

ACGME Program Requirements for Graduate Medical Education in Psychosomatic Medicine

One-year Common Program Requirements are in BOLD

Effective: June, 2003

Introduction

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

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

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

Int.C. Duration and Scope of Education

Int.C.1. An accredited program in psychosomatic medicine must provide 12 months of supervised graduate education.

- Int.C.2. To be eligible for accreditation, the subspecialty program must function as an integral part of an accredited residency program in psychiatry. There must be a reporting relationship, to ensure compliance with the Accreditation Council for Graduate Medical Education (ACGME) accreditation standards, from the program director of the subspecialty program to the program director of the parent psychiatry residency program.
- Int.C.3. Prior to entry into the program, each fellow must be notified in writing of the required length of training.

I. Institutions

I.A. Sponsoring Institution

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

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

I.B. Participating Sites

- I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.**

The PLA should:

- I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows;**
- I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document;**
- I.B.1.c) specify the duration and content of the educational experience; and,**
- I.B.1.d) state the policies and procedures that will govern fellow education during the assignment.**

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

- I.B.3. Participating sites should provide resources not otherwise available to the**

program.

- I.B.4. Assignments at participating sites must be of sufficient length to ensure a quality educational experience and should provide sufficient opportunity for continuity of care. Although the number of participating sites may vary with the various specialties' needs, all participating sites must demonstrate the ability to promote the program goals and educational and peer activities. Exceptions must be justified and prior-approved.

II. Program Personnel and Resources

II.A. Program Director

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

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

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

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

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

- II.A.2.c) **current medical licensure and appropriate medical staff appointment; and,**

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

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

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

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

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

- II.A.3.c).(1) all applications for ACGME accreditation of new programs;
- II.A.3.c).(2) changes in fellow complement;
- II.A.3.c).(3) major changes in program structure or length of training;
- II.A.3.c).(4) progress reports requested by the Review Committee;
- II.A.3.c).(5) responses to all proposed adverse actions;
- II.A.3.c).(6) requests for increases or any change to fellow duty hours;
- II.A.3.c).(7) voluntary withdrawals of ACGME-accredited programs;
- II.A.3.c).(8) requests for appeal of an adverse action; and,
- II.A.3.c).(9) appeal presentations to a Board of Appeal or the ACGME.
- II.A.3.d) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
 - II.A.3.d).(1) program citations, and/or
 - II.A.3.d).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.

II.B. Faculty

- II.B.1. **There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.**
 - II.B.1.a) In addition to the program director, there must be a minimum of one additional physician faculty member who meets the requirements in II.B.3. and II.B.4. below.
- II.B.2. **The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.**
- II.B.3. **The physician faculty must have current certification in the subspecialty by the American Board of Psychiatry and Neurology, or possess qualifications acceptable to the Review Committee.**

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

II.C. Other Program Personnel

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

II.D. Resources

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

II.E. Medical Information Access

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

III. Fellow Appointments

III.A. Eligibility Criteria

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

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

III.A.2. If such learners so appointed will, in the judgment of the Review Committee, detract from the education of the regularly appointed psychosomatic fellows, the accreditation status of the program may be adversely affected.

III.B. Number of Fellows

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

IV. Educational Program

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

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

IV.A.2. ACGME Competencies

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

IV.A.2.a) Patient Care

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

IV.A.2.b) Medical Knowledge

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

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

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

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

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

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

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

IV.A.2.e) Professionalism

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

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

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

IV.A.3. Curriculum

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

IV.A.3.a) Didactic experiences in psychosomatic medicine must provide fellows with sufficient opportunity to develop knowledge, skill and proficiency involving:

IV.A.3.a).(1) the nature and extent of psychiatric morbidity in medical illness and its treatments;

IV.A.3.a).(2) the impact of comorbid psychiatric disorders on the course of medical illness;

IV.A.3.a).(3) understanding of how and why patients respond to illness;

IV.A.3.a).(4) knowledge of appropriate treatment interventions for co-existing psychiatric disorders in the medically ill;

IV.A.3.a).(5) psychological and psychiatric effects of new medical or surgical therapies;

IV.A.3.a).(6) the epidemiology of psychiatric illness and its treatment in medical disease; and,

IV.A.3.a).(7) knowledge of the nature and factors that influence the physician-patient relationship.

IV.A.3.b) Clinical Components

IV.A.3.b).(1) Patient Population

There must be an adequate number of patients representing both sexes with a wide variety of clinical problems to provide a patient population sufficient to meet

the educational needs of the fellows. The number of critically-ill patients available for the fellows at the primary clinical site should be sufficient to meet the educational goals of the program.

- IV.A.3.b).(2) Clinical experiences in psychosomatic medicine must provide fellows with sufficient opportunity for the psychiatric evaluation of individuals involving:
- IV.A.3.b).(2).(a) psychiatric complications of medical illnesses;
 - IV.A.3.b).(2).(b) psychiatric complications of medical treatments, especially medications, new surgical or medical procedures, transplantation, and a range of experimental therapies;
 - IV.A.3.b).(2).(c) typical and atypical presentations of psychiatric disorders that are due to medical, neurological, and surgical illnesses;
 - IV.A.3.b).(2).(d) evaluation and management of delirium, dementia, and secondary (“organic”) psychiatric disorders;
 - IV.A.3.b).(2).(e) evaluation and management of somatoform disorders and chronic pain;
 - IV.A.3.b).(2).(f) assessment of capacity to give informed consent for medical and surgical procedures in the presence of cognitive impairment;
 - IV.A.3.b).(2).(g) provision of non-pharmacologic interventions, including cognitive-behavioral psychotherapy, interpersonal psychotherapy, as well as focused, short-term psychotherapy in patients suffering the effects of complex medical disorders or their treatments;
 - IV.A.3.b).(2).(h) indications for, and use of psychotropics in specific medical, neurological, obstetrical, and surgical conditions;
 - IV.A.3.b).(2).(i) interactions between psychotropic medications and the full range of medications used for a variety of medical and surgical conditions;
 - IV.A.3.b).(2).(j) collaboration with other physicians, and other members of the multidisciplinary treatment team;
 - IV.A.3.b).(2).(k) teaching other physicians and other members of the multidisciplinary team how to recognize and respond to various psychiatric disorders; and,

- IV.A.3.b).(2).(l) leading an integrated psychosocial health care team in the medical setting.
- IV.A.3.b).(3) Fellows must participate in continuity of patient care.
- IV.A.3.b).(4) A written statement defining the role of related disciplines must be in place outlining requirements for multidisciplinary care and fellow interactions with other specialties.
- IV.A.3.b).(5) The responsibility given to fellows in patient care should depend upon each fellow's knowledge, problem-solving ability, manual skills, experience, and the severity and complexity of each patient's illness.
- IV.A.3.b).(6) Supervision of the fellows by psychosomatic faculty members must be available at all times.

IV.B. Fellows' Scholarly Activities

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

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Formative Evaluation

- V.A.1.a) **The faculty must evaluate fellow performance in a timely manner.**
- V.A.1.b) **The program must:**
 - V.A.1.b).(1) **provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**
 - V.A.1.b).(2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,**
 - V.A.1.b).(3) **provide each fellow with documented semiannual evaluation of performance with feedback.**
- V.A.1.c) **The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.**

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy. This evaluation must:

- V.A.2.a)** document the fellow's performance during their education;
- V.A.2.b)** verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision; and,
- V.A.2.c) document proficiency in the following outcome areas:
 - V.A.2.c).(1) knowledge of abnormal behavior and psychiatric illnesses that occur among medical, neurological, obstetrics and gynecology, and surgical patients;
 - V.A.2.c).(2) knowledge of biological, psychological and social factors that influence the development, course and outcome of medical/surgical diseases;
 - V.A.2.c).(3) ability to diagnose and treat psychiatric disturbances that occur among the physically ill, including the administration of psychotropic medications to seriously ill patients;
 - V.A.2.c).(4) understanding of pharmacology, including the psychopharmacology of the medically ill, with emphasis on, and psychiatric side effects of, non-psychotropic medications and the interactions of psychotropic medications with other medications on the central nervous system;
 - V.A.2.c).(5) ability to provide consultation in medical and surgical settings;
 - V.A.2.c).(6) facilitative skills necessary to enhance the care of psychiatric disturbances among the physically ill through cooperative interaction with other physicians and allied health professionals;
 - V.A.2.c).(7) ability to effectively supervise medical students and fellows performing consultations and to teach medical and surgical colleagues about psychiatric complications of physical illness;
 - V.A.2.c).(8) participation in the development of new knowledge, evaluation of research findings, and the continuing acquisition of new knowledge, through the development of good habits of inquiry; and,

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

V.B. Faculty Evaluation

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

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

V.C. Program Evaluation and Improvement

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

V.C.1.a) fellow performance, and

V.C.1.b) faculty development

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

V.C.3. When averaged over any five-year period, a minimum of 80 percent of all program graduates must successfully complete the examinations of the ABPN.

VI. Fellow Duty Hours in the Learning and Working Environment

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

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

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

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

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

- VI.A.4.a)** be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,
- VI.A.4.b)** not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.
- VI.A.5.** The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
- VI.A.5.a)** assurance of the safety and welfare of patients entrusted to their care;
- VI.A.5.b)** provision of patient- and family-centered care;
- VI.A.5.c)** assurance of their fitness for duty;
- VI.A.5.d)** management of their time before, during, and after clinical assignments;
- VI.A.5.e)** recognition of impairment, including illness and fatigue, in themselves and in their peers;
- VI.A.5.f)** attention to lifelong learning;
- VI.A.5.g)** the monitoring of their patient care performance improvement indicators; and,
- VI.A.5.h)** honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
- VI.A.6.** All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.
- VI.B. Transitions of Care**
- VI.B.1.** Programs must design clinical assignments to minimize the number of transitions in patient care.
- VI.B.2.** Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
- VI.B.3.** Programs must ensure that fellows are competent in communicating

with team members in the hand-over process.

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;

VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.

VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.

VI.D. Supervision of Fellows

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

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

VI.D.1.a) This information should be available to fellows, faculty members, and patients.

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

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty

member. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care.

VI.D.3. Levels of Supervision

To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient.**
- VI.D.3.b) Indirect Supervision:**
 - VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**
 - VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**
- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.**
 - VI.D.4.a) The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
 - VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.**
 - VI.D.4.c) Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward**

independence, based on the needs of each patient and the skills of the individual fellow.

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

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

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.

VI.E. Clinical Responsibilities

The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.

VI.F. Teamwork

Fellows must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

VI.F.1. Contributors to effective interprofessional teams include consulting physicians, psychologists, psychiatric nurses, social workers and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients.

VI.G. Fellow Duty Hours

VI.G.1. Maximum Hours of Work per Week

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

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy

from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.3. Mandatory Time Free of Duty

Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

VI.G.4. Maximum Duty Period Length

Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

VI.G.4.a) It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

VI.G.4.b) Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

VI.G.4.c) In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

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

VI.G.4.c).(1).(a) appropriately hand over the care of all other

patients to the team responsible for their continuing care; and,

VI.G.4.c).(1).(b)

document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.c).(2)

The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.

VI.G.5.

Minimum Time Off between Scheduled Duty Periods

VI.G.5.a)

Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

Psychosomatic medicine fellows are considered to be in the final years of education.

VI.G.5.a).(1)

This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that fellows have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

VI.G.5.a).(1).(a)

Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.

VI.G.5.a).(1).(b)

There are no circumstances under which fellows may stay on duty with fewer than eight hours off.

VI.G.6.

Maximum Frequency of In-House Night Float

Fellows must not be scheduled for more than six consecutive nights of night float.

VI.G.7.

Maximum In-House On-Call Frequency

Fellows must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8.

At-Home Call

VI.G.8.a)

Time spent in the hospital by fellows on at-home call must

count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

VI.G.8.a).(1)

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.

VI.G.8.b)

Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

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