of the events transpiring, or humanistic attention**
960 **to the needs of a patient or family.**
961
962 **VI.G.4.c).(1)** **Under those circumstances, the fellow must:**
963
964 **VI.G.4.c).(1).(a)** **appropriately hand over the care of all other**
965 **patients to the team responsible for their**

966 **continuing care; and,**
967
968 **VI.G.4.c).(1).(b)** **document the reasons for remaining to care for**
969 **the patient in question and submit that**
970 **documentation in every circumstance to the**
971 **program director.**
972
973 **VI.G.4.c).(2)** **The program director must review each submission of**
974 **additional service, and track both individual fellow and**
975 **program-wide episodes of additional duty.**
976
977 **VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**
978
979 **VI.G.5.a)** **Fellows must be prepared to enter the unsupervised practice**
980 **of medicine and care for patients over irregular or extended**
981 **periods.**
982
983 Psychosomatic medicine fellows are considered to be in the final
984 years of education.
985
986 **VI.G.5.a).(1)** **This preparation must occur within the context of the**
987 **80-hour, maximum duty period length, and one-day-**
988 **off-in-seven standards. While it is desirable that**
989 **fellows have eight hours free of duty between**
990 **scheduled duty periods, there may be circumstances**
991 **when these fellows must stay on duty to care for their**
992 **patients or return to the hospital with fewer than eight**
993 **hours free of duty.**
994
995 **VI.G.5.a).(1).(a)** **Circumstances of return-to-hospital activities**
996 **with fewer than eight hours away from the**
997 **hospital by fellows must be monitored by the**
998 **program director.**
999
1000 VI.G.5.a).(1).(b) There are no circumstances under which fellows
1001 may stay on duty with fewer than eight hours off.
1002
1003 **VI.G.6.** **Maximum Frequency of In-House Night Float**
1004
1005 **Fellows must not be scheduled for more than six consecutive nights**
1006 **of night float.**
1007
1008 **VI.G.7.** **Maximum In-House On-Call Frequency**
1009
1010 **Fellows must be scheduled for in-house call no more frequently than**
1011 **every-third-night (when averaged over a four-week period).**
1012
1013 **VI.G.8.** **At-Home Call**
1014
1015 **VI.G.8.a)** **Time spent in the hospital by fellows on at-home call must**
1016 **count towards the 80-hour maximum weekly hour limit. The**

1017 **frequency of at-home call is not subject to the every-third-**
1018 **night limitation, but must satisfy the requirement for one-day-**
1019 **in-seven free of duty, when averaged over four weeks.**
1020
1021 **VI.G.8.a).(1)** **At-home call must not be so frequent or taxing as to**
1022 **preclude rest or reasonable personal time for each**
1023 **fellow.**
1024
1025 **VI.G.8.b)** **Fellows are permitted to return to the hospital while on at-**
1026 **home call to care for new or established patients. Each**
1027 **episode of this type of care, while it must be included in the**
1028 **80-hour weekly maximum, will not initiate a new "off-duty**
1029 **period".**
1030
1031 ***