ACGME Program Requirements for Graduate Medical Education in Psychiatry

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ACGME Program Requirements for Graduate Medical Education in Psychiatry

Common Program Requirements (Residency) are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Introduction

Int.A. ***Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, professionalism, and scholarship.***

Graduate medical education transforms medical students into physician scholars who care for the patient, family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.

Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care.

Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

Int.B. **Definition of Specialty**

Psychiatry is a medical specialty focused on the prevention, diagnosis, and treatment of behavioral ~~psychiatric mental~~, addictive, and emotional disorders. Graduates will possess sound clinical judgment, requisite skills, and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric

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52 disorders, together with other common medical and neurological disorders that
53 relate to the practice of psychiatry. (Core)*
54
55 **Int.C. Length of Educational Program**
56
57 The educational program in psychiatry must be 48 months in length. (Core)
58
59 **I. Oversight**
60
61 **I.A. Sponsoring Institution**
62
63 ***The Sponsoring Institution is the organization or entity that assumes the***
64 ***ultimate financial and academic responsibility for a program of graduate***
65 ***medical education, consistent with the ACGME Institutional Requirements.***
66
67 ***When the Sponsoring Institution is not a rotation site for the program, the***
68 ***most commonly utilized site of clinical activity for the program is the***
69 ***primary clinical site.***
70

Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the residents. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.

71
72 **I.A.1. The program must be sponsored by one ACGME-accredited**
73 **Sponsoring Institution. (Core)***
74
75 **I.B. Participating Sites**
76
77 ***A participating site is an organization providing educational experiences or***
78 ***educational assignments/rotations for residents.***
79
80 **I.B.1. The program, with approval of its Sponsoring Institution, must**
81 **designate a primary clinical site. (Core)**
82
83 **I.B.2. There must be a program letter of agreement (PLA) between the**
84 **program and each participating site that governs the relationship**
85 **between the program and the participating site providing a required**
86 **assignment. (Core)**
87
88 **I.B.2.a) The PLA must:**
89
90 **I.B.2.a).(1) be renewed at least every 10 years; and, (Core)**
91
92 **I.B.2.a).(2) be approved by the designated institutional official**
93 **(DIO). (Core)**

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94
95 **I.B.3. The program must monitor the clinical learning and working**
96 **environment at all participating sites.** (Core)
97
98 **I.B.3.a) At each participating site there must be one faculty member,**
99 **designated by the program director as the site director, who**
100 **is accountable for resident education at that site, in**
101 **collaboration with the program director.** (Core)
102

Background and Intent: While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites the program must ensure the quality of the educational experience. The requirements under I.B.3. are intended to ensure that this will be the case.

Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include:

- **Identifying the faculty members who will assume educational and supervisory responsibility for residents**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of residents**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern resident education during the assignment**

103
104 **I.B.4. The program director must submit any additions or deletions of**
105 **participating sites routinely providing an educational experience,**
106 **required for all residents, of one month full time equivalent (FTE) or**
107 **more through the ACGME's Accreditation Data System (ADS).** (Core)
108
109 I.B.5. The number of and distance between participating sites must allow for full
110 participation by residents in all organized educational aspects of the
111 program. (Core)
112
113 **I.C. The program, in partnership with its Sponsoring Institution, must engage in**
114 **practices that focus on mission-driven, ongoing, systematic recruitment**
115 **and retention of a diverse and inclusive workforce of residents, fellows (if**
116 **present), faculty members, senior administrative staff members, and other**
117 **relevant members of its academic community.** (Core)
118

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

119

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I.D. Resources

I.D.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)

I.D.1.a) Organized clinical services in inpatient, outpatient, emergency, consultation-~~/~~liaison, and child and adolescent psychiatry must be available. (Core)

I.D.1.b) There must be offices designated for residents to use to interview patients and accomplish their clinical duties in a professional manner. (Core)

I.D.1.c) There must be specifically-designated areas for residents to use to perform basic physical examinations and other necessary diagnostic procedures and treatment interventions. (Core)

I.D.1.d) There must be educational space and equipment, with the capability to record and playback specifically designated for seminars, lectures, and other educational activities. (Core)

I.D.1.e) There must be equipment with the capacity for recording and viewing clinical encounters available to residents. (Core)

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

I.D.1.g) There must ~~should~~ be an inpatient population that is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and genders. (Core)~~(Detail)~~

I.D.1.h) Patient services that are comprehensive and continuous must ~~should~~ be available. (Detail)

I.D.1.i) Allied medical and ancillary staff members must ~~should~~ be available for back-up support. (Core)~~(Detail)~~

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for: (Core)

I.D.2.a) access to food while on duty; (Core)

I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at

169
170 **I.D.2.c)** **clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care;** **(Core)**
171
172
173

their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may be stored. Food should be available when residents are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued resident.

Background and Intent: Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the resident with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the resident and the resident's family, as outlined in VI.C.1.d).(1).

174
175 **I.D.2.d)** **security and safety measures appropriate to the participating site; and,** **(Core)**
176
177
178 **I.D.2.e)** **accommodations for residents with disabilities consistent with the Sponsoring Institution's policy.** **(Core)**
179
180
181 **I.D.3.** **Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities.** **(Core)**
182
183
184
185
186 **I.D.4.** **The program's educational and clinical resources must be adequate to support the number of residents appointed to the program.** **(Core)**
187
188
189 **I.E.** **The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education.** **(Core)**
190
191
192
193
194 **I.E.1.** **The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC).** **(Core)**
195
196
197

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that residents' education is not compromised by the presence of other providers and learners.

198

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199 **II. Personnel**
200
201 **II.A. Program Director**
202
203 **II.A.1. There must be one faculty member appointed as program director**
204 **with authority and accountability for the overall program, including**
205 **compliance with all applicable program requirements.** **(Core)**
206
207 **II.A.1.a) The Sponsoring Institution's GMEC must approve a change in**
208 **program director.** **(Core)**
209
210 **II.A.1.b) Final approval of the program director resides with the**
211 **Review Committee.** **(Core)**
212

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the residency, and it is this individual's responsibility to communicate with the residents, faculty members, DIO, GMEC, and the ACGME. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Review Committee.

213
214 **II.A.1.c) The program must demonstrate retention of the program**
215 **director for a length of time adequate to maintain continuity**
216 **of leadership and program stability.** **(Core)**
217

Background and Intent: The success of residency programs is generally enhanced by continuity in the program director position. The professional activities required of a program director are unique and complex and take time to master. All programs are encouraged to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.

218
219 **II.A.2. At a minimum, the program director must be provided with the**
220 **salary support required to devote ~~20~~ 50 percent FTE of non-clinical**
221 **time to the administration of the program.** **(Core)**
222
223 II.A.2.a) ~~The sponsoring institution must:~~
224
225 II.A.2.a).(1) ~~provide at least 50 percent salary support and protected~~
226 ~~time of 50 percent FTE (at least 20 hours per week) for the~~
227 ~~program director dedicated to direct program~~
228 ~~administration and education; and, (Core)~~
229
230 ~~II.A.2.a).(2)~~ ~~provide additional dedicated time and salary support either~~
231 ~~for the program director or for associate program directors,~~
232 ~~based on program size. (Core)~~
233
234 ~~II.A.2.a).(3)~~ ~~At a minimum, the following total hours per week must be~~
235 ~~provided for the program director or combined program~~
236 ~~director and associate program director: (Core)~~
237

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

~~II.A.2.b)~~ ~~If the associate program director is used for this support, the associate program director must report directly to the program director. (Core)~~

II.A.2.a) Additional support for the program director and the associate program director(s) must be provided based on program size as follows: (Core)

Number of Approved Resident Positions	Minimum Program Director FTE	Aggregate Program Director/Associate Program Director FTE
1-23	0.5	0.5
24-40	0.5	0.75
41-79	0.5	1.0
>79	0.5	1.5

II.A.2.b) If the FTE is shared with an associate program director, the associate program director must report directly to the program director. (Core)

Background and Intent: Fifty percent FTE is defined as two-and-one-half (2.5) days per week.

“Administrative time” is defined as non-clinical time spent meeting the responsibilities of the program director as detailed in requirements II.A.4.-II.A.4.a).(16).

The requirement does not address the source of funding required to provide the specified salary support.

II.A.3. Qualifications of the program director:

II.A.3.a) must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; (Core)

Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.

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The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.

In certain circumstances, the program and Sponsoring Institution may propose and the Review Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.

259
260 **II.A.3.b)** **must include current certification in the specialty for which**
261 **they are the program director by the American Board of**
262 Psychiatry and Neurology (ABPN) **or by the American**
263 **Osteopathic Board of** Neurology and Psychiatry**, or specialty**
264 **qualifications that are acceptable to the Review Committee;**
265 **(Core)**
266
267 **II.A.3.c)** **must include current medical licensure and appropriate**
268 **medical staff appointment; and, (Core)**
269
270 **II.A.3.d)** **must include ongoing clinical activity. (Core)**
271

Background and Intent: A program director is a role model for faculty members and residents. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the Core Competencies for the faculty members and residents.

272
273 **II.A.4.** **Program Director Responsibilities**
274
275 **The program director must have responsibility, authority, and**
276 **accountability for: administration and operations; teaching and**
277 **scholarly activity; resident recruitment and selection, evaluation,**
278 **and promotion of residents, and disciplinary action; supervision of**
279 **residents; and resident education in the context of patient care. (Core)**
280
281 **II.A.4.a)** **The program director must:**
282
283 **II.A.4.a).(1)** **be a role model of professionalism; (Core)**
284

Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

285
286 **II.A.4.a).(2)** **design and conduct the program in a fashion**
287 **consistent with the needs of the community, the**

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288 **mission(s) of the Sponsoring Institution, and the**
289 **mission(s) of the program; (Core)**
290

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

291
292 **II.A.4.a).(3)** **administer and maintain a learning environment**
293 **conducive to educating the residents in each of the**
294 **ACGME Competency domains; (Core)**
295

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

296
297 **II.A.4.a).(4)** **develop and oversee a process to evaluate candidates**
298 **prior to approval as program faculty members for**
299 **participation in the residency program education and**
300 **at least annually thereafter, as outlined in V.B.; (Core)**
301
302 **II.A.4.a).(5)** **have the authority to approve program faculty**
303 **members for participation in the residency program**
304 **education at all sites; (Core)**
305
306 **II.A.4.a).(6)** **have the authority to remove program faculty**
307 **members from participation in the residency program**
308 **education at all sites; (Core)**
309
310 **II.A.4.a).(7)** **have the authority to remove residents from**
311 **supervising interactions and/or learning environments**
312 **that do not meet the standards of the program; (Core)**
313

Background and Intent: The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

314
315 **II.A.4.a).(8)** **submit accurate and complete information required**
316 **and requested by the DIO, GMEC, and ACGME; (Core)**
317

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318 **II.A.4.a).(9)** **provide applicants who are offered an interview with**
319 **information related to the applicant's eligibility for the**
320 **relevant specialty board examination(s);** **(Core)**
321
322 **II.A.4.a).(10)** **provide a learning and working environment in which**
323 **residents have the opportunity to raise concerns and**
324 **provide feedback in a confidential manner as**
325 **appropriate, without fear of intimidation or retaliation;**
326 **(Core)**
327
328 **II.A.4.a).(11)** **ensure the program's compliance with the Sponsoring**
329 **Institution's policies and procedures related to**
330 **grievances and due process;** **(Core)**
331
332 **II.A.4.a).(12)** **ensure the program's compliance with the Sponsoring**
333 **Institution's policies and procedures for due process**
334 **when action is taken to suspend or dismiss, not to**
335 **promote, or not to renew the appointment of a**
336 **resident;** **(Core)**
337

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and residents.

338
339 **II.A.4.a).(13)** **ensure the program's compliance with the Sponsoring**
340 **Institution's policies and procedures on employment**
341 **and non-discrimination;** **(Core)**
342
343 **II.A.4.a).(13).(a)** **Residents must not be required to sign a non-**
344 **competition guarantee or restrictive covenant.**
345 **(Core)**
346
347 **II.A.4.a).(14)** **document verification of program completion for all**
348 **graduating residents within 30 days;** **(Core)**
349
350 **II.A.4.a).(15)** **provide verification of an individual resident's**
351 **completion upon the resident's request, within 30**
352 **days; and,** **(Core)**
353

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.

354
355 **II.A.4.a).(16)** **obtain review and approval of the Sponsoring**
356 **Institution's DIO before submitting information or**
357 **requests to the ACGME, as required in the Institutional**
358 **Requirements and outlined in the ACGME Program**

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Director's Guide to the Common Program Requirements. (Core)

II.B. Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

Background and Intent: "Faculty" refers to the entire teaching force responsible for educating residents. The term "faculty," including "core faculty," does not imply or require an academic appointment or salary support.

II.B.1. At each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all residents at that location. (Core)

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; (Core)

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; (Core)

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

II.B.2.c) demonstrate a strong interest in the education of residents; (Core)

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401 **II.B.2.d)** **devote sufficient time to the educational program to fulfill**
402 **their supervisory and teaching responsibilities;** (Core)
403
404 **II.B.2.e)** **administer and maintain an educational environment**
405 **conducive to educating residents;** (Core)
406
407 **II.B.2.f)** **regularly participate in organized clinical discussions,**
408 **rounds, journal clubs, and conferences; and,** (Core)
409
410 **II.B.2.g)** **pursue faculty development designed to enhance their skills**
411 **at least annually:** (Core)
412

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the residency program faculty in the aggregate.

413
414 **II.B.2.g).(1)** **as educators;** (Core)
415
416 **II.B.2.g).(2)** **in quality improvement and patient safety;** (Core)
417
418 **II.B.2.g).(3)** **in fostering their own and their residents' well-being;**
419 **and,** (Core)
420
421 **II.B.2.g).(4)** **in patient care based on their practice-based learning**
422 **and improvement efforts.** (Core)
423

Background and Intent: Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's practice and review of the literature, one is able to make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for residents in practice-based learning.

424
425 **II.B.3.** **Faculty Qualifications**
426
427 **II.B.3.a)** **Faculty members must have appropriate qualifications in**
428 **their field and hold appropriate institutional appointments.**
429 (Core)
430
431 **II.B.3.b)** **Physician faculty members must:**
432
433 **II.B.3.b).(1)** **have current certification in the specialty by the**
434 **American Board of** Psychiatry and Neurology (ABPN) **or**
435 **the American Osteopathic Board of** Neurology and
436 Psychiatry**, or possess qualifications judged acceptable**
437 **to the Review Committee.** (Core)
438

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439 **II.B.3.c)** **Any non-physician faculty members who participate in**
440 **residency program education must be approved by the**
441 **program director.** (Core)
442

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators enables the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of the resident in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.

443
444 **II.B.4.** **Core Faculty**
445
446 **Core faculty members must have a significant role in the education**
447 **and supervision of residents and must devote a significant portion**
448 **of their entire effort to resident education and/or administration, and**
449 **must, as a component of their activities, teach, evaluate, and**
450 **provide formative feedback to residents.** (Core)
451

Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing residents' progress toward achievement of competence in the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual ACGME Faculty Survey.

452
453 **II.B.4.a)** **Core faculty members must be designated by the program**
454 **director.** (Core)
455
456 **II.B.4.b)** **Core faculty members must complete the annual ACGME**
457 **Faculty Survey.** (Core)
458
459 II.B.4.c) There must be at least five core faculty members within the
460 program. (Core)
461
462 **II.C.** **Program Coordinator**
463
464 **II.C.1.** **There must be a program coordinator.** (Core)
465
466 **II.C.2.** **At a minimum, the program coordinator must be supported at 50**
467 **percent FTE for administrative time.** (Core)
468
469 II.C.2.a) Additional support must be provided based on program size as
470 follows: (Core)
471

Number of Approved Resident Positions	Minimum FTE Coordinator(s) Required

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1-23	0.5 FTE
24-40	1.0 FTE
41-79	1.5 FTE
>79	2.0 FTE

Background and Intent: Fifty percent FTE is defined as two-and-one-half (2.5) days per week.

The requirement does not address the source of funding required to provide the specified salary support.

Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.

The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the ACGME and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of residents.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer residents may not require a full-time coordinator; one coordinator may support more than one program.

II.D. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. **(Core)**

Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.

III. Resident Appointments

III.A. Eligibility Requirements

III.A.1. An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: **(Core)**

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487
488 **III.A.1.a)** **graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)**
489
490
491
492
493
494
495 **III.A.1.b)** **graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: (Core)**
496
497
498
499 **III.A.1.b).(1)** **holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)**
500
501
502
503 **III.A.1.b).(2)** **holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)**
504
505
506
507 **III.A.2.** **All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)**
508
509
510
511
512
513
514
515
516 **III.A.2.a)** **Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)**
517
518
519
520

Background and Intent: Programs with ACGME-I Foundational Accreditation or from institutions with ACGME-I accreditation do not qualify unless the program has also achieved ACGME-I Advanced Specialty Accreditation. To ensure entrants into ACGME-accredited programs from ACGME-I programs have attained the prerequisite milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.

521
522 **III.A.3.** **A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)**
523
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532
533 **III.B. The program director must not appoint more residents than approved by**
534 **the Review Committee.** (Core)
535
536 **III.B.1. All complement increases must be approved by the Review**
537 **Committee.** (Core)
538
539 III.B.2. Programs should have at least three residents at each level of education.
540 (Detail)
541
542 **III.C. Resident Transfers**
543
544 **The program must obtain verification of previous educational experiences**
545 **and a summative competency-based performance evaluation prior to**
546 **acceptance of a transferring resident, and Milestones evaluations upon**
547 **matriculation.** (Core)
548
549 III.C.1. If previous ACGME-accredited education was not in a psychiatry
550 program, residents may receive up to but no more than 12 months' credit
551 for prior education as part of the expected 48 months of the educational
552 program. (Core)
553
554 **IV. Educational Program**
555
556 ***The ACGME accreditation system is designed to encourage excellence and***
557 ***innovation in graduate medical education regardless of the organizational***
558 ***affiliation, size, or location of the program.***
559
560 ***The educational program must support the development of knowledgeable, skillful***
561 ***physicians who provide compassionate care.***
562
563 ***In addition, the program is expected to define its specific program aims consistent***
564 ***with the overall mission of its Sponsoring Institution, the needs of the community***
565 ***it serves and that its graduates will serve, and the distinctive capabilities of***
566 ***physicians it intends to graduate. While programs must demonstrate substantial***
567 ***compliance with the Common and specialty-specific Program Requirements, it is***
568 ***recognized that within this framework, programs may place different emphasis on***
569 ***research, leadership, public health, etc. It is expected that the program aims will***
570 ***reflect the nuanced program-specific goals for it and its graduates; for example, it***
571 ***is expected that a program aiming to prepare physician-scientists will have a***
572 ***different curriculum from one focusing on community health.***
573
574 **IV.A. The curriculum must contain the following educational components:** (Core)
575
576 **IV.A.1. a set of program aims consistent with the Sponsoring Institution's**
577 **mission, the needs of the community it serves, and the desired**
578 **distinctive capabilities of its graduates;** (Core)
579
580 **IV.A.1.a) The program's aims must be made available to program**
581 **applicants, residents, and faculty members.** (Core)
582

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583 **IV.A.2.** **competency-based goals and objectives for each educational**
584 **experience designed to promote progress on a trajectory to**
585 **autonomous practice. These must be distributed, reviewed, and**
586 **available to residents and faculty members;** (Core)
587

Background and Intent: The trajectory to autonomous practice is documented by Milestones evaluation. The Milestones detail the progress of a resident in attaining skill in each competency domain. They are developed by each specialty group and allow evaluation based on observable behaviors. Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.

588
589 **IV.A.3.** **delineation of resident responsibilities for patient care, progressive**
590 **responsibility for patient management, and graded supervision;** (Core)
591

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

592
593 **IV.A.4.** **a broad range of structured didactic activities;** (Core)
594
595 **IV.A.4.a)** **Residents must be provided with protected time to participate**
596 **in core didactic activities.** (Core)
597

Background and Intent: It is intended that residents will participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.

598
599 **IV.A.5.** **advancement of residents' knowledge of ethical principles**
600 **foundational to medical professionalism; and,** (Core)
601
602 **IV.A.6.** **advancement in the residents' knowledge of the basic principles of**
603 **scientific inquiry, including how research is designed, conducted,**
604 **evaluated, explained to patients, and applied to patient care.** (Core)
605
606 **IV.B.** **ACGME Competencies**
607

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the

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specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.

608
609 **IV.B.1.** **The program must integrate the following ACGME Competencies**
610 **into the curriculum:** **(Core)**
611
612 **IV.B.1.a)** **Professionalism**
613
614 **Residents must demonstrate a commitment to**
615 **professionalism and an adherence to ethical principles.** **(Core)**
616
617 **IV.B.1.a).(1)** **Residents must demonstrate competence in:**
618
619 **IV.B.1.a).(1).(a)** **compassion, integrity, and respect for others;**
620 **(Core)**
621
622 **IV.B.1.a).(1).(b)** **responsiveness to patient needs that**
623 **supersedes self-interest;** **(Core)**
624

Background and Intent: This includes the recognition that under certain circumstances, the interests of the patient may be best served by transitioning care to another provider. Examples include fatigue, conflict or duality of interest, not connecting well with a patient, or when another physician would be better for the situation based on skill set or knowledge base.

625
626 **IV.B.1.a).(1).(c)** **respect for patient privacy and autonomy;** **(Core)**
627
628 **IV.B.1.a).(1).(d)** **accountability to patients, society, and the**
629 **profession;** **(Core)**
630
631 **IV.B.1.a).(1).(e)** **respect and responsiveness to diverse patient**
632 **populations, including but not limited to**
633 **diversity in gender, age, culture, race, religion,**
634 **disabilities, national origin, socioeconomic**
635 **status, and sexual orientation;** **(Core)**
636
637 **IV.B.1.a).(1).(f)** **ability to recognize and develop a plan for one's**
638 **own personal and professional well-being; and,**
639 **(Core)**
640
641 **IV.B.1.a).(1).(g)** **appropriately disclosing and addressing**
642 **conflict or duality of interest.** **(Core)**
643
644 **IV.B.1.b)** **Patient Care and Procedural Skills**
645

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. (See the Institute of Medicine [IOM]'s *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001 and Berwick D, Nolan T, Whittington J. *The Triple Aim: care, cost, and quality. Health Affairs.* 2008; 27(3):759-769.). In

addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.

646
647 **IV.B.1.b).(1)** **Residents must be able to provide patient care that is**
648 **compassionate, appropriate, and effective for the**
649 **treatment of health problems and the promotion of**
650 **health. (Core)**
651
652 IV.B.1.b).(1).(a) Residents must demonstrate competence in the
653 evaluation and treatment of patients of different
654 ages and genders from diverse backgrounds, and
655 from a variety of ethnic, racial, sociocultural, and
656 economic backgrounds; and; (Core)
657
658 IV.B.1.b).(1).(b) Residents must demonstrate competence in:
659
660 IV.B.1.b).(1).(b).(i) forging a therapeutic alliance with patients
661 and their families of all ages and genders,
662 from diverse backgrounds, and from a
663 variety of ethnic, racial, sociocultural, and
664 economic backgrounds; (Core)
665
666 IV.B.1.b).(1).(b).(ii) formulating a clinical diagnosis for patients
667 by conducting patient interviews, (Core)
668
669 IV.B.1.b).(1).(b).(iii) eliciting a clear and accurate history; (Core)
670
671 IV.B.1.b).(1).(b).(iv) performing a physical, neurological, and
672 mental status examination, including use of
673 appropriate diagnostic studies; (Core)
674
675 IV.B.1.b).(1).(b).(v) completing a systematic recording of
676 findings in the medical record; (Core)
677
678 IV.B.1.b).(1).(b).(vi) formulating an understanding of a patient's
679 biological, psychological, behavioral, and
680 sociocultural issues associated with etiology
681 and treatment; (Core)
682
683 IV.B.1.b).(1).(b).(vii) developing a differential diagnosis and
684 treatment plan for patients with psychiatric
685 disorders; (Core)
686
687 IV.B.1.b).(1).(b).(viii) managing and treating patients using
688 pharmacological regimens, including

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689 concurrent use of medications and
690 psychotherapy; (Core)
691
692 IV.B.1.b).(1).(b).(ix) managing and treating patients using both
693 brief and long-term supportive,
694 psychodynamic, and cognitive-behavioral
695 psychotherapies; (Core)
696
697 IV.B.1.b).(1).(b).(x) providing psychiatric consultation in a
698 variety of medical and surgical settings; (Core)
699
700 IV.B.1.b).(1).(b).(xi) managing and treating chronically-mentally
701 ill patients with appropriate
702 psychopharmacologic, psychotherapeutic,
703 and social rehabilitative interventions; (Core)
704
705 IV.B.1.b).(1).(b).(xii) providing psychiatric care to patients
706 receiving treatment from non-medical
707 therapists and coordinating such treatment;
708 and, (Core)
709
710 IV.B.1.b).(1).(b).(xiii) recognizing and appropriately responding to
711 family violence (e.g., child, partner, and
712 elder physical, emotional, and sexual abuse
713 and neglect) and its effect on both victims
714 and perpetrators. (Core)
715
716 **IV.B.1.b).(2) Residents must be able to perform all medical,**
717 **diagnostic, and surgical procedures considered**
718 **essential for the area of practice. (Core)**
719
720 **IV.B.1.c) Medical Knowledge**
721
722 **Residents must demonstrate knowledge of established and**
723 **evolving biomedical, clinical, epidemiological and social-**
724 **behavioral sciences, as well as the application of this**
725 **knowledge to patient care. (Core)**
726
727 IV.B.1.c).(1) Residents must demonstrate competence in their
728 knowledge of:
729
730 IV.B.1.c).(1).(a) major theoretical approaches to understanding the
731 patient-doctor relationship; (Core)
732
733 IV.B.1.c).(1).(b) biological, genetic, psychological, sociocultural,
734 economic, ethnic, gender, religious/spiritual, sexual
735 orientation, and family factors that significantly
736 influence physical and psychological development
737 throughout the life cycle; (Core)
738
739 IV.B.1.c).(1).(c) fundamental principles of the epidemiology,

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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; (Core)

IV.B.1.c).(1).(d) diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, including neoplasm, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, neurocognitive disorders, seizure disorders, stroke, intractable pain, and other related disorders; (Core)

IV.B.1.c).(1).(e) 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; (Core)

IV.B.1.c).(1).(f) indications for and uses of electroconvulsive and neuromodulation therapies; (Core)

IV.B.1.c).(1).(g) history of psychiatry and its relationship to the evolution of medicine; (Core)

IV.B.1.c).(1).(h) legal aspects of psychiatric practice; (Core)

IV.B.1.c).(1).(i) aspects of American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the resident and the patient, including the dynamics of differences in cultural identity, values and preferences, and power; and, (Core)

IV.B.1.c).(1).(j) medical conditions that can affect evaluation and care of patients. (Core)

IV.B.1.d) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)

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Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

The intention of this Competency is to help a physician develop the habits of mind required to continuously pursue quality improvement, well past the completion of residency.

790
791 **IV.B.1.d).(1)** **Residents must demonstrate competence in:**
792
793 **IV.B.1.d).(1).(a)** **identifying strengths, deficiencies, and limits in**
794 **one's knowledge and expertise; (Core)**
795
796 **IV.B.1.d).(1).(b)** **setting learning and improvement goals; (Core)**
797
798 **IV.B.1.d).(1).(c)** **identifying and performing appropriate learning**
799 **activities; (Core)**
800
801 **IV.B.1.d).(1).(d)** **systematically analyzing practice using quality**
802 **improvement methods, and implementing**
803 **changes with the goal of practice improvement;**
804 **(Core)**
805
806 **IV.B.1.d).(1).(e)** **incorporating feedback and formative**
807 **evaluation into daily practice; (Core)**
808
809 **IV.B.1.d).(1).(f)** **locating, appraising, and assimilating evidence**
810 **from scientific studies related to their patients'**
811 **health problems; and, (Core)**
812
813 **IV.B.1.d).(1).(g)** **using information technology to optimize**
814 **learning. (Core)**
815
816 **IV.B.1.e)** **Interpersonal and Communication Skills**
817
818 **Residents must demonstrate interpersonal and**
819 **communication skills that result in the effective exchange of**
820 **information and collaboration with patients, their families,**
821 **and health professionals. (Core)**
822
823 **IV.B.1.e).(1)** **Residents must demonstrate competence in:**
824
825 **IV.B.1.e).(1).(a)** **communicating effectively with patients,**
826 **families, and the public, as appropriate, across**
827 **a broad range of socioeconomic and cultural**
828 **backgrounds; (Core)**
829

830 **IV.B.1.e).(1).(b)** **communicating effectively with physicians,**
831 **other health professionals, and health-related**
832 **agencies; (Core)**
833
834 **IV.B.1.e).(1).(c)** **working effectively as a member or leader of a**
835 **health care team or other professional group;**
836 **(Core)**
837
838 **IV.B.1.e).(1).(d)** **educating patients, families, students,**
839 **residents, and other health professionals; (Core)**
840
841 **IV.B.1.e).(1).(e)** **acting in a consultative role to other physicians**
842 **and health professionals; and, (Core)**
843
844 **IV.B.1.e).(1).(f)** **maintaining comprehensive, timely, and legible**
845 **medical records, if applicable. (Core)**
846
847 **IV.B.1.e).(2)** **Residents must learn to communicate with patients**
848 **and families to partner with them to assess their care**
849 **goals, including, when appropriate, end-of-life goals.**
850 **(Core)**
851

Background and Intent: When there are no more medications or interventions that can achieve a patient's goals or provide meaningful improvements in quality or length of life, a discussion about the patient's goals, values, and choices surrounding the end of life is one of the most important conversations that can occur. Residents must learn to participate effectively and compassionately in these meaningful human interactions, for the sake of their patients and themselves.

Programs may teach this skill through direct clinical experience, simulation, or other means of active learning.

852
853 **IV.B.1.f)** **Systems-based Practice**
854
855 **Residents must demonstrate an awareness of and**
856 **responsiveness to the larger context and system of health**
857 **care, including the social determinants of health, as well as**
858 **the ability to call effectively on other resources to provide**
859 **optimal health care. (Core)**
860
861 **IV.B.1.f).(1)** **Residents must demonstrate competence in:**
862
863 **IV.B.1.f).(1).(a)** **working effectively in various health care**
864 **delivery settings and systems relevant to their**
865 **clinical specialty; (Core)**
866

Background and Intent: Medical practice occurs in the context of an increasingly complex clinical care environment where optimal patient care requires attention to compliance with external and internal administrative and regulatory requirements.

867

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868 **IV.B.1.f).(1).(b)** **coordinating patient care across the health care**
869 **continuum and beyond as relevant to their**
870 **clinical specialty; (Core)**
871

Background and Intent: Every patient deserves to be treated as a whole person. Therefore it is recognized that any one component of the health care system does not meet the totality of the patient's needs. An appropriate transition plan requires coordination and forethought by an interdisciplinary team. The patient benefits from proper care and the system benefits from proper use of resources.

872
873 **IV.B.1.f).(1).(c)** **advocating for quality patient care and optimal**
874 **patient care systems; (Core)**
875
876 **IV.B.1.f).(1).(d)** **working in interprofessional teams to enhance**
877 **patient safety and improve patient care quality;**
878 **(Core)**
879
880 **IV.B.1.f).(1).(e)** **participating in identifying system errors and**
881 **implementing potential systems solutions; (Core)**
882
883 **IV.B.1.f).(1).(f)** **incorporating considerations of value, cost**
884 **awareness, delivery and payment, and risk-**
885 **benefit analysis in patient and/or population-**
886 **based care as appropriate; (Core)**
887
888 **IV.B.1.f).(1).(g)** **understanding health care finances and its**
889 **impact on individual patients' health decisions;**
890 **(Core)**
891
892 IV.B.1.f).(1).(h) knowing how types of medical practice and delivery
893 systems differ from one another, including methods
894 of controlling health care cost, ensuring quality, and
895 allocating resources; (Core)
896
897 IV.B.1.f).(1).(i) practicing cost-effective health care and resource
898 allocation that is aligned with high quality of care,
899 including an understanding of the financing and
900 regulation of psychiatric practice, as well as
901 information about the structure of public and private
902 organizations that influence mental health care;
903 (Core)
904
905 IV.B.1.f).(1).(j) assisting patients in dealing with system
906 complexities and disparities in mental health care
907 resources; and, (Core)
908
909 IV.B.1.f).(1).(k) advocating for the promotion of mental health and
910 the prevention of mental disorders. (Core)
911
912 **IV.B.1.f).(2)** **Residents must learn to advocate for patients within**
913 **the health care system to achieve the patient's and**

914 family's care goals, including, when appropriate, end-
915 of-life goals. (Core)
916
917 **IV.C. Curriculum Organization and Resident Experiences**
918
919 **IV.C.1. The curriculum must be structured to optimize resident educational**
920 **experiences, the length of these experiences, and supervisory**
921 **continuity. (Core)**
922
923 IV.C.1.a) Curriculum design must be consistent with the program's aims
924 (IV.A.1.) and must demonstrate a systematic approach, with
925 attention to evidence-based principles and scientific literature,
926 standards of the psychiatric profession, and developmental
927 appropriateness for learners. (Core)
928
929 IV.C.1.b) The assignment of rotations must be structured to minimize the
930 frequency of rotational transitions. (Core)
931

Background and Intent: In some specialties, frequent rotational transitions, inadequate continuity of faculty member supervision, and dispersed patient locations within the hospital have adversely affected optimal resident education and effective team-based care. The need for patient care continuity varies from specialty to specialty and by clinical situation, and may be addressed by the individual Review Committee.

932
933 **IV.C.2. The program must provide instruction and experience in pain**
934 **management if applicable for the specialty, including recognition of**
935 **the signs of addiction. (Core)**
936
937 IV.C.3. Required Clinical Experiences
938
939 ~~IV.C.3.a)~~ Residents must have major responsibility for the care of a
940 sufficient number of patients to demonstrate competence with
941 acute and chronic psychiatric illnesses. (Core)
942
943 ~~IV.C.3.b)~~ There must be patient care assignments that permit residents to
944 practice appropriate treatment, and to have sufficient time for
945 other aspects of their educational program. (Core)
946
947 IV.C.3.b).(1) These clinical responsibilities must be coordinated with
948 and not impinge on the non-patient care aspects of the
949 educational program. (Core)
950
951 ~~IV.C.3.c)~~ There must be structured clinical experiences that are organized
952 to provide opportunities to conduct initial evaluations, to
953 participate in the subsequent diagnostic process, and to follow
954 patients during the treatment phase and/or evolution of their
955 psychiatric disorders/conditions. (Core)
956
957 ~~IV.C.3.d)~~ The first year in psychiatry must include:
958

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959 IV.C.3.d).(1) a minimum of four months in a clinical setting that provides
960 comprehensive clinical care; and, (Core)
961
962 IV.C.3.d).(1).(a) This requirement should be met in a primary are
963 specialty setting. (Detail)
964
965 IV.C.3.d).(2) no more than eight months FTE in psychiatry. (Core)
966
967 ~~IV.C.3.e)~~ Resident experience in neurology must include two months FTE of
968 supervised clinical experience in the diagnosis and treatment of
969 patients with neurological disorders/conditions. (Core)
970
971 IV.C.3.e).(1) At least one month of this experience should occur in the
972 first or second year of the program. (Detail)
973
974 ~~IV.C.3.f)~~ Resident experience in inpatient psychiatry must include at least
975 six months, but no more than 16 months FTE, of inpatient
976 psychiatry. (Core)
977
978 IV.C.3.f).(1) This must include a minimum of six months of significant
979 responsibility for the assessment, diagnosis, and treatment
980 of general psychiatric patients who are admitted to
981 traditional psychiatry units. (Core)
982
983 ~~IV.C.3.g)~~ Resident experience in outpatient psychiatry must include 12
984 months FTE of organized, continuous, and supervised clinical
985 experience. (Core)
986
987 IV.C.3.g).(1) Each resident must have significant experience treating
988 outpatients longitudinally for at least one year, to include:
989 (Core)
990
991 IV.C.3.g).(1).(a) initial evaluation and treatment of ongoing
992 individual psychotherapy patients, some of whom
993 should be seen weekly; (Core)
994
995 IV.C.3.g).(1).(b) participation in multiple treatment modalities that
996 emphasize developmental, biological,
997 psychological, and social approaches to outpatient
998 treatment; (Core)
999
1000 IV.C.3.g).(1).(c) application of psychosocial rehabilitation
1001 techniques for the evaluation and treatment of
1002 differing disorders in a chronically-ill patient
1003 population; and, (Core)
1004
1005 IV.C.3.g).(1).(d) no more than 20 percent children and adolescent
1006 patients. (Core)
1007
1008 ~~IV.C.3.h)~~ Resident experience in child and adolescent psychiatry: must
1009 include two months FTE of organized clinical experience. (Core)

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1010
1011 IV.C.3.h).(1) Supervising faculty members must have current ABPN certification in child and adolescent psychiatry. (Core)
1012
1013
1014 IV.C.3.h).(2) Residents must participate in assessing, evaluating, and treating a variety of diagnoses in male and female children and adolescents and their families, using a variety of interventional modalities. (Core)
1015
1016
1017
1018
1019 ~~IV.C.3.i)~~ Resident experience in geriatric psychiatry must include one month FTE of organized experience focused on areas unique to the care of the elderly. (Core)
1020
1021
1022
1023 IV.C.3.i).(1) Each resident's geriatric psychiatry experience must include:
1024
1025
1026 IV.C.3.i).(1).(a) diagnosis and management of mental disorders in geriatric patients with coexistent medical disorders; (Core)
1027
1028
1029
1030 IV.C.3.i).(1).(b) diagnosis and management, including management of the cognitive component, of degenerative disorders; (Core)
1031
1032
1033
1034 IV.C.3.i).(1).(c) basic neuropsychological testing of cognitive functioning in the elderly; and, (Core)
1035
1036
1037 IV.C.3.i).(1).(d) management of drug interactions. (Core)
1038
1039 ~~IV.C.3.j)~~ Resident experience in addiction psychiatry must include one month FTE of organized experience focused on the evaluation and clinical management of patients with substance abuse/dependence problems, including dual diagnosis. (Core)
1040
1041
1042
1043
1044 IV.C.3.j).(1) Residents must have experience with treatment modalities that include:
1045
1046
1047 IV.C.3.j).(1).(a) detoxification, overdose management, and maintenance pharmacotherapy; (Core)
1048
1049
1050 IV.C.3.j).(1).(b) the use of therapeutic techniques that address the psychological and social consequences of addiction, to include confronting and intervening in chronic addiction rehabilitation used in recovery stages from pre-contemplation to maintenance; and, (Core)
1051
1052
1053
1054
1055
1056
1057 IV.C.3.j).(1).(c) self-help groups. (Core)
1058
1059 ~~IV.C.3.k)~~ Resident experience in consultation-liaison psychiatry must include two months FTE in which residents consult, under
1060

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supervision, on other medical and surgical services. (Core)

~~IV.C.3.l)~~ Resident experience in forensic psychiatry must include experience evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency. (Core)

~~IV.C.3.m)~~ Resident experience in emergency psychiatry must be conducted in an organized, supervised psychiatric emergency service. (Core)

IV.C.3.m).(1) This experience must not be counted as part of the 12-month outpatient requirement. (Core)

IV.C.3.m).(2) Resident experiences must include crisis evaluation and management, and triage of psychiatric patients. (Core)

IV.C.3.m).(3) On-call experiences alone must not fulfill the requirement for resident experience in emergency psychiatry. (Detail)

~~IV.C.3.n)~~ Resident experience in community psychiatry must provide residents with a cohort of persistently and chronically-ill patients in the public sector, such as in community mental health centers, public hospitals and agencies, and other community-based settings. (Core)

IV.C.3.n).(1) This experience must include learning about, and using community resources and services in planning patient care, as well as consulting and working collaboratively with case managers, crisis teams, and other mental health professionals. (Core)

~~IV.C.3.o)~~ Electives must have written curriculum with goals and objectives, and learning experiences that lead to specified learning outcomes. (Core)

IV.C.3.o).(1) The choice of electives must be made with the advice and approval of the program director and the appropriate preceptor. (Core)

IV.C.4. Residents at all levels must be provided at least two hours of faculty ~~preceptorship~~ supervision weekly, one hour of which must be individual. (Core)

IV.C.5. Residents must have experience participating in psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance, and performance improvement. (Core)

IV.C.6. For residents who enter subspecialty education in child and adolescent psychiatry prior to completing general psychiatry requirements, certain clinical experiences with children, adolescents, and families taken during

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1112 the period when the resident is designated as a child and adolescent
1113 psychiatry resident may be counted toward general psychiatry
1114 requirements as well as child and adolescent requirements, thereby
1115 fulfilling program requirements in both general and child and adolescent
1116 psychiatry. The following guidelines must be met for these experiences:
1117 (Core)
1118
1119 ~~IV.C.6.a)~~ experience is limited to child and adolescent psychiatry patients;
1120 (Core)
1121
1122 ~~IV.C.6.b)~~ no more than 12 months may be double-counted; (Core)
1123
1124 ~~IV.C.6.c)~~ there must be documentation from the child and adolescent
1125 psychiatry program director for all areas for which credit is given in
1126 both programs; (Core)
1127
1128 ~~IV.C.6.d)~~ there must be no reduction in total length of time devoted to
1129 education in child and adolescent psychiatry; and, (Core)
1130
1131 ~~IV.C.6.e)~~ only the following experiences should be used to meet
1132 requirements in both general and child and adolescent psychiatry:
1133
1134 IV.C.6.e).(1) one month FTE of child neurology; (Core)
1135
1136 IV.C.6.e).(2) one month FTE of pediatric consultation; (Core)
1137
1138 IV.C.6.e).(3) one month FTE of addiction psychiatry; (Core)
1139
1140 IV.C.6.e).(4) forensic psychiatry experience; (Core)
1141
1142 IV.C.6.e).(5) community psychiatry experience; and, (Core)
1143
1144 IV.C.6.e).(6) no more than 20 percent of the resident's psychiatry
1145 outpatient experience. (Core)
1146
1147 IV.C.7. <u>Regularly scheduled didactic sessions must be a component of the</u>
1148 <u>program. (Core)</u> ~~Didactics~~
1149
1150 ~~IV.C.7.a)~~ Each resident should <u>participate in</u> ~~attend~~ a minimum of 70
1151 percent of regularly scheduled didactic sessions. (Detail)
1152
1153 ~~IV.C.7.b)~~ Residents and faculty members should participate in journal clubs,
1154 research conferences, didactics, and/or other activities that
1155 address critical appraisal of the literature and understanding of the
1156 research process. (Detail)
1157
1158 ~~IV.C.7.c)~~ Didactic instruction should include regularly scheduled lectures,
1159 seminars, and assigned readings that are coordinated with
1160 concurrent clinical experiences and are specific to each resident's
1161 level of education. (Detail)
1162

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IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

IV.D.1.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety. While some faculty members are responsible for fulfilling the traditional elements of scholarship through research, integration, and teaching, all faculty members are responsible for advancing residents' scholarly approach to patient care.

Elements of a scholarly approach to patient care include:

- **Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan**
- **Challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature**
- **When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)**
- **Improving resident learning by encouraging them to teach using a scholarly approach**

The scholarly approach to patient care begins with curiosity, is grounded in the principles of evidence-based medicine, expands the knowledge base through dissemination, and develops the habits of lifelong learning by encouraging residents to be scholarly teachers.

1195
1196 **IV.D.2. Faculty Scholarly Activity**
1197
1198 **IV.D.2.a)** **Among their scholarly activity, programs must demonstrate**
1199 **accomplishments in at least three of the following domains:**
1200 **(Core)**
1201
1202 - **Research in basic science, education, translational**
1203 **science, patient care, or population health**
1204 - **Peer-reviewed grants**
1205 - **Quality improvement and/or patient safety initiatives**
1206 - **Systematic reviews, meta-analyses, review articles,**
1207 **chapters in medical textbooks, or case reports**
1208 - **Creation of curricula, evaluation tools, didactic**
1209 **educational activities, or electronic educational**
1210 **materials**
1211 - **Contribution to professional committees, educational**
1212 **organizations, or editorial boards**
1213 - **Innovations in education**
1214
1215 **IV.D.2.b)** **The program must demonstrate dissemination of scholarly**
1216 **activity within and external to the program by the following**
1217 **methods:**
1218

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the residents' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

1219
1220 **IV.D.2.b).(1)** **faculty participation in grand rounds, posters,**
1221 **workshops, quality improvement presentations,**
1222 **podium presentations, grant leadership, non-peer-**
1223 **reviewed print/electronic resources, articles or**
1224 **publications, book chapters, textbooks, webinars,**
1225 **service on professional committees, or serving as a**
1226 **journal reviewer, journal editorial board member, or**
1227 **editor; (Outcome)‡**
1228
1229 **IV.D.2.b).(2)** **peer-reviewed publication. (Outcome)**
1230
1231 **IV.D.3. Resident Scholarly Activity**

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1232
1233 **IV.D.3.a) Residents must participate in scholarship. (Core)**
1234
1235 IV.D.3.a).(1) The program must provide residents with opportunities for
1236 research and development of research skills for residents
1237 interested in conducting research in psychiatry or related
1238 fields. (Core)
1239
1240 IV.D.3.a).(2) The program must provide interested residents access to
1241 and the opportunity to participate actively in ongoing
1242 research under a mentor. (Core)
1243
1244 IV.D.3.a).(3) All residents must be educated in research literacy and in
1245 the concepts and process of evidence-based clinical
1246 practice to develop skills in question formulation,
1247 information searching, critical appraisal, and medical
1248 decision-making. (Core)
1249
1250 **V. Evaluation**
1251
1252 **V.A. Resident Evaluation**
1253
1254 **V.A.1. Feedback and Evaluation**
1255

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring resident learning* and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- **residents identify their strengths and weaknesses and target areas that need work**
- **program directors and faculty members recognize where residents are struggling and address problems immediately**

Summative evaluation is *evaluating a resident's learning* by comparing the residents against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

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Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.

1256
1257 **V.A.1.a)** **Faculty members must directly observe, evaluate, and**
1258 **frequently provide feedback on resident performance during**
1259 **each rotation or similar educational assignment.** (Core)
1260

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Residents require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.

1261
1262 **V.A.1.b)** **Evaluation must be documented at the completion of the**
1263 **assignment.** (Core)
1264
1265 **V.A.1.b).(1)** **For block rotations of greater than three months in**
1266 **duration, evaluation must be documented at least**
1267 **every three months.** (Core)
1268
1269 **V.A.1.b).(2)** **Longitudinal experiences, such as continuity clinic in**
1270 **the context of other clinical responsibilities, must be**
1271 **evaluated at least every three months and at**
1272 **completion.** (Core)
1273
1274 **V.A.1.c)** **The program must provide an objective performance**
1275 **evaluation based on the Competencies and the specialty-**
1276 **specific Milestones, and must:** (Core)
1277
1278 **V.A.1.c).(1)** **use multiple evaluators (e.g., faculty members, peers,**
1279 **patients, self, and other professional staff members);**
1280 **and,** (Core)
1281
1282 **V.A.1.c).(2)** **provide that information to the Clinical Competency**
1283 **Committee for its synthesis of progressive resident**
1284 **performance and improvement toward unsupervised**
1285 **practice.** (Core)
1286
1287 **V.A.1.d)** **The program director or their designee, with input from the**
1288 **Clinical Competency Committee, must:**
1289
1290 **V.A.1.d).(1)** **meet with and review with each resident their**
1291 **documented semi-annual evaluation of performance,**
1292 **including progress along the specialty-specific**
1293 **Milestones;** (Core)
1294
1295 **V.A.1.d).(2)** **assist residents in developing individualized learning**
1296 **plans to capitalize on their strengths and identify areas**
1297 **for growth; and,** (Core)

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1298
1299 **V.A.1.d).(3)** **develop plans for residents failing to progress,**
1300 **following institutional policies and procedures.** **(Core)**
1301

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

1302
1303 **V.A.1.e)** **At least annually, there must be a summative evaluation of**
1304 **each resident that includes their readiness to progress to the**
1305 **next year of the program, if applicable.** **(Core)**
1306
1307 **V.A.1.f)** **The evaluations of a resident's performance must be**
1308 **accessible for review by the resident.** **(Core)**
1309
1310 V.A.1.g) The final evaluation must include a summary of any documented
1311 evidence of unethical behavior, unprofessional behavior, or clinical
1312 incompetence, or a statement that none has occurred. (Core)
1313
1314 V.A.1.g).(1) Where there is such evidence, it must be comprehensively
1315 recorded, along with the resident's response(s) to that
1316 evidence. (Core)
1317
1318 V.A.1.h) In at least three evaluations with any patient type, in any clinical
1319 setting, and at any time during the program, residents must
1320 demonstrate satisfactory competence in: establishing an
1321 appropriate doctor/patient relationship, psychiatric interviewing,
1322 performing the mental status examination, and case presentation.
1323 (Outcome)
1324
1325 V.A.1.h).(1) Each of the three required evaluations must be conducted
1326 by an ABPN- or AOBNP-certified psychiatrist, and at least
1327 two of the evaluations must be conducted by different
1328 ABPN- or AOBNP-certified psychiatrists. (Core)
1329

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1330 V.A.1.h).(2) Satisfactory demonstration of the competencies during the three required evaluations must be documented prior to completion of the program. (Core)

1334 V.A.1.i) The program must conduct an annual formal evaluation of the core medical knowledge of each resident 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. (Core)

1340 V.A.1.j) The program must formally conduct a clinical skills examination for each resident. (Core)

1343 V.A.1.j).(1) This examination should include an annual evaluation of the resident's:

1346 V.A.1.j).(1).(a) ability to interview patients and families; (Detail)

1348 V.A.1.j).(1).(b) ability to establish an appropriate doctor/patient relationship; (Detail)

1351 V.A.1.j).(1).(c) ability to elicit an appropriate present and past psychiatric, medical, social, and developmental history; (Detail)

1355 V.A.1.j).(1).(d) ability to assess mental status; (Detail)

1357 V.A.1.j).(1).(e) ability to make organized presentation of the pertinent history, including the mental status examination; and, (Detail) [Moved from V.A.1.j).(1).(f)]

1361 V.A.1.j).(1).(f) ability to provide a relevant formulation, differential diagnosis, and provisional treatment plan. (Detail) [Moved from V.A.1.j).(1).(e)]

1365 V.A.1.j).(2) The program must monitor clinical records on major rotations to assess resident competence to: (Core)

1368 V.A.1.j).(2).(a) document an adequate history and perform mental status, physical, and neurological examinations; (Core)

1372 V.A.1.j).(2).(b) organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues; (Core)

1376 V.A.1.j).(2).(c) proceed with appropriate laboratory and other diagnostic procedures; (Core)

1379 V.A.1.j).(2).(d) develop and implement an appropriate treatment plan followed by regular and relevant progress

1381 notes regarding both therapy and medication
1382 management; and, (Core)
1383
1384 V.A.1.j).(2).(e) prepare an adequate discharge summary and plan.
1385 (Core)
1386
1387 V.A.1.k) Residents' teaching abilities must be documented by evaluations
1388 from faculty members and/or learners. (Core)
1389
1390 V.A.1.l) The record of evaluation must demonstrate that each resident has
1391 met the educational requirements of the program with regard to
1392 variety of patients, diagnoses, and treatment modalities. (Core)
1393
1394 V.A.1.l).(1) In the case of transferring residents, the records must
1395 include the experiences in the prior and current program.
1396 (Core)
1397
1398 **V.A.2. Final Evaluation**
1399
1400 **V.A.2.a) The program director must provide a final evaluation for each**
1401 **resident upon completion of the program. (Core)**
1402
1403 **V.A.2.a).(1) The specialty-specific Milestones, and when applicable**
1404 **the specialty-specific Case Logs, must be used as**
1405 **tools to ensure residents are able to engage in**
1406 **autonomous practice upon completion of the program.**
1407 **(Core)**
1408
1409 **V.A.2.a).(2) The final evaluation must:**
1410
1411 **V.A.2.a).(2).(a) become part of the resident's permanent record**
1412 **maintained by the institution, and must be**
1413 **accessible for review by the resident in**
1414 **accordance with institutional policy; (Core)**
1415
1416 **V.A.2.a).(2).(b) verify that the resident has demonstrated the**
1417 **knowledge, skills, and behaviors necessary to**
1418 **enter autonomous practice; (Core)**
1419
1420 **V.A.2.a).(2).(c) consider recommendations from the Clinical**
1421 **Competency Committee; and, (Core)**
1422
1423 **V.A.2.a).(2).(d) be shared with the resident upon completion of**
1424 **the program. (Core)**
1425
1426 **V.A.3. A Clinical Competency Committee must be appointed by the**
1427 **program director. (Core)**
1428
1429 **V.A.3.a) At a minimum, the Clinical Competency Committee must**
1430 **include three members of the program faculty, at least one of**
1431 **whom is a core faculty member. (Core)**

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1432
1433 **V.A.3.a).(1)** **Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents.** (Core)
1434
1435
1436
1437

Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for resident evaluation and promotion decisions.

Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.

1438
1439 **V.A.3.b)** **The Clinical Competency Committee must:**
1440
1441 **V.A.3.b).(1)** **review all resident evaluations at least semi-annually;** (Core)
1442
1443
1444 **V.A.3.b).(2)** **determine each resident's progress on achievement of the specialty-specific Milestones; and,** (Core)
1445
1446
1447 **V.A.3.b).(3)** **meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.** (Core)
1448
1449
1450
1451 **V.B.** **Faculty Evaluation**
1452
1453 **V.B.1.** **The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually.** (Core)
1454
1455
1456

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the diverse operating environments and configurations, the residency program director may need to work

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with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

1457
1458 **V.B.1.a)** **This evaluation must include a review of the faculty member's**
1459 **clinical teaching abilities, engagement with the educational**
1460 **program, participation in faculty development related to their**
1461 **skills as an educator, clinical performance, professionalism,**
1462 **and scholarly activities.** (Core)
1463
1464 **V.B.1.b)** **This evaluation must include written, anonymous, and**
1465 **confidential evaluations by the residents.** (Core)
1466
1467 **V.B.2.** **Faculty members must receive feedback on their evaluations at least**
1468 **annually.** (Core)
1469
1470 **V.B.3.** **Results of the faculty educational evaluations should be**
1471 **incorporated into program-wide faculty development plans.** (Core)
1472

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the residents' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

1473
1474 **V.C.** **Program Evaluation and Improvement**
1475
1476 **V.C.1.** **The program director must appoint the Program Evaluation**
1477 **Committee to conduct and document the Annual Program**
1478 **Evaluation as part of the program's continuous improvement**
1479 **process.** (Core)
1480
1481 **V.C.1.a)** **The Program Evaluation Committee must be composed of at**
1482 **least two program faculty members, at least one of whom is a**
1483 **core faculty member, and at least one resident.** (Core)
1484
1485 **V.C.1.b)** **Program Evaluation Committee responsibilities must include:**
1486
1487 **V.C.1.b).(1)** **acting as an advisor to the program director, through**
1488 **program oversight;** (Core)
1489
1490 **V.C.1.b).(2)** **review of the program's self-determined goals and**
1491 **progress toward meeting them;** (Core)
1492

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1493 **V.C.1.b).(3)** **guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)**
1494
1495
1496
1497 **V.C.1.b).(4)** **review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)**
1498
1499
1500

Background and Intent: In order to achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of residents and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

1501
1502 **V.C.1.c)** **The Program Evaluation Committee should consider the following elements in its assessment of the program:**
1503
1504
1505 **V.C.1.c).(1)** **curriculum; (Core)**
1506
1507 **V.C.1.c).(2)** **outcomes from prior Annual Program Evaluation(s); (Core)**
1508
1509
1510 **V.C.1.c).(3)** **ACGME letters of notification, including citations, Areas for Improvement, and comments; (Core)**
1511
1512
1513 **V.C.1.c).(4)** **quality and safety of patient care; (Core)**
1514
1515 **V.C.1.c).(5)** **aggregate resident and faculty:**
1516
1517 **V.C.1.c).(5).(a)** **well-being; (Core)**
1518
1519 **V.C.1.c).(5).(b)** **recruitment and retention; (Core)**
1520
1521 **V.C.1.c).(5).(c)** **workforce diversity; (Core)**
1522
1523 **V.C.1.c).(5).(d)** **engagement in quality improvement and patient safety; (Core)**
1524
1525
1526 **V.C.1.c).(5).(e)** **scholarly activity; (Core)**
1527
1528 **V.C.1.c).(5).(f)** **ACGME Resident and Faculty Surveys; and, (Core)**
1529
1530
1531 **V.C.1.c).(5).(g)** **written evaluations of the program. (Core)**
1532
1533 **V.C.1.c).(6)** **aggregate resident:**
1534
1535 **V.C.1.c).(6).(a)** **achievement of the Milestones; (Core)**
1536

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1537 **V.C.1.c).(6).(b)** **in-training examinations (where applicable);**
1538 **(Core)**
1539
1540 **V.C.1.c).(6).(c)** **board pass and certification rates; and, (Core)**
1541
1542 **V.C.1.c).(6).(d)** **graduate performance. (Core)**
1543
1544 **V.C.1.c).(7)** **aggregate faculty:**
1545
1546 **V.C.1.c).(7).(a)** **evaluation; and, (Core)**
1547
1548 **V.C.1.c).(7).(b)** **professional development. (Core)**
1549
1550 **V.C.1.d)** **The Program Evaluation Committee must evaluate the**
1551 **program's mission and aims, strengths, areas for**
1552 **improvement, and threats. (Core)**
1553
1554 **V.C.1.e)** **The annual review, including the action plan, must:**
1555
1556 **V.C.1.e).(1)** **be distributed to and discussed with the members of**
1557 **the teaching faculty and the residents; and, (Core)**
1558
1559 **V.C.1.e).(2)** **be submitted to the DIO. (Core)**
1560
1561 **V.C.2.** **The program must complete a Self-Study prior to its 10-Year**
1562 **Accreditation Site Visit. (Core)**
1563
1564 **V.C.2.a)** **A summary of the Self-Study must be submitted to the DIO.**
1565 **(Core)**
1566

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Self-Study and the 10-Year Accreditation Site Visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the Self-Study process, as well as information on how to prepare for the 10-Year Accreditation Site Visit, is available on the ACGME website.

1567
1568 ***V.C.3.*** ***One goal of ACGME-accredited education is to educate physicians***
1569 ***who seek and achieve board certification. One measure of the***
1570 ***effectiveness of the educational program is the ultimate pass rate.***
1571
1572 ***The program director should encourage all eligible program***
1573 ***graduates to take the certifying examination offered by the***
1574 ***applicable American Board of Medical Specialties (ABMS) member***
1575 ***board or American Osteopathic Association (AOA) certifying board.***
1576

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1577 **V.C.3.a)** **For specialties in which the ABMS member board and/or AOA**
1578 **certifying board offer(s) an annual written exam, in the**
1579 **preceding three years, the program's aggregate pass rate of**
1580 **those taking the examination for the first time must be higher**
1581 **than the bottom fifth percentile of programs in that specialty.**
1582 **(Outcome)**
1583
1584 **V.C.3.b)** **For specialties in which the ABMS member board and/or AOA**
1585 **certifying board offer(s) a biennial written exam, in the**
1586 **preceding six years, the program's aggregate pass rate of**
1587 **those taking the examination for the first time must be higher**
1588 **than the bottom fifth percentile of programs in that specialty.**
1589 **(Outcome)**
1590
1591 **V.C.3.c)** **For specialties in which the ABMS member board and/or AOA**
1592 **certifying board offer(s) an annual oral exam, in the preceding**
1593 **three years, the program's aggregate pass rate of those**
1594 **taking the examination for the first time must be higher than**
1595 **the bottom fifth percentile of programs in that specialty.**
1596 **(Outcome)**
1597
1598 **V.C.3.d)** **For specialties in which the ABMS member board and/or AOA**
1599 **certifying board offer(s) a biennial oral exam, in the preceding**
1600 **six years, the program's aggregate pass rate of those taking**
1601 **the examination for the first time must be higher than the**
1602 **bottom fifth percentile of programs in that specialty. (Outcome)**
1603
1604 **V.C.3.e)** **For each of the exams referenced in V.C.3.a)-d), any program**
1605 **whose graduates over the time period specified in the**
1606 **requirement have achieved an 80 percent pass rate will have**
1607 **met this requirement, no matter the percentile rank of the**
1608 **program for pass rate in that specialty. (Outcome)**
1609

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

1610
1611 **V.C.3.f)** **Programs must report, in ADS, board certification status**
1612 **annually for the cohort of board-eligible residents that**
1613 **graduated seven years earlier. (Core)**
1614

Background and Intent: It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the

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program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

1615
1616 **VI. The Learning and Working Environment**
1617
1618 ***Residency education must occur in the context of a learning and working***
1619 ***environment that emphasizes the following principles:***
1620
1621 - ***Excellence in the safety and quality of care rendered to patients by residents***
1622 ***today***
1623
1624 - ***Excellence in the safety and quality of care rendered to patients by today's***
1625 ***residents in their future practice***
1626
1627 - ***Excellence in professionalism through faculty modeling of:***
1628
1629 - ***the effacement of self-interest in a humanistic environment that supports***
1630 ***the professional development of physicians***
1631
1632 - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***
1633
1634 - ***Commitment to the well-being of the students, residents, faculty members, and***
1635 ***all members of the health care team***
1636

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and residents to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, resident education, and resident well-being. The requirements are intended to support the development of a sense of professionalism by encouraging residents to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for residents to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and resident and faculty member

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well-being. The requirements are intended to support programs and residents as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and residents. With this flexibility comes a responsibility for residents and faculty members to recognize the need to hand off care of a patient to another provider when a resident is too fatigued to provide safe, high quality care and for programs to ensure that residents remain within the 80-hour maximum weekly limit.

1637
1638 **VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability**
1639
1640 **VI.A.1. Patient Safety and Quality Improvement**
1641
1642-1650 ***All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.***
1651
1652-1656 ***Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.***
1657
1658-1660 ***It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.***
1661
1662 **VI.A.1.a) Patient Safety**
1663
1664 **VI.A.1.a).(1) Culture of Safety**
1665
1666-1671 ***A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.***
1672
1673-1676 **VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.** (Core)
1677
1678-1680 **VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care.** (Core)

1681
1682 **VI.A.1.a).(2)** **Education on Patient Safety**
1683
1684 **Programs must provide formal educational activities**
1685 **that promote patient safety-related goals, tools, and**
1686 **techniques.** **(Core)**
1687

Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

1688
1689 **VI.A.1.a).(3)** **Patient Safety Events**
1690
1691 ***Reporting, investigation, and follow-up of adverse***
1692 ***events, near misses, and unsafe conditions are pivotal***
1693 ***mechanisms for improving patient safety, and are***
1694 ***essential for the success of any patient safety***
1695 ***program. Feedback and experiential learning are***
1696 ***essential to developing true competence in the ability***
1697 ***to identify causes and institute sustainable systems-***
1698 ***based changes to ameliorate patient safety***
1699 ***vulnerabilities.***
1700
1701 **VI.A.1.a).(3).(a)** **Residents, fellows, faculty members, and other**
1702 **clinical staff members must:**
1703
1704 **VI.A.1.a).(3).(a).(i)** **know their responsibilities in reporting**
1705 **patient safety events at the clinical site;**
1706 **(Core)**
1707
1708 **VI.A.1.a).(3).(a).(ii)** **know how to report patient safety**
1709 **events, including near misses, at the**
1710 **clinical site; and,** **(Core)**
1711
1712 **VI.A.1.a).(3).(a).(iii)** **be provided with summary information**
1713 **of their institution's patient safety**
1714 **reports.** **(Core)**
1715
1716 **VI.A.1.a).(3).(b)** **Residents must participate as team members in**
1717 **real and/or simulated interprofessional clinical**
1718 **patient safety activities, such as root cause**
1719 **analyses or other activities that include**
1720 **analysis, as well as formulation and**
1721 **implementation of actions.** **(Core)**
1722
1723 **VI.A.1.a).(4)** **Resident Education and Experience in Disclosure of**
1724 **Adverse Events**
1725
1726 ***Patient-centered care requires patients, and when***
1727 ***appropriate families, to be apprised of clinical***
1728 ***situations that affect them, including adverse events.***

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1729 *This is an important skill for faculty physicians to*
1730 *model, and for residents to develop and apply.*
1731
1732 **VI.A.1.a).(4).(a)** **All residents must receive training in how to**
1733 **disclose adverse events to patients and**
1734 **families.** **(Core)**
1735
1736 **VI.A.1.a).(4).(b)** **Residents should have the opportunity to**
1737 **participate in the disclosure of patient safety**
1738 **events, real or simulated.** **(Detail)**
1739
1740 **VI.A.1.b)** **Quality Improvement**
1741
1742 **VI.A.1.b).(1)** **Education in Quality Improvement**
1743
1744 *A cohesive model of health care includes quality-*
1745 *related goals, tools, and techniques that are necessary*
1746 *in order for health care professionals to achieve*
1747 *quality improvement goals.*
1748
1749 **VI.A.1.b).(1).(a)** **Residents must receive training and experience**
1750 **in quality improvement processes, including an**
1751 **understanding of health care disparities.** **(Core)**
1752
1753 **VI.A.1.b).(2)** **Quality Metrics**
1754
1755 *Access to data is essential to prioritizing activities for*
1756 *care improvement and evaluating success of*
1757 *improvement efforts.*
1758
1759 **VI.A.1.b).(2).(a)** **Residents and faculty members must receive**
1760 **data on quality metrics and benchmarks related**
1761 **to their patient populations.** **(Core)**
1762
1763 **VI.A.1.b).(3)** **Engagement in Quality Improvement Activities**
1764
1765 *Experiential learning is essential to developing the*
1766 *ability to identify and institute sustainable systems-*
1767 *based changes to improve patient care.*
1768
1769 **VI.A.1.b).(3).(a)** **Residents must have the opportunity to**
1770 **participate in interprofessional quality**
1771 **improvement activities.** **(Core)**
1772
1773 **VI.A.1.b).(3).(a).(i)** **This should include activities aimed at**
1774 **reducing health care disparities.** **(Detail)**
1775
1776 **VI.A.2.** **Supervision and Accountability**
1777
1778 **VI.A.2.a)** ***Although the attending physician is ultimately responsible for***
1779 ***the care of the patient, every physician shares in the***

1780 ***responsibility and accountability for their efforts in the***
1781 ***provision of care. Effective programs, in partnership with***
1782 ***their Sponsoring Institutions, define, widely communicate,***
1783 ***and monitor a structured chain of responsibility and***
1784 ***accountability as it relates to the supervision of all patient***
1785 ***care.***
1786
1787 ***Supervision in the setting of graduate medical education***
1788 ***provides safe and effective care to patients; ensures each***
1789 ***resident's development of the skills, knowledge, and attitudes***
1790 ***required to enter the unsupervised practice of medicine; and***
1791 ***establishes a foundation for continued professional growth.***
1792
1793 **VI.A.2.a).(1)** **Each patient must have an identifiable and**
1794 **appropriately-credentialed and privileged attending**
1795 **physician (or licensed independent practitioner as**
1796 **specified by the applicable Review Committee) who is**
1797 **responsible and accountable for the patient's care.**
1798 **(Core)**
1799
1800 **VI.A.2.a).(1).(a)** **This information must be available to residents,**
1801 **faculty members, other members of the health**
1802 **care team, and patients. (Core)**
1803
1804 **VI.A.2.a).(1).(b)** **Residents and faculty members must inform**
1805 **each patient of their respective roles in that**
1806 **patient's care when providing direct patient**
1807 **care. (Core)**
1808
1809 **VI.A.2.b)** ***Supervision may be exercised through a variety of methods.***
1810 ***For many aspects of patient care, the supervising physician***
1811 ***may be a more advanced resident or fellow. Other portions of***
1812 ***care provided by the resident can be adequately supervised***
1813 ***by the appropriate availability of the supervising faculty***
1814 ***member, fellow, or senior resident physician, either on site or***
1815 ***by means of telecommunication technology. Some activities***
1816 ***require the physical presence of the supervising faculty***
1817 ***member. In some circumstances, supervision may include***
1818 ***post-hoc review of resident-delivered care with feedback.***
1819

Background and Intent: There are circumstances where direct supervision without physical presence does not fulfill the requirements of the specific Review Committee. Review Committees will further specify what is meant by direct supervision without physical presence in specialties where allowed. "Physically present" is defined as follows: The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

1820
1821 **VI.A.2.b).(1)** **The program must demonstrate that the appropriate**
1822 **level of supervision in place for all residents is based**
1823 **on each resident's level of training and ability, as well**

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1824 **as patient complexity and acuity. Supervision may be**
1825 **exercised through a variety of methods, as appropriate**
1826 **to the situation.** **(Core)**
1827
1828 **VI.A.2.b).(2)** **The program must define when physical presence of a**
1829 **supervising physician is required.** **(Core)**
1830
1831 **VI.A.2.c)** **Levels of Supervision**
1832
1833 **To promote appropriate resident supervision while providing**
1834 **for graded authority and responsibility, the program must use**
1835 **the following classification of supervision:** **(Core)**
1836
1837 **VI.A.2.c).(1)** **Direct Supervision:**
1838
1839 **VI.A.2.c).(1).(a)** **the supervising physician is physically present**
1840 **with the resident during the key portions of the**
1841 **patient interaction.** **(Core)**
1842
1843 **VI.A.2.c).(1).(a).(i)** **PGY-1 residents must initially be**
1844 **supervised directly, only as described in**
1845 **VI.A.2.c).(1).(a).** **(Core)**
1846
1847 VI.A.2.c).(1).(a).(i).(a) PGY-1 residents should progress to
1848 being supervised indirectly with
1849 direct supervision available only
1850 after demonstrating competence in:
1851 [Moved from VI.A.2.e).(1).(b)]
1852
1853 VI.A.2.c).(1).(a).(i).(a).(i) the ability and willingness to
1854 ask for help when indicated;
1855 (Detail) [Moved from
1856 VI.A.2.e).(1).(b).(i)]
1857
1858 VI.A.2.c).(1).(a).(i).(a).(ii) gathering an appropriate
1859 history; (Detail) [Moved from
1860 VI.A.2.e).(1).(b).(ii)]
1861
1862 VI.A.2.c).(1).(a).(i).(a).(iii) the ability to perform an
1863 emergent psychiatric
1864 assessment; and, (Detail)
1865 [Moved from
1866 VI.A.2.e).(1).(b).(iii)]
1867
1868 VI.A.2.c).(1).(a).(i).(a).(iv) presenting patient findings
1869 and data accurately to a
1870 supervisor who has not seen
1871 the patient. (Detail) [Moved from
1872 VI.A.2.e).(1).(b).(iv)]
1873

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1874 **VI.A.2.c).(2)** **Indirect Supervision: the supervising physician is not**
1875 **providing physical or concurrent visual or audio**
1876 **supervision but is immediately available to the**
1877 **resident for guidance and is available to provide**
1878 **appropriate direct supervision.** (Core)
1879
1880 **VI.A.2.c).(3)** **Oversight – the supervising physician is available to**
1881 **provide review of procedures/encounters with**
1882 **feedback provided after care is delivered.** (Core)
1883
1884 **VI.A.2.d)** **The privilege of progressive authority and responsibility,**
1885 **conditional independence, and a supervisory role in patient**
1886 **care delegated to each resident must be assigned by the**
1887 **program director and faculty members.** (Core)
1888
1889 **VI.A.2.d).(1)** **The program director must evaluate each resident's**
1890 **abilities based on specific criteria, guided by the**
1891 **Milestones.** (Core)
1892
1893 **VI.A.2.d).(2)** **Faculty members functioning as supervising**
1894 **physicians must delegate portions of care to residents**
1895 **based on the needs of the patient and the skills of**
1896 **each resident.** (Core)
1897
1898 **VI.A.2.d).(3)** **Senior residents or fellows should serve in a**
1899 **supervisory role to junior residents in recognition of**
1900 **their progress toward independence, based on the**
1901 **needs of each patient and the skills of the individual**
1902 **resident or fellow.** (Detail)
1903
1904 **VI.A.2.e)** **Programs must set guidelines for circumstances and events**
1905 **in which residents must communicate with the supervising**
1906 **faculty member(s).** (Core)
1907
1908 **VI.A.2.e).(1)** **Each resident must know the limits of their scope of**
1909 **authority, and the circumstances under which the**
1910 **resident is permitted to act with conditional**
1911 **independence.** (Outcome)
1912

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

1913
1914 **VI.A.2.f)** **Faculty supervision assignments must be of sufficient**
1915 **duration to assess the knowledge and skills of each resident**
1916 **and to delegate to the resident the appropriate level of patient**
1917 **care authority and responsibility.** (Core)
1918
1919 **VI.B.** **Professionalism**
1920

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1921 **VI.B.1.** **Programs, in partnership with their Sponsoring Institutions, must**
1922 **educate residents and faculty members concerning the professional**
1923 **responsibilities of physicians, including their obligation to be**
1924 **appropriately rested and fit to provide the care required by their**
1925 **patients.** (Core)
1926
1927 **VI.B.2.** **The learning objectives of the program must:**
1928
1929 **VI.B.2.a)** **be accomplished through an appropriate blend of supervised**
1930 **patient care responsibilities, clinical teaching, and didactic**
1931 **educational events;** (Core)
1932
1933 **VI.B.2.b)** **be accomplished without excessive reliance on residents to**
1934 **fulfill non-physician obligations; and,** (Core)
1935

Background and Intent: Routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education.

1936
1937 **VI.B.2.c)** **ensure manageable patient care responsibilities.** (Core)
1938

Background and Intent: The Common Program Requirements do not define "manageable patient care responsibilities" as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

1939
1940 **VI.B.3.** **The program director, in partnership with the Sponsoring Institution,**
1941 **must provide a culture of professionalism that supports patient**
1942 **safety and personal responsibility.** (Core)
1943
1944 **VI.B.4.** **Residents and faculty members must demonstrate an understanding**
1945 **of their personal role in the:**
1946
1947 **VI.B.4.a)** **provision of patient- and family-centered care;** (Outcome)
1948
1949 **VI.B.4.b)** **safety and welfare of patients entrusted to their care,**
1950 **including the ability to report unsafe conditions and adverse**
1951 **events;** (Outcome)
1952

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Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the resident.

1953
1954 **VI.B.4.c)** **assurance of their fitness for work, including:** **(Outcome)**
1955

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and residents to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, residents, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

1956
1957 **VI.B.4.c).(1)** **management of their time before, during, and after**
1958 **clinical assignments; and,** **(Outcome)**
1959
1960 **VI.B.4.c).(2)** **recognition of impairment, including from illness,**
1961 **fatigue, and substance use, in themselves, their peers,**
1962 **and other members of the health care team.** **(Outcome)**
1963
1964 **VI.B.4.d)** **commitment to lifelong learning;** **(Outcome)**
1965
1966 **VI.B.4.e)** **monitoring of their patient care performance improvement**
1967 **indicators; and,** **(Outcome)**
1968
1969 **VI.B.4.f)** **accurate reporting of clinical and educational work hours,**
1970 **patient outcomes, and clinical experience data.** **(Outcome)**
1971
1972 **VI.B.5.** **All residents and faculty members must demonstrate**
1973 **responsiveness to patient needs that supersedes self-interest. This**
1974 **includes the recognition that under certain circumstances, the best**
1975 **interests of the patient may be served by transitioning that patient's**
1976 **care to another qualified and rested provider.** **(Outcome)**
1977
1978 **VI.B.6.** **Programs, in partnership with their Sponsoring Institutions, must**
1979 **provide a professional, equitable, respectful, and civil environment**
1980 **that is free from discrimination, sexual and other forms of**
1981 **harassment, mistreatment, abuse, or coercion of students,**
1982 **residents, faculty, and staff.** **(Core)**
1983
1984 **VI.B.7.** **Programs, in partnership with their Sponsoring Institutions, should**
1985 **have a process for education of residents and faculty regarding**
1986 **unprofessional behavior and a confidential process for reporting,**
1987 **investigating, and addressing such concerns.** **(Core)**
1988
1989 **VI.C.** **Well-Being**
1990
1991 ***Psychological, emotional, and physical well-being are critical in the***
1992 ***development of the competent, caring, and resilient physician and require***
1993 ***proactive attention to life inside and outside of medicine. Well-being***

1994 ***requires that physicians retain the joy in medicine while managing their***
1995 ***own real-life stresses. Self-care and responsibility to support other***
1996 ***members of the health care team are important components of***
1997 ***professionalism; they are also skills that must be modeled, learned, and***
1998 ***nurtured in the context of other aspects of residency training.***
1999
2000 ***Residents and faculty members are at risk for burnout and depression.***
2001 ***Programs, in partnership with their Sponsoring Institutions, have the same***
2002 ***responsibility to address well-being as other aspects of resident***
2003 ***competence. Physicians and all members of the health care team share***
2004 ***responsibility for the well-being of each other. For example, a culture which***
2005 ***encourages covering for colleagues after an illness without the expectation***
2006 ***of reciprocity reflects the ideal of professionalism. A positive culture in a***
2007 ***clinical learning environment models constructive behaviors, and prepares***
2008 ***residents with the skills and attitudes needed to thrive throughout their***
2009 ***careers.***
2010

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website.

As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.

2011
2012 **VI.C.1.** **The responsibility of the program, in partnership with the**
2013 **Sponsoring Institution, to address well-being must include:**
2014
2015 **VI.C.1.a)** **efforts to enhance the meaning that each resident finds in the**
2016 **experience of being a physician, including protecting time**
2017 **with patients, minimizing non-physician obligations,**
2018 **providing administrative support, promoting progressive**
2019 **autonomy and flexibility, and enhancing professional**
2020 **relationships;** **(Core)**
2021
2022 **VI.C.1.b)** **attention to scheduling, work intensity, and work**
2023 **compression that impacts resident well-being;** **(Core)**
2024
2025 **VI.C.1.c)** **evaluating workplace safety data and addressing the safety of**
2026 **residents and faculty members;** **(Core)**
2027

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that

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monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.

2028
2029 **VI.C.1.d)** **policies and programs that encourage optimal resident and**
2030 **faculty member well-being; and,** (Core)
2031

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

2032
2033 **VI.C.1.d).(1)** **Residents must be given the opportunity to attend**
2034 **medical, mental health, and dental care appointments,**
2035 **including those scheduled during their working hours.**
2036 (Core)
2037

Background and Intent: The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

2038
2039 **VI.C.1.e)** **attention to resident and faculty member burnout,**
2040 **depression, and substance abuse. The program, in**
2041 **partnership with its Sponsoring Institution, must educate**
2042 **faculty members and residents in identification of the**
2043 **symptoms of burnout, depression, and substance abuse,**
2044 **including means to assist those who experience these**
2045 **conditions. Residents and faculty members must also be**
2046 **educated to recognize those symptoms in themselves and**
2047 **how to seek appropriate care. The program, in partnership**
2048 **with its Sponsoring Institution, must:** (Core)
2049

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance abuse. Materials and more information are available on the Physician Well-being section of the ACGME website (http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being).

2050
2051 **VI.C.1.e).(1)** **encourage residents and faculty members to alert the**
2052 **program director or other designated personnel or**
2053 **programs when they are concerned that another**
2054 **resident, fellow, or faculty member may be displaying**
2055 **signs of burnout, depression, substance abuse,**
2056 **suicidal ideation, or potential for violence;** (Core)
2057

Background and Intent: Individuals experiencing burnout, depression, substance abuse, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a

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negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

2058
2059 **VI.C.1.e).(2)** **provide access to appropriate tools for self-screening;**
2060 **and,** (Core)
2061
2062 **VI.C.1.e).(3)** **provide access to confidential, affordable mental**
2063 **health assessment, counseling, and treatment,**
2064 **including access to urgent and emergent care 24**
2065 **hours a day, seven days a week.** (Core)
2066

Background and Intent: The intent of this requirement is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

2067
2068 **VI.C.2.** **There are circumstances in which residents may be unable to attend**
2069 **work, including but not limited to fatigue, illness, family**
2070 **emergencies, and parental leave. Each program must allow an**
2071 **appropriate length of absence for residents unable to perform their**
2072 **patient care responsibilities.** (Core)
2073
2074 **VI.C.2.a)** **The program must have policies and procedures in place to**
2075 **ensure coverage of patient care.** (Core)
2076
2077 **VI.C.2.b)** **These policies must be implemented without fear of negative**
2078 **consequences for the resident who is or was unable to**
2079 **provide the clinical work.** (Core)
2080

Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

2081

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2082 **VI.D. Fatigue Mitigation**
2083
2084 **VI.D.1. Programs must:**
2085
2086 **VI.D.1.a) educate all faculty members and residents to recognize the**
2087 **signs of fatigue and sleep deprivation; (Core)**
2088
2089 **VI.D.1.b) educate all faculty members and residents in alertness**
2090 **management and fatigue mitigation processes; and, (Core)**
2091
2092 **VI.D.1.c) encourage residents to use fatigue mitigation processes to**
2093 **manage the potential negative effects of fatigue on patient**
2094 **care and learning. (Detail)**
2095

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

2096
2097 **VI.D.2. Each program must ensure continuity of patient care, consistent**
2098 **with the program's policies and procedures referenced in VI.C.2–**
2099 **VI.C.2.b), in the event that a resident may be unable to perform their**
2100 **patient care responsibilities due to excessive fatigue. (Core)**
2101
2102 **VI.D.3. The program, in partnership with its Sponsoring Institution, must**
2103 **ensure adequate sleep facilities and safe transportation options for**
2104 **residents who may be too fatigued to safely return home. (Core)**
2105
2106 **VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care**
2107
2108 **VI.E.1. Clinical Responsibilities**
2109
2110 **The clinical responsibilities for each resident must be based on PGY**
2111 **level, patient safety, resident ability, severity and complexity of**
2112 **patient illness/condition, and available support services. (Core)**
2113

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an

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environment that has safe patient care and a sense of resident well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

2114
2115 **VI.E.2. Teamwork**
2116
2117 **Residents must care for patients in an environment that maximizes**
2118 **communication. This must include the opportunity to work as a**
2119 **member of effective interprofessional teams that are appropriate to**
2120 **the delivery of care in the specialty and larger health system.** **(Core)**
2121
2122 VI.E.2.a) Contributors to effective interprofessional teams should include
2123 consulting physicians, psychologists, psychiatric nurses, social
2124 workers, and other professional and paraprofessional mental
2125 health personnel involved in the evaluation and treatment of
2126 patients. (Detail)
2127
2128 **VI.E.3. Transitions of Care**
2129
2130 **VI.E.3.a) Programs must design clinical assignments to optimize**
2131 **transitions in patient care, including their safety, frequency,**
2132 **and structure.** **(Core)**
2133
2134 **VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,**
2135 **must ensure and monitor effective, structured hand-over**
2136 **processes to facilitate both continuity of care and patient**
2137 **safety.** **(Core)**
2138
2139 **VI.E.3.c) Programs must ensure that residents are competent in**
2140 **communicating with team members in the hand-over process.**
2141 **(Outcome)**
2142
2143 **VI.E.3.d) Programs and clinical sites must maintain and communicate**
2144 **schedules of attending physicians and residents currently**
2145 **responsible for care.** **(Core)**
2146
2147 **VI.E.3.e) Each program must ensure continuity of patient care,**
2148 **consistent with the program's policies and procedures**
2149 **referenced in VI.C.2-VI.C.2.b), in the event that a resident may**
2150 **be unable to perform their patient care responsibilities due to**
2151 **excessive fatigue or illness, or family emergency.** **(Core)**
2152
2153 **VI.F. Clinical Experience and Education**
2154
2155 ***Programs, in partnership with their Sponsoring Institutions, must design***
2156 ***an effective program structure that is configured to provide residents with***
2157 ***educational and clinical experience opportunities, as well as reasonable***
2158 ***opportunities for rest and personal activities.***
2159

Background and Intent: In the new requirements, the terms "clinical experience and education," "clinical and educational work," and "clinical and educational work hours" replace the terms "duty hours," "duty periods," and "duty." These changes have been made in response to concerns that the previous use of the term "duty" in reference to number of hours worked may have led some to conclude that residents' duty to "clock out" on time superseded their duty to their patients.

2160
2161 **VI.F.1. Maximum Hours of Clinical and Educational Work per Week**
2162
2163 **Clinical and educational work hours must be limited to no more than**
2164 **80 hours per week, averaged over a four-week period, inclusive of all**
2165 **in-house clinical and educational activities, clinical work done from**
2166 **home, and all moonlighting.** (Core)
2167

Background and Intent: Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing residents to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling
While the ACGME acknowledges that, on rare occasions, a resident may work in excess of 80 hours in a given week, all programs and residents utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule residents to work 80 hours per week and still permit residents to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that residents are scheduled to work fewer than 80 hours per week, which would allow residents to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight
With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for residents to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home
While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time

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spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident's supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a resident spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the resident need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by residents. The new requirements are not an attempt to micromanage this process. Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

PGY-1 and PGY-2 Residents
PGY-1 and PGY-2 residents may not have the experience to make decisions about when it is appropriate to utilize flexibility or may feel pressured to use it when unnecessary. Programs are responsible for ensuring that residents are provided with manageable workloads that can be accomplished during scheduled work hours. This includes ensuring that a resident's assigned direct patient load is manageable, that residents have appropriate support from their clinical teams, and that residents are not overburdened with clerical work and/or other non-physician duties.

2168
2169 **VI.F.2. Mandatory Time Free of Clinical Work and Education**
2170
2171 **VI.F.2.a) The program must design an effective program structure that**
2172 **is configured to provide residents with educational**
2173 **opportunities, as well as reasonable opportunities for rest**
2174 **and personal well-being.** (Core)
2175
2176 **VI.F.2.b) Residents should have eight hours off between scheduled**
2177 **clinical work and education periods.** (Detail)
2178
2179 **VI.F.2.b).(1) There may be circumstances when residents choose**
2180 **to stay to care for their patients or return to the**
2181 **hospital with fewer than eight hours free of clinical**
2182 **experience and education. This must occur within the**

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2183 **context of the 80-hour and the one-day-off-in-seven**
2184 **requirements.** (Detail)
2185

Background and Intent: While it is expected that resident schedules will be structured to ensure that residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

2186
2187 **VI.F.2.c)** **Residents must have at least 14 hours free of clinical work**
2188 **and education after 24 hours of in-house call.** (Core)
2189

Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.

2190
2191 **VI.F.2.d)** **Residents must be scheduled for a minimum of one day in**
2192 **seven free of clinical work and required education (when**
2193 **averaged over four weeks). At-home call cannot be assigned**
2194 **on these free days.** (Core)
2195

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some residents may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide residents with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes resident well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

2196
2197 **VI.F.3.** **Maximum Clinical Work and Education Period Length**
2198
2199 **VI.F.3.a)** **Clinical and educational work periods for residents must not**
2200 **exceed 24 hours of continuous scheduled clinical**
2201 **assignments.** (Core)
2202

Background and Intent: The Task Force examined the question of "consecutive time on task." It examined the research supporting the current limit of 16 consecutive hours of time on task for PGY-1 residents; the range of often conflicting impacts of this requirement on patient safety, clinical care, and continuity of care by resident teams;

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and resident learning found in the literature. Finally, it heard a uniform request by the specialty societies, certifying boards, membership societies and organizations, and senior residents to repeal this requirement. It heard conflicting perspectives from resident unions, a medical student association, and a number of public advocacy groups, some arguing for continuation of the requirement, others arguing for extension of the requirement to all residents.

Of greatest concern to the Task Force were the observations of disruption of team care and patient care continuity brought about with residents beyond the PGY-1 level adhering to differing requirements. The graduate medical education community uniformly requested that the Task Force remove this requirement. The most frequently-cited reason for this request was the complete disruption of the team, separating the PGY-1 from supervisory faculty members and residents who were best able to judge the ability of the resident and customize the supervision of patient care for each PGY-1. Cited nearly as frequently was the separation of the PGY-1 from the team, delaying maturation of clinical skills, and threatening to create a "shift" mentality in disciplines where overnight availability to patients is essential in delivery of care.

The Task Force examined the impact of the request to consider 16-consecutive-hour limits for all residents, and rejected the proposition. It found that model incompatible with the actual practice of medicine and surgery in many specialties, excessively limiting in configuration of clinical services in many disciplines, and potentially disruptive of the inculcation of responsibility and professional commitment to altruism and placing the needs of patients above those of the physician.

After careful consideration of the information available, the testimony and position of all parties submitting information, and presentations to the Task Force, the Task Force removed the 16-hour-consecutive-time-on-task requirement for PGY-1 residents. It remains crucial that programs ensure that PGY-1 residents are supervised in compliance with the applicable Program Requirements, and that resident well-being is prioritized as described in Section VI.C. of these requirements.

2203
2204 **VI.F.3.a).(1)** **Up to four hours of additional time may be used for**
2205 **activities related to patient safety, such as providing**
2206 **effective transitions of care, and/or resident education.**
2207 **(Core)**
2208
2209 **VI.F.3.a).(1).(a)** **Additional patient care responsibilities must not**
2210 **be assigned to a resident during this time. (Core)**
2211

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

2212
2213 **VI.F.4.** **Clinical and Educational Work Hour Exceptions**
2214

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2215 **VI.F.4.a)** **In rare circumstances, after handing off all other**
2216 **responsibilities, a resident, on their own initiative, may elect**
2217 **to remain or return to the clinical site in the following**
2218 **circumstances:**
2219
2220 **VI.F.4.a).(1)** **to continue to provide care to a single severely ill or**
2221 **unstable patient;** **(Detail)**
2222
2223 **VI.F.4.a).(2)** **humanistic attention to the needs of a patient or**
2224 **family; or,** **(Detail)**
2225
2226 **VI.F.4.a).(3)** **to attend unique educational events.** **(Detail)**
2227
2228 **VI.F.4.b)** **These additional hours of care or education will be counted**
2229 **toward the 80-hour weekly limit.** **(Detail)**
2230

Background and Intent: This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

2231
2232 **VI.F.4.c)** **A Review Committee may grant rotation-specific exceptions**
2233 **for up to 10 percent or a maximum of 88 clinical and**
2234 **educational work hours to individual programs based on a**
2235 **sound educational rationale.**
2236
2237 The Review Committee for Psychiatry will not consider requests
2238 for exceptions to the 80-hour limit to the residents' work week.
2239
2240 **VI.F.4.c).(1)** **In preparing a request for an exception, the program**
2241 **director must follow the clinical and educational work**
2242 **hour exception policy from the** ***ACGME Manual of***
2243 ***Policies and Procedures.*** **(Core)**
2244
2245 **VI.F.4.c).(2)** **Prior to submitting the request to the Review**
2246 **Committee, the program director must obtain approval**
2247 **from the Sponsoring Institution's GMEC and DIO.** **(Core)**
2248

Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all residents should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty.

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DIO/GMEC approval is required before the request will be considered by the Review Committee.

2249
2250 **VI.F.5. Moonlighting**
2251
2252 **VI.F.5.a)** **Moonlighting must not interfere with the ability of the resident**
2253 **to achieve the goals and objectives of the educational**
2254 **program, and must not interfere with the resident's fitness for**
2255 **work nor compromise patient safety.** **(Core)**
2256
2257 **VI.F.5.b)** **Time spent by residents in internal and external moonlighting**
2258 **(as defined in the ACGME Glossary of Terms) must be**
2259 **counted toward the 80-hour maximum weekly limit.** **(Core)**
2260
2261 **VI.F.5.c)** **PGY-1 residents are not permitted to moonlight.** **(Core)**
2262

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements).

2263
2264 **VI.F.6. In-House Night Float**
2265
2266 **Night float must occur within the context of the 80-hour and one-**
2267 **day-off-in-seven requirements.** **(Core)**
2268
2269 VI.F.6.a) Residents should not be scheduled for more than four consecutive
2270 weeks of night float during the required one-year, full-time
2271 outpatient psychiatry experience. (Detail)
2272
2273 VI.F.6.b) Residents should not be scheduled for more than a total of eight
2274 weeks of night float during the one-year of consecutive outpatient
2275 experience. (Detail)
2276

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

2277
2278 **VI.F.7. Maximum In-House On-Call Frequency**
2279
2280 **Residents must be scheduled for in-house call no more frequently**
2281 **than every third night (when averaged over a four-week period).** **(Core)**
2282
2283 VI.F.7.a) On psychiatry rotations, in-house call must occur no more
2284 frequently than every fourth night, averaged over a four-week
2285 period. (Core)
2286
2287 **VI.F.8. At-Home Call**
2288
2289 **VI.F.8.a)** **Time spent on patient care activities by residents on at-home**
2290 **call must count toward the 80-hour maximum weekly limit.**
2291 **The frequency of at-home call is not subject to the every-**

2292 **third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.** **(Core)**
2293
2294
2295
2296 **VI.F.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)**
2297
2298
2299
2300 **VI.F.8.b)** **Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.** **(Detail)**
2301
2302
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Background and Intent: This requirement has been modified to specify that clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.

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2307 ***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.
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2310 †**Detail Requirements:** Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.
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2315 ‡**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.
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2319 **Osteopathic Recognition**
2320 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).
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