Section 5

ACGME Common Program Requirements

ACGME Program Requirements

Essentials of Accredited Residencies in Graduate Medical Education

ACGME General Competencies

ACGME Competency Assessment Toolbox

Annual Clinical Skills Examination

Evidence-Based Medicine Scholarly Presentation (sample)

Journal Club (sample)

Psychotherapy Competencies (psychotherapy competency evaluation forms)

Compact Between Resident Physicians and Their Teachers

Common Program Requirements

Effective: July 1, 2007

I. Institutions

A. Sponsoring Institution

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

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.

B. Participating Sites

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:

   a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

   b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

   c) specify the duration and content of the educational experience; and,

   d) state the policies and procedures that will govern resident education during the assignment.

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

   [As further specified by the Review Committee]

II. Program Personnel and Resources

A. Program Director

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.

   [As further specified by the Review Committee]

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

3. Qualifications of the program director must include:

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

   b) current certification in the specialty by the American Board of _____, or specialty qualifications that are acceptable to the Review Committee; and,

   c) current medical licensure and appropriate medical staff appointment.

   [As further specified by the Review Committee]

4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:

   a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

   b) approve a local director at each participating site who is accountable for resident education;

   c) approve the selection of program faculty as appropriate;

   d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;

e) monitor resident supervision at all participating sites;

f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;

g) provide each resident with documented semiannual evaluation of performance with feedback;

h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

i) provide verification of residency education for all residents, including those who leave the program prior to completion;

j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

(1) distribute these policies and procedures to the residents and faculty;

(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

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

k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

l) comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;

m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:

(1) all applications for ACGME accreditation of new programs;

(2) changes in resident complement;

(3) major changes in program structure or length of training;

(4) progress reports requested by the Review Committee;

(5) responses to all proposed adverse actions;

(6) requests for increases or any change to resident duty hours;

(7) voluntary withdrawals of ACGME-accredited programs;

(8) requests for appeal of an adverse action;

(9) appeal presentations to a Board of Appeal or the ACGME; and,

(10) proposals to ACGME for approval of innovative educational approaches.

o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:

(1) program citations, and/or

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

[As further specified by the Review Committee].

B. Faculty

1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

   The faculty must:

   a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and

   b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

2. The physician faculty must have current certification in the specialty by the American Board of _____, or possess qualifications acceptable to the Review Committee.

   [As further specified by the Review Committee]

3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

   a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

   b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

      (1) peer-reviewed funding;

      (2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

      (3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

(4) participation in national committees or educational organizations.

c) Faculty should encourage and support residents in scholarly activities.

[As further specified by the Review Committee]

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.

[As further specified by the Review Committee]

D. Resources

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

[As further specified by the Review Committee]

E. Medical Information Access

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

III. Resident Appointments

A. Eligibility Criteria

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

[As further specified by the Review Committee]

B. Number of Residents

The program director may not appoint more residents 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 residents appointed to the program.

[As further specified by the Review Committee]

C. Resident Transfers

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

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

D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

[As further specified by the Review Committee]

IV. Educational Program

A. The curriculum must contain the following educational components:

1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

3. Regularly scheduled didactic sessions;

4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

5. ACGME Competencies

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

a) Patient Care

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

[As further specified by the Review Committee]

b) Medical Knowledge

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

[As further specified by the Review Committee]

c) 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 life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;

(2) set learning and improvement goals;

(3) identify and perform appropriate learning activities;

(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

(5) incorporate formative evaluation feedback into daily practice;

(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;

(7) use information technology to optimize learning; and,

(8) participate in the education of patients, families, students, residents and other health professionals.

[As further specified by the Review Committee]

d) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

(2) communicate effectively with physicians, other health professionals, and health related agencies;

(3) work effectively as a member or leader of a health care team or other professional group;

(4) act in a consultative role to other physicians and health professionals; and,

(5) maintain comprehensive, timely, and legible medical records, if applicable.

[As further specified by the Review Committee]

e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

(1) compassion, integrity, and respect for others;

(2) responsiveness to patient needs that supersedes self-interest;

(3) respect for patient privacy and autonomy;

(4) accountability to patients, society and the profession; and,

(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

[As further specified by the Review Committee]

f) Systems-based Practice

Residents 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. Residents are expected to:

(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;

(2) coordinate patient care within the health care system relevant to their clinical specialty;

(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

(4) advocate for quality patient care and optimal patient care systems;

(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,

(6) participate in identifying system errors and implementing potential systems solutions.

[As further specified by the Review Committee]

B. Residents' Scholarly Activities

1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

2. Residents should participate in scholarly activity.

   [As further specified by the Review Committee]

3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

   [As further specified by the Review Committee]

V. Evaluation

A. Resident Evaluation

1. Formative Evaluation

a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

b) The program must:

(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;

(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

(3) document progressive resident performance improvement appropriate to educational level; and,

(4) provide each resident with documented semiannual evaluation of performance with feedback.

c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional

policy.

2. Summative Evaluation

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

a) document the resident's performance during the final period of education, and

b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

B. Faculty Evaluation

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

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.

3. This evaluation must include at least annual written confidential evaluations by the residents.

C. Program Evaluation and Improvement

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:

a) resident performance;

b) faculty development;

c) graduate performance, including performance of program graduates on the certification examination; and,

d) program quality. Specifically:

(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.

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.

VI. Resident Duty Hours in the Learning and Working Environment

A. Principles

1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.

2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.

3. Didactic and clinical education must have priority in the allotment of residents' time and energy.

4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

B. Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

C. Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care,

time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.

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

2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.

3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

E. On-call Activities

1. In-house call must occur no more frequently than every third night, averaged over a four-week period.

2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

3. No new patients may be accepted after 24 hours of continuous duty.

4. At-home call (or pager call)

   a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.

   b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

   c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

F. Moonlighting

1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

G. Duty Hours 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.

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.

2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VII. Experimentation and Innovation

Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

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ACGME: February 2007 Effective: July 1, 2007

ACGME Program Requirements for Graduate Medical Education in Psychiatry

Common Program Requirements are in BOLD

Effective: July 1, 2007

Introduction

A. Definition of the Specialty

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

B. Duration and Scope of Education

1. Admission Requirements

Physicians may enter psychiatry programs at either the first-year or second-year postgraduate level. Physicians entering at the second-year postgraduate level must document successful completion of a clinical year of education in an ACGME-accredited specialty requiring comprehensive and continuous patient care, such as a program in internal medicine, family medicine, pediatrics, or transitional year program. For physicians entering at the PG-2 level after completion of such a program, the PG-1 year may be credited toward the 48-month requirement.

2. Length of the Program

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

b) A program may petition the residency review committee to alter the length of education beyond these minimum requirements by presenting a clear educational rationale consistent with the program requirements. The program director must obtain the approval of the sponsoring institution and the Review Committee prior to implementation and at each subsequent review of the program.

c) Prior to entry into the program, each resident must be notified in writing of the required length of education for which the program is accredited. The required length of education for a particular resident may not be changed during his or her program without mutual agreement, unless there is a break in education or the resident requires remedial education.

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

e) Electives should enrich the educational experience of residents in conformity to their needs, interest, and/or future professional plans. Electives must have written goals and objectives, and must be well constructed, purposeful, and lead to effective learning experiences. The choice of electives must be made with the advice and approval of the program director and the appropriate preceptor.

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

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

3. First Year of Education

The program director of the psychiatry residency program must monitor performance and maintain personal contact with residents during the first postgraduate-year while they are on services other than psychiatry. A first postgraduate-year in psychiatry should include:

a) a minimum of four-months in a primary care clinical setting that provides comprehensive and continuous patient care in specialties such as internal medicine, family medicine, and/or pediatrics. Neurology rotations may not be used to fulfill this four-month requirement. One month of this requirement may be fulfilled by either an emergency medicine or intensive care rotation, provided the experience is predominantly with medical evaluation and treatment and not surgical procedures, and

b) no more than eight months in psychiatry.

I. Institutions

A. Sponsoring Institution

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

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.

B. Participating Sites

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:

a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

c) specify the duration and content of the educational experience; and,

d) state the policies and procedures that will govern resident education during the assignment.

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

3. The number and distribution of participating training sites must not preclude satisfactory participation by residents in teaching and didactic exercises. Geographic proximity of participating sites will be one factor in evaluating program cohesion, continuity, and peer interaction.

II. Program Personnel and Resources

A. Program Director

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.

2. The program director should continue in his or her position for

a length of time adequate to maintain continuity of leadership and program stability.

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

   a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**

   b) **current certification in the specialty by the American Board of** Psychiatry and Neurology**, or specialty qualifications that are acceptable to the Review Committee; and,**

   c) **current medical licensure and appropriate medical staff appointment.**

   d) In general, the minimum term of appointment must be at least the duration of the program plus one year.

4. **The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**

   a) **oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**

   b) **approve a local director at each participating site who is accountable for resident education;**

   c) **approve the selection of program faculty as appropriate;**

   d) **evaluate program faculty and approve the continued participation of program faculty based on evaluation;**

   e) **monitor resident supervision at all participating sites;**

   f) **prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**

   g) **provide each resident with documented semiannual evaluation of performance with feedback;**

h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

i) provide verification of residency education for all residents, including those who leave the program prior to completion;

j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

(1) distribute these policies and procedures to the residents and faculty;

(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

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

k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

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

m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:

(1) all applications for ACGME accreditation of new programs;

(2) changes in resident complement;

(3) major changes in program structure or length of training;

(4) progress reports requested by the Review Committee;

(5) responses to all proposed adverse actions;

(6) requests for increases or any change to resident duty hours;

(7) voluntary withdrawals of ACGME-accredited programs;

(8) requests for appeal of an adverse action;

(9) appeal presentations to a Board of Appeal or the ACGME; and,

(10) proposals to ACGME for approval of innovative educational approaches.

o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:

(1) program citations, and/or

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

(3) The sponsoring institution's designated institutional official must approve all major program changes prior to submission to the ACGME through ADS.

p) The program director must make resident appointments and assignments in accordance with institutional and departmental policies and procedures.

q) The program director must supervise residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff.

r) The program director must regularly evaluate residents' knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician.

s) The program director must monitor residents' stress, including physical or emotional conditions which inhibit performance or learning, as well as drug- or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Educational situations that consistently produce undesirable stress on residents must be evaluated and modified.

t) The program director must dedicate no less than 50% (at least 20 hours per week) of his or her professional effort to the psychiatry educational program and receive institutional support for this time. This effort must be devoted to administrative and educational activities of the psychiatry educational program.

B. Faculty

1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

The faculty must:

a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and

b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

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

a) A physician faculty member may be appointed to the School of Medicine as a voluntary faculty member.

3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

(1) peer-reviewed funding;

(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

(4) participation in national committees or educational organizations.

c) Faculty should encourage and support residents in scholarly activities.

6. The faculty must participate regularly and systematically in the educational program, and must be readily available for consultation whenever a resident is faced with a major therapeutic or diagnostic problem.

7. The faculty should actively participate in the planning, organization, and presentation of conferences as well as in clinical teaching and supervision.

8. A member of the teaching staff in each participating institution must be designated to assume responsibility for the day-to-day activities

of the program at that institution, with overall coordination by the program director.

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.

1. Associate Program Director

   An associate program director is a member of the physician teaching faculty who assists the program director in the administrative and clinical oversight of the educational program. The Sponsoring Institution must provide additional dedicated time either for the program director or for associate program directors based on program size and complexity of training sites. At a minimum, a total of 30 hours per week, program director or combined program director and associate program director time, is required for an approved complement of 24 to 40 residents, and 40 hours per week for an approved complement of 41 to 79 residents. When a program is approved for 80 or more residents, there must be additional time allocated for directing the program

2. There must be a residency coordinator who has adequate time, based on program size and complexity, to support the residency program.

3. Chair of Psychiatry

   The chair of psychiatry must be:

   a) a physician who is appointed to and in good standing with the medial staff of an institution participating in the program;

   b) qualified and have at least three years' experience as a clinician, administrator, and educator in psychiatry;

   c) certified in psychiatry by the American Board of Psychiatry and Neurology or possess appropriate qualifications judged to be acceptable by the Review Committee;

   d) actively involved in psychiatry through continuing medical education, professional societies, and scholarly activities; and,

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

4. Education Policy Committee

The director of the residency program should have an educational policy committee composed of members of the psychiatry program teaching staff. This committee should include representation from the residents as well as a member of the teaching staff from each ACGME-approved subspecialty residency that may be affiliated with the psychiatry residency. There should be a written description of the committee, including its responsibility to the sponsoring department or institution and to the program director. This committee should participate actively in:

a) planning, developing, implementing, and evaluating all significant features of the residency program, including the selection of residents (unless there is a separate residency selection committee);

b) determining curriculum goals and objectives; and

c) evaluating both the teaching staff and the residents.

D. Resources

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

1. All programs must have adequate patient populations for each mode of required education and, minimally, must include organized clinical services in inpatient, outpatient, emergency, consultation/liaison, and child and adolescent psychiatry.

2. Residency programs must have available to them adequate inpatient and outpatient facilities and other suitable clinical placements where the residents can meet the educational objectives of the program. The program should specify the facilities in which the goals and objectives are to be implemented.

3. All residents must have available to them offices adequate in size and decor to allow them to interview patients and accomplish their duties in a professional manner. The facility must also provide

adequate and specifically-designated areas in which residents can perform basic physical examination and other necessary diagnostic procedures and treatment interventions.

4. There must be adequate space and equipment, including equipment with the capability to record and playback session, specifically designated for seminars, lectures, and other educational activities.

E. Medical Information Access

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

III. Resident Appointments

A. Eligibility Criteria

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

1. The program director must accept only those applicants whose qualifications of residency include sufficient command of English to permit accurate and unimpeded communication.

B. Number of Residents

The program director may not appoint more residents 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 residents appointed to the program.

1. In order to promote an educationally-sound, intellectually-stimulating atmosphere of effective and graded responsibility, programs must have at least three residents at each level of education. Programs that fall below this prescribed critical mass will be reviewed, and if this deficiency is not corrected, they may be cited for noncompliance, except when the number of PG-4 residents is fewer than three because residents have entered child and adolescent psychiatry training.

2. Any permanent change in the number of approved positions requires prior approval by the Review Committee. Programs

seeking interim approval of a permanent increase in the number of approved resident positions should contact the Executive Director of the Review Committee. Prior approval is not required for temporary changes in resident numbers owing to makeup or remedial time for currently-enrolled residents, or to fill vacancies. Approval of permanent increases above the approved range of residents will require documentation that didactic and clinical education, including supervision, will not be compromised.

C. Resident Transfers

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

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

3. Verification must include evaluation of professional integrity of residents transferring from one program to another, including from a general psychiatry to a child and adolescent psychiatry program.

4. A transferring resident's educational program must be sufficiently individualized so that he/she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation.

D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

IV. Educational Program

A. The curriculum must contain the following educational components:

1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

3. Regularly scheduled didactic sessions;

4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

5. ACGME Competencies

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

a) Patient Care

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

(1) must have supervised experience in the evaluation and treatment of patients. These patients should be of different ages and gender from across the life cycle, and from a variety of ethnic, racial, sociocultural, and economic backgrounds;

(2) should be familiar with Axis III conditions that can affect evaluation and care (e.g., CNS lesions, HIV/AIDS, and other medical conditions).

(3) should develop competence in:

(a) formulating a clinical diagnosis for patients by conducting patient interviews, eliciting a clear and accurate history; performing physical, neurological, and mental status examination, including appropriate diagnostic studies; completing a systematic recording of findings; relating history and clinical findings to the relevant biological psychological, behavioral, and sociocultural issues associated with

etiology and treatment;

(b) developing a differential diagnosis and treatment plan for all psychiatric disorders in the current standard nomenclature, i.e., DSM, taking into consideration all relevant data;

(c) using pharmacological regimens, including concurrent use of medications and psychotherapy;

(d) understanding the indications and uses of electroconvulsive therapy;

(e) applying supportive, psychodynamic, and cognitive-behavioral psychotherapies to both brief and long-term individual practice, as well as to assuring exposure to family, couples, group and other individual evidence-based psychotherapies;

(f) providing psychiatric consultation in a variety of medical and surgical settings;

(g) providing care and treatment for the chronically-mentally ill with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions;

(h) participating in psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance and performance improvement;

(i) providing psychiatric care to patients who are receiving treatment from nonmedical therapists and coordinating such treatment; and,

(j) recognizing and appropriately responding to family violence (e.g., child, partner, and elder physical, emotional, and sexual abuse and neglect) and its effect on both victims and perpetrators.

(4) will have major responsibility for the care of a

significant number of patients with acute and chronic psychiatric illnesses;

(a) Patient care assignments must permit residents to practice appropriate treatment, and to have sufficient time for other aspects of their educational program.

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

(c) Experiences may be completed on a full or part-time basis so long as the stated full-time equivalent experience is met. For residents who plan to enter subspecialty education in child and adolescent psychiatry prior to completing general psychiatry requirements, certain clinical experiences with children, adolescents and families taken during the period when the resident is designated as a child and adolescent psychiatry resident may be counted toward general psychiatry requirements as well as child and adolescent requirements, thereby fulfilling program requirements in both general and child and adolescent psychiatry. The following guidelines must be met for these experiences:

    (i) they must be limited to child and adolescent psychiatry patients;

    (ii) no more than 12 months may be double counted;

    (iii) there should be documentation from the child and adolescent psychiatry program director for all areas for which credit is given in both programs;

    (iv) there will be no reduction in total length of time devoted to education in child and

adolescent psychiatry; this must remain at two years; and,

(v) only the following experiences can be used to meet requirements in both general and child and adolescent psychiatry:

(a) one month full-time equivalent of child neurology;

(b) one month full-time equivalent of pediatric consultation;

(c) one month full-time equivalent of addiction psychiatry;

(d) forensic psychiatry experience;

(e) community psychiatry experience; and

(f) no more than 20% of outpatient experience of the Program Requirements for Psychiatry.

(5) will have the required clinical experiences which include the following:

(a) Neurology: two full-time equivalent months of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions. At least one month should occur in the first or second year of the program;

(b) Inpatient Psychiatry: six but no more than 16 months full-time equivalent of inpatient psychiatry of which there must be a minimum of six months of significant responsibility for the assessment, diagnosis, and treatment of general psychiatric patients who are admitted to traditional psychiatry units, day hospital programs, research units, residential treatment programs, and other settings that meet the following criteria:

(i) The patient population is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and gender; and,

(ii) Patient services are comprehensive and continuous and allied medical and ancillary staff are available for backup support at all times.

(c) Outpatient Psychiatry: 12 month full-time equivalent organized, continuous, and supervised clinical experience in the assessment, diagnosis, and treatment of outpatients with a wide variety of disorders and treatment modalities, with experience in both brief and long-term care of patients. Each resident must have significant experience treating outpatients longitudinally for at least one year. This longitudinal experience should include:

(i) evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly under supervision;

(ii) exposure to multiple treatment modalities that emphasize developmental, biological, psychological and social approaches to outpatient treatment;

(iii) opportunities to apply psychosocial rehabilitation techniques, and to evaluate and treat differing disorders in a chronically ill patient population; and,

(iv) no more than 20% of the patients seen may be children and adolescents. This portion of education may be used to fulfill the two -month Child and Adolescent Psychiatry requirements, so long as this component meets the requirement for child and adolescent psychiatry as set forth in d.i and d.ii

below.

(d) Child and Adolescent Psychiatry: two month full-time equivalent organized clinical experience in which the residents are:

(i) supervised by child and adolescent psychiatrists who are certified by ABPN or judged by the Review Committee to have equivalent qualifications; and

(ii) provided opportunities to assess development and to evaluate and treat a variety of diagnoses in male and female children and adolescents and their families, using a variety of interventional modalities.

(e) Geriatric Psychiatry: one month full-time equivalent organized experience focused on the specific competencies in areas that are unique to the care of the elderly. These include the diagnosis and management of mental disorders in patients with multiple comorbid medical disorders, familiarity with the differential diagnosis and management (including management of the cognitive component) of the degenerative disorders, an understanding of neuropsychological testing as it relates to cognitive functioning in the elderly, and the unique pharmacokinetic and pharmacodynamic considerations encountered in the elderly, including drug interactions.

(f) Addiction Psychiatry: one month full-time equivalent organized experience focused on the evaluation and clinical management of patients with substance abuse/dependence problems, including dual diagnosis. Treatment modalities should include detoxification, management of overdose, maintenance pharmacotherapy, the use of psychological and social consequences of addiction in confronting and intervening in chronic addiction rehabilitation used in recovery stages from pre-contemplation to maintenance, and the use of

self-help groups.

(g) Consultation/Liaison: two month full-time equivalent in which residents consult under supervision on other medical and surgical services.

(h) Forensic Psychiatry: This experience must expose residents to the evaluation of forensic issues such as patients facing criminal charges, establishing competency to stand trial, criminal responsibility, commitment, and an assessment of their potential to harm themselves or others. This experience should include writing a forensic report. Where feasible, giving testimony in court is highly desirable.

(i) Emergency Psychiatry: This experience must be conducted in an organized, 24-hour psychiatric emergency service, a portion of which may occur in ambulatory urgent-care settings, but not as part of the 12-month outpatient requirement. Residents must be provided experiences in evaluation, crisis evaluation and management, and triage of psychiatric patients. On-call experiences may be a part of this experience, but no more than 50%.

(j) Community Psychiatry: This experience must expose residents to persistently and chronically-ill patients in the public sector, (e.g., community mental health centers, public hospitals and agencies, and other community-based settings). The program should provide residents the opportunity to consult with, learn about, and use community resources and services in planning patient care, as well as to consult and work collaboratively with case managers, crisis teams, and other mental health professionals.

(k) Addiction, Community, Forensic, and Geriatric psychiatry requirements can be met as part of the inpatient requirements above the minimum

six months, and/or as part of the outpatient requirement

b) Medical Knowledge

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

must meet the following requirements.

(1) Didactic instruction must be systematically organized, thoughtfully integrated, based on sound educational principles, and include regularly scheduled lectures, seminars, and assigned readings.

(2) The didactic sessions must be scheduled to ensure a minimum of 70% of resident attendance while adhering to program duty hour policy. Didactic and clinical education must have priority in the allotment of residents' time and energy.

(3) The didactic curriculum must include the following specific components:

(a) the major theoretical approaches to understanding the patient-doctor relationship;

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

(c) the fundamental principles of the epidemiology, etiologies, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, sociocultural, and iatrogenic factors that affect the prevention, incidence, prevalence and long-term course and treatment of psychiatric disorders and conditions;

(d) comprehensive discussions of the diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, such as neoplasm, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, multiple sclerosis, seizure disorders, stroke, intractable pain, and other related disorders;

(e) the use, reliability, and validity of the generally-accepted diagnostic techniques, including physical examination of the patient, laboratory testing, imaging, neurophysiologic and neuropsychological testing, and psychological testing;

(f) the use and interpretation of psychological testing (under the supervision and guidance of a qualified clinical psychologist, residents should have experience with the interpretation of the psychological tests most commonly used, some of which experience should be with their own patients);

(g) the history of psychiatry and its relationship to the evolution of medicine;

(h) the legal aspects of psychiatric practice, and when and how to refer;

(i) an understanding of American culture and subcultures, particularly those found in the patient community associated with the educational program, with specific focus for residents with cultural backgrounds that are different from those of their patients;

(j) use of case formulation that includes neurobiological, phenomenological, psychological, and sociocultural issues involved in the diagnosis and management of cases; and,

(i) Each program must provide the following:

(ii) All residents must be educated in research literacy. Research literacy is the ability to critically appraise and understand the relevant research literature and to apply research findings appropriately to clinical practice. The concepts and process of Evidence Based Clinical Practice include skill development in question formulation, information searching, critical appraisal, and medical decision-making, thus providing the structure for teaching research literacy to psychiatry residents. The program must promote an atmosphere of scholarly inquiry, including the access to ongoing research activity in psychiatry Residents must be taught the design and interpretation of data.

(iii) The program must provide residents with research opportunities and the opportunity for development of research skills for residents interested in conducting research in psychiatry or related fields. The program must provide interested residents access to and the opportunity to participate actively in ongoing research under a mentor. If unavailable in the local program, efforts to establish such mentoring programs are encouraged.

(iv) The program must ensure the participation of residents and faculty in journal clubs, research conferences, didactics, and/or other activities that address critical appraisal of the literature and understanding of the research process.

c) 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 life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;

(2) set learning and improvement goals;

(3) identify and perform appropriate learning activities;

(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

(5) incorporate formative evaluation feedback into daily practice;

(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;

(7) use information technology to optimize learning; and,

(8) **participate in the education of patients, families, students, residents and other health professionals.**

(9) taking primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and rotation-specific goals and objectives, as well as attendance at conferences;

(a) Resident's teaching abilities should be documented by evaluations from faculty and/or learners.

(i) There must be a record that demonstrates that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment

modalities. In the case of transferring residents, the records should include the experiences in the prior and current program.

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

d) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

(2) communicate effectively with physicians, other health professionals, and health related agencies;

(3) work effectively as a member or leader of a health care team or other professional group;

(4) act in a consultative role to other physicians and health professionals; and,

(5) maintain comprehensive, timely, and legible medical records, if applicable.

(6) interviewing patients and family in an effective manner to facilitate accurate diagnosis and biological, psychological and social formulation.

e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to

ethical principles. Residents are expected to demonstrate:

(1) compassion, integrity, and respect for others;

(2) responsiveness to patient needs that supersedes self-interest;

(3) respect for patient privacy and autonomy;

(4) accountability to patients, society and the profession; and,

(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

(6) high standards of ethical behavior which include respect for patient privacy and autonomy, maintaining appropriate professional boundaries, and understanding the nuances specific to psychiatric practice. Programs are expected to distribute to residents and operate in accordance with the AMA Principles of Ethics with "Special Annotations for Psychiatry," as developed by the American Psychiatric Association to ensure that the application and teaching of these principles are an integral part of the educational process.

f) Systems-based Practice

Residents 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. Residents are expected to:

(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;

(2) coordinate patient care within the health care system relevant to their clinical specialty;

(3) incorporate considerations of cost awareness and

risk-benefit analysis in patient and/or population-based care as appropriate;

(4) advocate for quality patient care and optimal patient care systems;

(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,

(6) participate in identifying system errors and implementing potential systems solutions.

(7) knowing how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;

(8) practicing cost-effective health care and resource allocation that does not compromise quality of care, including an understanding of the financing and regulation of psychiatric practice, as well as information about the structure of public and private organizations that influence mental health care;

(9) advocating for quality patient care and assisting patients in dealing with system complexities, including disparity in mental health care;

(10) working with health care managers and health care providers to assess, coordinate, and improve health care, particularly as it relates to access to mental health care;

(11) knowing how to advocate for the promotion of mental health and the prevention of disease;

(12) maintaining a mechanism to ensure that charts are appropriately maintained and readily accessible for patient care and regular review for supervisory and educational purposes;

(13) collaborating with psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel in the treatment of patients; and

(14) monitoring clinical records on major rotations to assess resident competencies to:

(a) document an adequate history and perform mental status, physical, and neurological examinations;

(b) organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues;

(c) proceed with appropriate laboratory and other diagnostic procedures;

(d) develop and implement an appropriate treatment plan followed by regular and relevant progress notes regarding both therapy and medication management; and,

(e) prepare an adequate discharge summary and plan.

B. Residents' Scholarly Activities

1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

2. Residents should participate in scholarly activity.

a) Residents will have instruction in research methods in the clinical, biological, and behavioral sciences related to psychiatry, including techniques to appraise the professional and scientific literature and to apply evidence based findings to patient care.

3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

V. Evaluation

A. Resident Evaluation

1. Formative Evaluation

a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

b) The program must:

(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;

(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

(3) document progressive resident performance improvement appropriate to educational level; and,

(4) provide each resident with documented semiannual evaluation of performance with feedback.

c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

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

e) The program must formally examine the cognitive knowledge of each resident at least annually in the PG-2, PG-3 and PG-4 years, and conduct an examination across biological, psychological and social spheres that are defined in the program's written goals and objectives.

f) The program must formally conduct a clinical skills examination. A required component of this assessment is

an annual evaluation of the following skills:

(1) ability to interview patients and families;

(2) ability to establish an appropriate doctor/patient relationship;

(3) ability to elicit an appropriate present and past psychiatric, medical, social, and developmental history;

(4) ability to assess mental status; and

(5) ability to provide a relevant formulation, differential diagnosis and provisional treatment plan.

g) Performance on all evaluations must be documented and quantified, whenever possible, and provided to the resident. When necessary, remediation opportunities must be provided. Residents must not advance to the next year of education, or graduate from the program, unless the competence for their level of education in each area is documented. Demonstration of competence in psychiatric interviewing must be attained prior to completion of the program.

2. Summative Evaluation

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

a) document the resident's performance during the final period of education, and

b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

c) The final evaluation should also include a summary of any documented evidence of unethical behavior, unprofessional behavior, or clinical incompetence or a statement that none such has occurred. Where there is such evidence, it must be comprehensively recorded, along with the resident's

response(s) to such evidence.

B. Faculty Evaluation

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

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.

3. This evaluation must include at least annual written confidential evaluations by the residents.

C. Program Evaluation and Improvement

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:

a) resident performance;

b) faculty development;

c) graduate performance, including performance of program graduates on the certification examination; and,

d) program quality. Specifically:

(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.

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.

3. In its evaluation of residency programs, the Review Committee will take into consideration the information provided by the American Board of Psychiatry and Neurology regarding resident performance on the certifying examinations during the most recent five years. The expectation is that the rate of those passing the examination on their first attempt is 50% and that 70% of those who complete the program will take the certifying examination

VI. Resident Duty Hours in the Learning and Working Environment

A. Principles

1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.

2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.

3. Didactic and clinical education must have priority in the allotment of residents' time and energy.

4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

B. Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

1. Each resident must receive a minimum of two hours of direct supervision per week, at least one of which is individual.

C. Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)

Duty hours are defined as all clinical and academic activities related

to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.

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

2. **Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.**

3. **Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**

E. On-call Activities

1. **In-house call must occur no more frequently than every third night, averaged over a four-week period.**

    a) On psychiatry rotations, in-house call must occur no more frequently than every fourth night, averaged over a four week period.

2. **Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**

3. **No new patients may be accepted after 24 hours of continuous duty.**

    a) A new patient is defined as any patient for whom the resident has not previously provided care.

4. **At-home call (or pager call)**

    a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.

    b) Residents taking at-home call must be provided with

one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

F. Moonlighting

1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

G. Duty Hours 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.

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.

2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VII. Experimentation and Innovation

Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Procedures located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

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Section II
Essentials of Accredited Residencies in Graduate Medical Education

Section II -- Essentials of Accredited Residencies in Graduate Medical Education: Institutional and Program Requirements-- begins with a preface containing general information about the three major phases of the education of physicians, the accreditation of graduate medical education programs, and a glossary of selected terms, followed by a copy of the Institutional Requirements effective July 1997. The bulk of Section II consists of Program Requirements organized by specialty/related subspecialty.

Preface

I. The Education of Physicians
Medical education in the United States occurs in three major phases.

A. Undergraduate Medical Education
Undergraduate medical education is the first or "medical school" phase. The medical school curriculum provides instruction in the sciences that underlie medical practice and in the application of those sciences to health care. Students learn basic information-gathering, decision-making, and patient-management skills in rotations through the various clinical services. Students are granted the MD or DO degree on the successful completion of the medical school curriculum and are eligible to undertake the next phase of medical education.

Accreditation of educational programs leading to the MD degree is the responsibility of the Liaison Committee on Medical Education (LCME). Accreditation of educational programs leading to the DO degree is the responsibility of the American Osteopathic Association.

B. Graduate Medical Education
Graduate medical education (GME), the second phase, prepares physicians for practice in a medical specialty. GME focuses on the development of clinical skills and professional competencies and on the acquisition of detailed factual knowledge in a medical specialty. This learning process prepares the physician for the independent practice of medicine in that specialty. The programs are based in hospitals or other health care institutions and, in most specialties, utilize both inpatient and ambulatory settings, reflecting the importance of care for adequate numbers of patients in the GME experience. GME programs, including Transitional Year programs, are usually called residency programs, and the physicians being educated in them, residents.

The single most important responsibility of any program of GME is to provide an organized educational program with guidance and supervision of the resident, facilitating the resident's professional and personal development while ensuring safe and appropriate care for patients. A resident takes on progressively greater responsibility throughout the course of a residency, consistent with individual growth in clinical experience, knowledge, and skill.

The education of resident physicians relies on an integration of didactic activity in a structured curriculum with diagnosis and management of patients under appropriate levels of supervision and scholarly activity aimed at developing and maintaining life-long learning skills. The quality of this experience is directly related to the quality of patient care, which is always the highest priority. Educational quality and patient care quality are interdependent and must be pursued in such a manner that they enhance one another. A proper balance must be maintained so that a program of GME does not rely on residents to meet service needs at the expense of educational objectives.

A resident is prepared to undertake independent medical practice within a chosen specialty on the satisfactory completion of a residency. Residents in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) typically complete educational requirements for certification by a specialty board recognized by the American Board of Medical Specialties (ABMS).

The accreditation of GME programs is the responsibility of the ACGME, its associated Residency Review Committees (RRCs) for the various specialties, and the Transitional Year Review Committee (TYRC)(hereafter referred to as "review

committees"). Further information on the ACGME and the review committees is provided below.

C. Continuing Medical Education
Continuing medical education (CME) is the third phase of medical education. This phase continues the specialty education begun in graduate training; it reflects the commitment to lifelong learning inherent in the medical profession.

The Accreditation Council for Continuing Medical Education (ACCME) is responsible for accrediting the providers of CME.

II. Accreditation of GME Programs

A. Accreditation, Certification, Licensure
In the context of GME, accreditation is the process for determining whether an educational program is in substantial compliance with established educational standards as promulgated in the institutional and program requirements. Accreditation represents a professional judgment about the quality of an educational program. Decisions about accreditation are made by the review committees under the authority of the ACGME.

Certification is the process for determining whether an individual physician has met established requirements within a particular specialty. The standards for certification are determined by the appropriate member specialty board recognized by the ABMs

Licensure is distinct from both accreditation and certification. Licensure is a process of government through which an individual physician is given permission to practice medicine within a particular licensing jurisdiction. Medical licenses are granted by the Board of Medical Examiners (or the equivalent) in each licensing jurisdiction (the 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands).

B. Accreditation of Residency Programs
Accreditation of residency programs is a voluntary process. By participating in the process, residency programs undergo regular review. The review helps programs in their goals of attaining and maintaining educational excellence. The review also serves to inform the public, specialty boards, residents, and medical students whether specific residency programs are in substantial compliance with the standards that have been established for GME.

For a program to become accredited, the sponsoring institution must demonstrate a commitment to GME. The sponsoring institution must be in substantial compliance with the Institutional Requirements and must assume responsibility for the educational quality of its sponsored program(s). (Further information concerning a "sponsoring institution" is provided below.)

The Institutional Requirements, which have been established by the ACGME, apply to all institutions that seek to sponsor programs in GME. An assessment of whether institutions fulfill these requirements is made by the ACGME through its institutional review process and by the review committees through their program review process.

The program must demonstrate to its RRC that it is in substantial compliance with the Program Requirements for its particular discipline and that it is sponsored by an institution in substantial compliance with the Institutional Requirements. Materials used by the review committees in making this determination include the results of the most recent institutional review conducted by the ACGME.

The Program Requirements are developed by each review committee for programs in its specialty. The Program Requirements specify essential educational content, instructional activities, responsibilities for patient care and supervision, and the necessary facilities of accredited programs in a particular specialty. In developing and updating Program Requirements, a review committee obtains comments on the proposed documents from interested parties and agencies. The review committee then decides on the final proposal to be submitted to the ACGME. The ACGME has final authority for approving all Program Requirements.

Accreditation actions taken by the review committees are based on information submitted by program directors and on the reports of site visitors. Actions of the committees, under the authority of the ACGME, determine the accreditation status of residency programs.

The ACGME is responsible for adjudication of appeals of adverse decisions and has established policies and procedures for such appeals.

Current operating policies and procedures for review, accreditation, and appeal are contained in the ACGME Manual of

Policies and Procedures for Graduate Medical Education Review Committees. The Manual is reviewed annually and is revised as appropriate. (A copy of the Manual, as well as copies of the Institutional Requirements and of the Program Requirements, may be obtained from the Office of the Executive Director, ACGME, 515 N State St, Ste 2000, Chicago, IL, 60610.)

Information about the accreditation status of a residency program may be obtained by contacting the executive director of the ACGME.

C. Structure of the ACGME and of the RRCs
   1. The ACGME is a voluntary association formed by five member organizations. Its member organizations are national professional bodies, each of which has major interests in and involvement with residency education.

      The five member organizations of the ACGME are as follows:

      American Board of Medical Specialties (ABMs)
      American Hospital Association (AHA)
      American Medical Association (AMA)
      Association of American Medical Colleges (AAMC)
      Council of Medical Specialty Societies (CMSS)

      Each member organization selects four representatives to the ACGME. The representatives of the member organizations in turn select two public members.

      The Resident Physician Section of the AMA, with the advice of other national organizations that represent residents, selects a resident representative to the ACGME. The Secretary of the US Department of Health and Human Services designates a representative of the federal government to the ACGME.

      The Chair of the RRC Council, an advisory body of the ACGME, sits with the representatives of the member organizations and official observers as the representative of the RRC Council.

   2. There is an RRC for each of the specialties in which certification is offered by a specialty board that is a member of the ABMs Each RRC is sponsored by the AMA's Council on Medical Education, by the board that certifies physicians within that specialty, and in most cases, by the professional college or other professional association within the specialty.

      The Transitional Year Review Committee, which accredits 1 year of GME consisting of rotations in multiple clinical disciplines, is appointed directly by the ACGME.

The established RRCs and their respective sponsors are listed in the chart below.

Residency Review Committee Sponsoring Organizations

Residency Review Committee	Sponsoring Organizations	Residency Review Committee	Sponsoring Organizations
Allergy and Immunology	American Board of Allergy and Immunology (A Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics) AMA Council on Medical Education	Anesthesiology	American Board of Anesthesiology AMA Council on Medical Education American Society of Anesthesiologists

Colon and Rectal Surgery	American Board of Colon and Rectal Surgery American College of Surgeons AMA Council on Medical Education	Dermatology	American Board of Dermatology AMA Council on Medical Education
Emergency Medicine	American Board of Emergency Medicine American College of Emergency Physicians AMA Council on Medical Education	Family Medicine	American Academy of Family Physicians American Board of Family Medicine AMA Council on Medical Education
Internal Medicine	American Board of Internal Medicine American College of Physicians AMA Council on Medical Education<	Medical Genetics	American Board of Medical Genetics American College of Medical Genetics AMA Council on Medical Education
Neurological Surgery	American Board of Neurological Surgery American College of Surgeons AMA Council on Medical Education	Neurology	American Academy of Neurology American Board of Psychiatry and Neurology AMA Council on Medical Education
Nuclear Medicine	American Board of Nuclear Medicine AMA Council on Medical Education Society of Nuclear Medicine	Obstetrics-Gynecology	American Board of Obstetrics and Gynecology American College of Obstetricians and Gynecologists AMA Council on Medical Education
Ophthalmology	American Academy of Ophthalmology American Board of Ophthalmology AMA Council on Medical Education	Orthopaedic Surgery	American Academy of Orthopaedic Surgeons American Board of Orthopaedic Surgery AMA Council on Medical Education
Otolaryngology	American Board of Otolaryngology American College of Surgeons AMA Council on Medical Education Residency Review Committee Sponsoring Organizations	Pathology	American Board of Pathology AMA Council on Medical Education
Pediatrics	American Academy of Pediatrics American Board of Pediatrics AMA Council on Medical Education	Physical Medicine and Rehabilitation	American Academy of Physical Medicine and Rehabilitation American Board of Physical Medicine and Rehabilitation AMA Council on Medical Education

Plastic Surgery	American Board of Plastic Surgery American College of Surgeons AMA Council on Medical Education	Preventive Medicine	American Board of Preventive Medicine AMA Council on Medical Education
Psychiatry	American Board of Psychiatry and Neurology AMA Council on Medical Education American Psychiatric Association	Diagnostic Radiology	American Board of Radiology American College of Radiology AMA Council on Medical Education
Radiation Oncology	American Board of Radiology American College of Radiology AMA Council on Medical Education	Surgery	American Board of Surgery American College of Surgeons AMA Council on Medical Education
Thoracic Surgery	American Board of Thoracic Surgery American College of Surgeons AMA Council on Medical Education	Urology	American Board of Urology American College of Surgeons AMA Council on Medical Education

ACGME: September 1998 Effective: September 1998

ACGME GENERAL COMPETENCIES

The new ACGME guidelines went into effect January, 2001. Now residency programs in psychiatry must demonstrate an effective plan for assessing resident performance throughout the program utilizing assessment results to improve resident performance. The five general competencies include: Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems-Based Practice. Our Department had been moving forward in implementing assessment of these competencies by means of goals and objectives for each specific competency as well as revising the resident evaluation form to reflect these competencies. Teaching of the competencies occurs in didactic and clinical programs. The institution has begun an ACGME Core Competencies Lecture Series held once a month.

We are now using an ACGME General Competency "Toolbox" covering the six areas listed above. In order to better assess each competency, in addition to faculty evaluations, other means of assessing competency has been included. These include: completion of Patient Logs, Patient Survey Questionnaires (PSQ's), "Mock Oral" Exam results, a new Journal Club format, Evidence-Based Scholarly Presentation, 360° global rating evaluations, evaluations from medical students and writing up a training portfolio case of a patient that demonstrates knowledge of systems-based care. Annual Clinical Skills Examination (ACSE), Psychotherapy Competency Checklist, videotaped interview review, standardized examinations (PRITE, Columbia Psychodynamic Psychotherapy, USMLE, various rotational exercises and experiences and self-assessment exercises.

New "Toolbox" Assessment Forms

Patient Satisfaction Questionnaires (PSQ's) – These forms will be handed out to random patients seen by the resident during clinical rotations and longitudinal outpatient experience.

"Mock Oral" Exam Form – This form has been updated to reflect additional ACGME competencies.

Faculty Evaluation Forms, Individual Supervision and Longitudinal Outpatient Forms – These global assessments have been updated to more fully reflect the six ACGME core competencies.

Medical Student Evaluation Forms – At the end of each rotation, the medical students will fill out an evaluation form on each resident they had contact with during the four-week block.

Journal Club –The resident and attending will be responsible for presenting one journal article pertinent to a case the resident has been following. The article should be critiqued using the attached handout. In addition, the resident will briefly discuss how the use of this article contributed to patient care. The article should be reviewed with the attending supervisor and given to Pat to distribute to residents at least two weeks in advance. Each presentation should take the full hour and we would expect each resident to do at least two of these throughout their years of adult training. The supervising attending will facilitate the discussion and evaluate the presentation.

360º Global Rating Evaluations – Each resident will be rated by psychiatry staff in the areas listed on the evaluation form. This is similar to the 360º ratings for psychiatry attendings.

Training Portfolio Case of a patient that demonstrates knowledge of Systems-Based care – The resident will select a case that demonstrates Systems-Based care. Residents are expected to demonstrate both an understanding of the context of systems in which health care is provided and the ability to apply this knowledge to improve and optimize health care. This would include being able to apply evidence-based, cost-conscious strategies to prevention, diagnosis and disease management and collaboration with other members of the healthcare team to assist patients in dealing effectively with these complex systems and to improve systematic processes of care. Examples of systems-based practice with an inpatient rotation would include the use of hospital resources to achieve optimal patient care (i.e. consultants, social services, financial department, etc.), recognize and surmount obstacles to care, find appropriate patient care follow up and to institute discharge planning at the beginning of admission. This may involve using the county or state mental health systems. In the outpatient rotations, the resident should be able to identify and utilize community and clinic resources for optimal patient care and collaborate with consultants and payors to achieve required and appropriate care. No matter where the patient is treated, many systems are involved. Some examples would include insurance issues, managed care, community resources, appropriate consultations – from other specialties and ancillary services (i.e. social services, physical therapy, occupational therapy, etc.), family therapy, couples therapy, county, state and/or federal agencies, forensic issues, etc.). Using evidence-based or practice guidelines would also fall under this heading. An example would be the Penn

Maps approach to administering antipsychotic medication used in the State Hospital system. Residents should be able to write up and present a case demonstrating knowledge and use of a variety of systems. The written case will remain a part of the resident's portfolio and presentation should be made to the Training Director at a mutually agreeable time.

Annual Clinical Skills Examination – Refer to appropriate section (next page).

Chart Review – Faculty supervisor and/or resident review patient charts to assess appropriate clinical intervention and documentation.

Patient logs – Resident documentation of patients seen during training identifying sex, age, diagnosis, location seen, intervention and SES.

Videotaped Interview Review – Resident videotapes a session of any type (inpatient, outpatient, partial, etc.) and any purpose (initial evaluation, follow-up, medication check, etc.) for review with a faculty supervisor to improve interviewing skills. The focus is on process rather than content.

Policy and Procedures for Evaluation of Resident's Clinical Skills
Annual Clinical Skills Examination (ACSE)

Background:

Interpersonal communications skills remain a hallmark skill in psychiatry and excellence in these skills remain at the heart of clinical work in psychiatry. These skills are taught and evaluated in each clinical rotation throughout the residency, and progress is assessed and encouraged by the faculty throughout the residency program.

However to provide a formal assessment of clinical skills, each resident will receive a yearly exam of clinical skills by senior faculty members of Penn State's Department of Psychiatry.

Procedures:

1. In the spring of each academic year, each resident will receive a formal examination of clinical skills.
2. The resident must pass this exam of clinical skills to progress to the next postgraduate year of training.
3. The first part of the examination will consist of a half hour interview with a live patient, with the faculty examiner in the room also with the patient. During this half hour interview, the faculty member will assess the resident's ability to establish appropriate doctor/patient relationship, interview skills, as well as the ability to elicit information in the present illness, past history, and mental status exam. As in other clinical evaluations, confidentiality will be assured for the patient, and respected by the resident and faculty examiner.
5. Following the half hour interview, the resident will be examined on clinical management skills. This presentation portion will last for at least one half hour. He or she will be asked to present the case, with the presentation including essential elements of the history of present illness, past history including important elements of family history, developmental history, social history, medical history and psychiatric history including substance abuse history. The mental status exam must also be formally presented.
6. The resident will then be asked to present a relevant formulation, differential diagnosis, and then a final diagnosis for the patient in a multi-axial presentation.
7. The resident will then present a treatment plan for the patient based on the diagnostic assessment of the case.
8. As the resident progresses throughout the years of post graduate training, he or she will be expected to gain added skills and demonstrate them throughout the course of the examination procedures. All residents must perform all aspects competently as per their training level.
9. Residents will be given evaluation of their performance on the yearly clinical skills exam verbally by the faculty evaluator and receive a copy of their written evaluation as well.

10. It is expected that not all residents will be competent in these skills at the examination. Remediation for the residents who do not pass the exam will proceed as follows: The faculty member will meet with the resident and discuss verbal feedback of the specific areas of the examination where competence was not achieved. Specific ways of improving performance will be presented. The resident will then be given the opportunity for a new test within a brief period to again demonstrate competence in clinical skills before the end of the academic year.
11. The resident, if still not successful, will be assigned a faculty member who will work directly with the resident to improve his/her clinical interviewing skills.
12. Results of the annual clinical examination will be kept in the resident's performance file. Results of the examination will also be reviewed with the resident by the residency training director during their semi annual performance review.
13. Residents will receive a copy of this set of procedures for the exam before the examination.

SUGGESTED FORM FOR CLINICAL EXAMINATION:
(Each topic will be rated on a one to five scale)

1 = very poor
2= less than competent
3= competent
4= good clinical performance
5= excellent clinical performance

SKILLS:

Interpersonal Relationship skills with the patient and ability to establish an appropriate doctor/patient relationship

Ability to conduct and manage the interview

Ability to elicit important information in the history of present illness

Ability to elicit past history (including family history, personal history, events in adult life, medical history, psychiatric and substance abuse history)

Ability to conduct a mental status exam

Differential Diagnosis

Final Diagnostic Formulation

Ability to Formulate Treatment Plan

Overall score:

ACGME Competency Assessment Toolbox

Competency	Assessment	Evaluator	Frequency
Patient Care	Global Assessment – rotations individual supervision (faculty evals)	Faculty supervisor(s)	q 3-6 months
	Annual Clinical Skills Exam (ACSE) – direct observation	Faculty physician	q year
	Chart Review	Resident, Faculty supervisor	each outpatient day
	Patient Logs	Resident	q 3-6 months
	Patient Survey Questionnaires (PSQ's)	Patients	yearly
	Evidence-Based Medicine Scholarly Presentation	Faculty member	2x during residency
	"Mock Oral" Exam- Patient Interview	Faculty physician	various rotations
	Psychotherapy Competency Checklist	Faculty supervisor	complete by end of residency
	Videotaped Interview Review	Faculty supervisor	2x/year
Medical Knowledge	Global Assessment - rotations individual supervision	Faculty supervisor(s)	q 3-6 months

	(faculty evals)		
	Annual Clinical Skills Exam (ACSE) – direct observation	Faculty physician	q year
	USMLE or COMLEX Parts I, II, III	USMLE	by end of PGY-2 year
	PRITE (in training exam)		q year
	Psychodynamic Psychotherapy Test written exam		q year
	"Mock Oral" Exam	Faculty physician	various rotations
	Inservice Pre/Post Tests		various rotations
	Evidence-Based Medicine Scholarly Presentation	Faculty member	2x during residency
	Journal Club	Faculty member	2x during residency
	Videotaped Interview Review	Faculty supervisor	2x each year
Professionalism	Global Assessment – rotations individual supervision (faculty evals)	Attending physician	q 3-6 months
	360^0 Global Evaluation (survey)	Ancillary staff, peers	q year

Annual Clinical Skills Exam (ACSE) – direct observation	Faculty physician	q year
Patient Survey Questionnaires (PSQ's)	Patients	q year
Medical Student Teaching Evaluations (written)	Medical Students	q month
Professionalism Survey Form	Faculty supervisor(s)	PRN

Systems-Based Care	Global Assessment – rotations individual supervision (faculty evals)	Faculty supervisor(s)	q 3-6 months
	Annual Clinical Skills Exam (ACSE) – direct observation	Faculty physician	q year
	Training Portfolio Case for Systems-Based Care	Faculty supervisor	q year PGY-2-4
	Assessment on Administrative Psychiatry Rotation – QI Project, Peer Review Experience	Faculty supervisor	at time of rotation
	Assessment on Community Psychiatry Rotation	Faculty physician	at time of rotation
Practice-Based Learning	Global Assessment – rotations individual supervision (faculty evals)	Faculty supervisor(s)	q 3-6 months
	Assessment on Administrative Psychiatry Rotation – QI Project, Peer Review Experience	Faculty supervisor	at time of rotation
	Evidence-Based Medicine Scholarly Presentation	Faculty member	2x during residency
	Medical Student Teaching Evals	Medical Students	q month
	Semi-Annual Evaluation Session (practice improvement goals,	Resident, Training Director	q 6 months

self-assessment)

Chart Review	Resident	each outpatient day
Journal Club	Faculty supervisor	2x during residency

Interpersonal & Communication Skills	Faculty Evaluations rotations individual supervision longitudinal outpatients	Faculty supervisor(s)	q 3-6 months
	360^0 Global Evaluation	Ancillary staff, peers	q year
	Patient Survey Questionnaires (PSQ's)	Patients	q year
	Medical Student Teaching Evals	Medical students	q month
	Videotaped Interview Review	Faculty supervisor	2x/q year
	"Mock Oral" Exam	Faculty physician	various rotations
	Chart Review	CQI member	quarterly
	Assessment of Community Psychiatry Rotation – Treatment Team Leadership	Faculty supervisor	at time of rotation

Evidence-Based Medicine Scholarly Presentation

Goal: The resident will demonstrate the ACGME competencies of Practice-Based Learning and Improvement and Medical Knowledge by demonstrating achievement of Evidence-Based Medicine (EBM) skills.

Objectives:

1. The resident will demonstrate the ability to locate information in the medical literature using various types of information technology.

2. The resident will demonstrate the ability to appraise the information, collect it and assimilate the evidence from scientific studies into a Scholarly Presentation.

3. The resident will demonstrate how the information obtained through this exercise contributed to optimum patient care.

Method:

1. Each resident will be expected to perform up to 2 presentations over his/her four years of training.

2. Each presentation will last for approximately one hour and will occur during the first Thursday of each month between October and June.

3. Several months prior to the scheduled presentation the resident will discuss the chosen topic with Dr. Singareddy for appropriateness. The topic should be generated from a patient care issue.

4. The resident should meet with Dr. Singareddy on a regular (as necessary) basis to prepare for the presentation and to meet the objectives listed above.

5. The resident should also meet with medical library staff in order to become more familiar with utilizing information technology. Register at http://www.hmc.psu.edu/library/services/Instruction/classreg.htm

6. The presentation should adhere to the following outline:

    a. The presentation of the clinical case and the problem which will be addressed.
    b. The question or topic to be researched.
    c. Information used for analysis
    d. The evidence
    e. The conclusion
    f. How the information obtained contributed to optimum patient care.

7. It is strongly suggested that you make this a Power Point presentation. Also please include a handout and bibliography.

8. Please access the following website for an example of this exercise.
http://www.clinicalpsychiatrynews.com/article/PIIS0270664407703879/fulltext
See sample attached.

Sleep Can Protect Memories From Associative Interference

BY MARY JO M. DALES
Editorial Director

BOSTON — Sleep strengthens declarative memory, a finding that could one day be exploited to combat cognitive declines associated with dementia and neurologic disorders, Dr. Jeffrey M. Ellenbogen reported at the annual meeting of the American Academy of Neurology.

Sleep previously has been shown to improve motor, visual, and perceptual memories in humans, but this study is one of the first to substantiate a role for sleep in protecting declarative or consciously discussed memories from associative interference, said Dr. Ellenbogen of Harvard Medical School, Boston.

For the study, 48 healthy individuals, aged 18-30 years, were evaluated. No participants took any medications, and all had normal sleep patterns. Subjects were placed in one of four groups, and all were asked to remember 20 words, each of which was paired with an associated word cue.

All groups were tested for their abilities to remember the associated words 12 hours after learning the list. No one in the study was sleep deprived, but the subjects in two groups slept before testing and those in the other two groups did not.

The individuals who slept remembered 94% of the associations; those who did not sleep remembered 82% of the words. Those differences fell just short of statistical significance ($P = .06$).

The differences were marked, however, in the remaining two groups subjected to associative interference. For this part of the study, both groups also learned the same list of 20 word associations.

Again, one group slept and the other did not, and both groups were tested at 12 hours. But 12 minutes before they were tested on the list of words, both groups were subjected to associative interference. They were asked to learn a second list of 20 additional words related to the same word cues. Subjects who had slept and were introduced to the second list of words were able to recall 76% of the word associations from the first list. The subjects who had not slept were able to remember just 32% of the words. The difference in performance was highly significant (P less than .0001).

Sleep is ultimately a brain state that may hold the keys to understanding the neurobiology of memory consolidation, he said. The next step in his research will be to look at the relationships between sleep disorders, cognitive impairment, and neurologic disorders. Dr. Ellenbogen's research was supported by the National Institutes of Health and the University of Pennsylvania's Nassau Undergraduate Research Fund. ■

Depressive Symptoms, Not Hostility or Anxiety, Link to CAD

Depressive symptoms appear to correlate with the development of coronary artery disease, but hostility and anxiety may not, Jesse C. Stewart, Ph.D., and his associates reported.

Several studies have linked various negative emotions with the development of coronary artery disease in initially healthy subjects. But teasing out the relative contributions of depression, anxiety, and hostility has been difficult because they tend to overlap. Dr. Stewart and his associates of the University of Pittsburgh assessed a wide range of such symptoms in a prospective cohort study of subclinical atherosclerosis in healthy subjects aged 50-70 years.

The 324 subjects underwent ultrasonographic assessment of carotid intimal medial thickness (IMT), a noninvasive measure of subclinical atherosclerosis, as well as tests evaluating emotional factors, including the Beck Depression Inventory, the Beck Anxiety Inventory, the Cooke-Medley Hostility Scale, and the State-Trait Anger Expression Inventory.

During 3-year follow-up, only mild to moderate depressive symptoms correlated with the decreasing carotid IMT that signals progression of subclinical atherosclerosis. Hostility symptoms of anxiety, the experience of anger, and the expression of anger showed no correlation with carotid IMT change.

This study is the first ever to report an association between depressive symptoms and carotid IMT change, the investigators said (Arch. Gen. Psychiatry 2007;64:225-33).

The exact mechanism underlying this association is unclear, but depression is known to affect physiologic pathways also involved in atherosclerosis, such as autonomic nervous system dysfunction, hypothalamic-pituitary-adrenal axis dysregulation, inflammatory processes, and altered platelet function, they said.

A post hoc analysis of the data showed that IMT worsening was associated with somatic-vegetative symptoms of depression such as fatigue, sleep disturbance, loss of appetite, and anhedonia, but not associated with more cognitive-affective depressive symptoms such as sadness, pessimism, discontent, or indecisiveness.

—Mary Ann Moon

EVIDENCE-BASED PSYCHIATRIC MEDICINE

Neurocognitive Effects of Sleep Apnea

The Problem

You have a patient with an obvious high body mass index. His spouse tells you that he snores and experiences brief episodes of apnea. Polysomnographic recordings confirm a diagnosis of obstructive sleep apnea (OSA). You try to educate him to the sequelae of OSA.

The Question

What is known about the potential neurocognitive consequences of OSA?

The Analysis

First, we searched the Cochrane Database of Systematic Reviews (www.cochrane.org/reviews) but found no review articles on this topic. We then performed a Medline search that combined "sleep apnea" and "cognitive, or cognition."

BY JAN LEARD-HANSSON, M.D.

BY LAURENCE GUTTMACHER, M.D.

The Evidence

OSA is characterized by repetitive and transient upper-airway obstructions during sleep. Obstructions can be complete (apnea) or partial (hypopnea). OSA affects medical disorders such as hypertension, coronary artery disease, and diabetes mellitus (Cleve. Clin. J. Med. 2007;74:72-8). OSA also affects psychiatric disorders such as depression and anxiety, and—in children—hyperactivity and lowered IQ (Int. Rev. Psychiatry 2005;17:277-82). OSA has been estimated to occur in 2%-3% of children and adults (Curr. Opin. Pulm. Med. 2005;11:494-500).

Our search yielded a recently published review article (Acta Neurol. Scand. 2007;115:1-11). The authors first reviewed a number of studies showing common cognitive deficits in attention, concentration, vigilance, memory, and learning ability secondary to OSA. They then focused on the effects of OSA on executive functions, which they defined as a person's ability to respond in an adaptive manner to situations and to engage successfully in independent, purposive, and self-serving behavior. Executive functions are important in behavioral inhibition; set-shifting; self-regulation of affect; memory; and analysis/synthesis.

In all, 40 studies were included. The number of patients ranged from 8 to 199 (median, 24). Of these studies, 19 had fewer than 24 patients. Ages ranged from 40 to 65 years (median, 49 years). Education ranged from 9 to 15 years (median, 13 years), but only half of the studies reported education levels. The proportion of men ranged from 47% to 100%, and in 83% of the studies the patient group consisted of more than 75% men.

A control group was included in 31 of these studies. In 15 studies, a healthy control group was used, although only nine studies confirmed health by polysomnography; in six studies, heavy nonapneic snorers or patients with dementia, chronic obstructive pulmonary disease, or carbon monoxide poisoning were used; and in 10 studies, OSA patients receiving continuous positive airway pressure (CPAP) treatment were compared with OSA patients receiving placebo or conservative treatment.

The duration of CPAP treatment ranged from 1 week to 12 months (median, 8 weeks), with a median compliance with therapy of 5.3 hours per night. Twelve different standardized neuropsychological tests of executive functions were used. The number of tests applied varied from one or two tests in 20 studies to nine tests in three studies. Patient samples were mostly heterogeneous with respect to OSA severity.

In studies comparing healthy controls with OSA patients, the domains of executive function impairment were working memory, phonologic fluency, cognitive flexibility, and planning. CPAP treatment was shown to improve cognitive flexibility and planning, but deficits of working memory persisted after CPAP treatment, and only one study reported improvement in phonologic fluency. (The authors thought that it would be misleading to compare OSA patients with other patient groups, such as dementia patients, because cognitive defects are common sequelae of both groups.)

The Conclusion

The best available evidence shows that obstructive sleep apnea negatively affects numerous cognitive/executive functions, such as working memory (a system for temporarily storing and managing information required to carry out complex tasks, such as learning, reasoning, and comprehension); phonologic fluency (the ability to access verbal memory and retrieve words rapidly); cognitive flexibility (the ability to manage more than one aspect of a task at one time); and planning. Only some of these impairments—cognitive flexibility and planning—are reversible with CPAP.

These conclusions should be tempered by the limitations of the study. Of the 40 studies, 19 had fewer than 24 patients, and only one-half of the studies indicated patient education level. Level of education is an important variable affecting cognitive test performance, because high intelligence may protect against OSA cognitive impairment. Also, samples consisted mainly of men, and study groups were heterogeneous in terms of severity; the number of patients in different severity groups was not reported.

DR. LEARD-HANSSON *is a psychiatrist who practices in San Diego.* DR. GUTTMACHER *is chief of psychiatry at the Rochester (N.Y.) Psychiatric Center. They can be reached at cpnews@elsevier.com.*

JOURNAL CLUB

Goal: To improve residents' ability to search, understand and utilize current research literature.

Objectives:

1. Demonstrate the ability to search the research database.

2. Show how the information in the article was useful in providing appropriate clinical care.

3. Demonstrate ability to critically review a research article in a systematic manner.

4. Demonstrate an understanding of research methodology used in a recent scientific article.

PSYCHOTHERAPY COMPETENCIES

ACGME requirements instituted recently mandate that residency programs in Psychiatry must demonstrate that residents have achieved "competency" in at least the following forms of treatment: brief therapy, cognitive-behavioral therapy (CBT), combined psychotherapy and psychopharmacology, psychodynamic therapy and supportive therapy.

Please find attached a listing of Resident Psychotherapy Competencies. For each of the five therapies I have formulated goals and objectives with the help of several faculty members and information provided by the American Association of Directors of Psychiatry Residency Training (AADPRT). Please review the goals and objectives listed. They will be used to determine "competency" in these therapies. Tentative methods of assessment are listed for each competency. For most, these will be primarily through the traditional supervisor-resident teaching relationship.

Also enclosed is an evaluation check list for supervisors to document the achievement of each competency. By the end of their adult training, each resident is to have met a significant number of the goals and objectives of each psychotherapy listed. Inpatients, outpatients, or continuity outpatients may be used in order to demonstrate competency. Residents should inform their supervisor that he/she would like to work with an identified patient(s) using a chosen form of psychotherapy. The supervisor will then instruct and monitor progress made and, if successful, will document "competency" in that particular type of psychotherapy as defined above by initialing the evaluation form(s). Goals and objectives may be met with one patient and supervisor or it may take several patients and supervisors in order to meet all goals and objectives.

This is only a starting point but is necessary for our program to begin moving forward in this direction in order to comply with ACGME guidelines. There is no accepted definition of what it means to be competent in these psychotherapies or how to measure it so every residency program is struggling with the same issues. It is up to each residency program to define these terms. I would expect that over the next several years, experience would lead to some common concepts of "competence" that all residency programs could employ.

I would welcome feedback from residents and faculty on this issue. The goals and objectives are very comprehensive. I would envision a paring down of this to result in a realistic number of "core competencies".

RESIDENT PSYCHOTHERAPY COMPETENCIES

COGNITIVE-BEHAVIORAL THERAPY (CBT)

Goal:

The resident will develop an understanding of the theory behind cognitive-behavioral therapy. Residents will observe the techniques of CBT as used with patients in the Adult Partial Hospitalization Program and Adult Inpatient Program and learn how to apply the technique in those settings as well as with their outpatients.

Objectives:

A. Knowledge

1. The resident will know how to apply the techniques of CBT in the treatment of anxiety and depressive disorders.
2. The resident will demonstrate understanding of the basic principles of the cognitive model including the relationship of thoughts to emotion, behavior and physiology; the concept of automatic thoughts and cognitive distortions; the common cognitive errors; the significance and origin of core beliefs and relationship of schemas to dysfunctional thoughts and assumptions, behavioral strategies and psychopathology.
3. The resident will demonstrate understanding of the basic principles underlying the use of behavioral techniques including activity scheduling, exposure and response prevention, relaxation training, graded task assignment, exposure hierarchies/systematic desensitization.
4. The resident will demonstrate understanding of the basic principles underlying the use of cognitive techniques including identifying automatic thoughts, cognitive restructuring, problem solving, advantage/disadvantage analyses, examining the evidence, thought recording, and modification of core beliefs.
5. The resident will demonstrate understanding that continued education in cognitive behavioral therapy is necessary for further skill development.

B. Clinical skills

1. The resident will be able to apply cognitive techniques to psychiatric disorders.
2. The resident will be able to establish and maintain a therapeutic alliance.
3. The resident will be able to educate the patient about the cognitive model including the centrality of core beliefs/schemas, and the responsibilities of the patient in actively engaging in treatment.
4. The resident will be able to educate the patient about the core beliefs/schemas most relevant to the presenting problem, and help him/her understand the basic origin of these beliefs.
5. The resident will be able to structure and focus the therapy sessions including collaboratively setting the agenda, bridging from the previous session, reviewing

homework and assigning appropriate new homework, working on key problems, summarizing and closing the session, and eliciting and responding to feedback.

6. The resident will be able to utilize relaxation techniques, exposure and response prevention, and graded exposure to feared situations as the clinical situation indicates.
7. The resident will be able to employ the dysfunctional thought record and measure the impact this has on mood and behavior.
8. The resident will be able to present a cognitive behavioral formulation.

C. Clinical attitudes

1. The resident will appreciate the usefulness and application of cognitive-behavioral therapy to specific psychiatry disorders.
2. The resident will be empathic, respectful, curious, open, nonjudgmental, collaborative, able to tolerate ambiguity and display confidence in the efficacy of cognitive behavioral therapy.
3. The resident will be sensitive to sociocultural, socioeconomic, and educational issues that arise in the therapeutic relationship.

Methods of Evaluation:

A. By participation in didactic lectures
B. Individual supervision – longitudinal outpatient and clinical rotations
C. Review of hospital records

RESIDENT PSYCHOTHERAPY COMPETENCIES

SUPPORTIVE THERAPY

Goal:

The resident will understand the theory behind supportive psychotherapy and become familiar with the techniques and its use. The resident will demonstrate competence with supportive therapy in any or all of the following areas: consultation/liaison psychiatry, inpatient psychiatric units, partial hospitalization programs and longitudinal outpatients.

Objectives:

A. Knowledge

1. The resident will demonstrate knowledge that the principle objectives of supportive therapy are to maintain or improve the patient's self-esteem, minimize or prevent recurrence of symptoms, and to maximize the patient's adaptive capacities.
2. The resident will demonstrate understanding that the practice of supportive therapy is commonly utilized in many therapeutic encounters.
3. The resident will demonstrate knowledge that the patient-therapist relationship is of paramount importance.
4. The resident will demonstrate understanding that continued education in supportive therapy is necessary for further skill development.

B. Clinical skills

1. The resident will be able to identify patients suitable for supportive therapy.
2. The resident will be able to use the major techniques of supportive therapy (i.e. communication, confrontation, explanation, clarification and interpretation)
3. The resident will be able to give sound directive interventions when appropriate.
4. The resident will be able to use psychoeducation when indicated.
5. The resident will be able to effectively support the individual in a crisis situation.
6. The resident will be able to establish and maintain a therapeutic alliance.
7. The resident will be able to establish treatment goals.
8. The resident will be able to be responsive to the patient and give feedback and advice when appropriate.
9. The resident will be able to confront in a collaborative manner behaviors that are dangerous or damaging to the patient.
10. The resident will be able to support, promote, and recognize the patient's ability to achieve goals that will promote his/her well-being.
11. The resident will be able to provide strategies to manage problems with affect regulation, thought disorders, and impaired reality testing.

C. Clinical attitudes

1. The resident will appreciate the usefulness and application of supportive psychotherapy to specific psychiatric disorders.
2. The resident will be empathic, respectful, curious, open, nonjudgmental, collaborative, able to tolerate ambiguity and display confidence in the efficacy of supportive therapy.
3. The resident will be sensitive to sociocultural, socioeconomic, and educational issues that arise in the therapeutic relationship.
4. The resident will be open to review of audio or videotapes or direct observations of treatment sessions.

Methods of Evaluation:

A. Participation in didactic lectures
B. Individual supervision – longitudinal outpatient and clinical rotations
C. Review of hospital records

RESIDENT PSYCHOTHERAPY COMPETENCIES

COMBINED PSYCHOPHARMACOLOGY AND PSYCHOTHERAPY

Goal:

The resident will appreciate the importance and become skilled in the use of combining psychotherapy and psychopharmacology and will be able to use both in a variety of settings including inpatient, outpatient and partial hospitalization.

Objectives:

A. Knowledge

1. The resident will understand how the use of psychotherapy and psychoactive medication combined can lead to improved outcomes.
2. The resident will demonstrate knowledge of the diagnoses and clinical conditions which warrant consideration of psychopharmacological treatment in addition to psychotherapy, and psychotherapy in addition to psychopharmacology.
3. The resident will demonstrate knowledge of the specific indications for a recommendation of psychotherapy and psychopharmacology and the rationale for the type of psychotherapy and medication recommended.
4. The resident will demonstrate knowledge that taking medication may have multiple psychological and sociocultural meanings to a patient.
5. The resident will demonstrate understanding that continued education in combined psychotherapy and psychopharmacology is necessary for further skill development.

C. Clinical skills

1. The resident will be able to provide psychoeducation about diagnosis and the use of therapeutic options of psychotherapy and psychopharmacology.
2. The resident will be able to integrate biological and psychological aspects of a patient's history.
3. The resident will be able to identify factors leading to non compliance with medication.
4. The resident will be able to know when medications should and should not be used in the therapeutic context.

5. The resident will be able to use both medication and therapy according to accepted treatment practice patterns.
6. The resident will be able to understand the influences of other factors on combined psychotherapy and psychopharmacology such as conscious and unconscious aspects of the doctor-patient relationship, placebo effects, and concurrent medical conditions.
7. The resident will be able to use psychotherapeutic techniques to diminish resistance to and facilitate use of medication when appropriate.
8. The resident will be able to understand and explore the psychological and sociocultural meaning to a patient of taking medication.
9. The resident will be able to collaborate effectively with non-psychiatric psychotherapists and respond to conflicts and problems in the three-person treatment as the clinical situation dictates.

C. Clinical attitudes

1. The resident will be empathic, respectful, curious, open, nonjudgmental, collaborative, able to tolerate ambiguity and display confidence in the efficacy of combined psychotherapy and psychopharmacology.
2. The resident will be sensitive to sociocultural, socioeconomic, and educational issues and belief systems that arise in the therapeutic setting.
3. The resident will understand that treatment is integrated such that the individual components of combined psychotherapy and psychopharmacology constitute the whole treatment and are not divisible into independent parts.
4. The resident will be open to review of audio or videotapes or direct observations of treatment sessions.

Methods of Evaluation:

A. Participation in didactic presentations
B. Individual supervision – longitudinal outpatient and clinical rotations
C. PRITE scores

RESIDENT PSYCHOTHERAPY COMPETENCIES

BRIEF PSYCHOTHERAPY

Goal:

The resident will understand the theory and practice of brief psychotherapy in order to be competent in the use of this therapy with both in and outpatients.

Objectives:

A. Knowledge

1. The resident will demonstrate understanding of the spectrum of theoretical models and clinical concepts of brief therapy.
2. The resident will demonstrate understanding of the use of a focus and time limit as therapeutic tools.
3. The resident will demonstrate understanding of the course of brief therapy, including phases of the treatment.
4. The resident will demonstrate understanding of indications and contraindications for brief therapy.
5. The resident will demonstrate understanding that continued education in brief therapy is necessary for further skill development.

B. Clinical skills

1. The resident will be able to identify the specific achievable goals and objectives in the treatment plan amenable to treatment with brief therapy.
2. The resident will be able to set parameters for brief therapy (i.e. appropriate patient selection, length of therapy, etc.).
3. The resident will be able to effectively use crisis intervention, psychoeducation and/or community resources during brief therapy.
4. The resident will be able to select suitable patients for the particular model chosen for brief therapy.
5. The resident will be able to establish and maintain a therapeutic alliance.
6. The resident will be able to establish and adhere to a time limit.
7. The resident will be able to establish and adhere to a focus.
8. The resident will be able to educate the patient about the goals, objectives, and time frame of brief therapy.

C. Clinical attitudes

1. The resident will be empathic, respectful, curious, open, nonjudgmental, collaborative, able to tolerate ambiguity and display confidence in the efficacy of brief therapy.

2. The resident will be sensitive to sociocultural, socioeconomic, and educational issues that arise in the therapeutic setting.
3. The resident will be open to review of audio or videotapes or direct observations of treatment sessions.

Methods of Evaluation:

A. Participation in didactics
B. Individual supervision – longitudinal outpatient and clinical rotations

RESIDENT PSYCHOTHERAPY COMPETENCIES

PSYCHODYNAMIC PSYCHOTHERAPY

Goal:

The resident will understand and be able to apply the principles of psychoanalytic theory to diagnosis and treatment in outpatient and inpatient settings. To accomplish this lectures, case conferences and supervision will be utilized over the four years of the residency program.

Objectives:

A. Knowledge

1. The resident will understand the core concepts of psychodynamic theory including the tenets of topographical and structural theory.
2. The resident will be knowledgeable about the dynamics of symptom formation and the neurotic process.
3. The resident will be able to integrate emerging neuro-biological findings with psychodynamic theory.
4. The resident will be familiar with dream theory and its clinical applications.
5. The resident will demonstrate understanding of the indications and contraindications for the psychiatric disorders and problems treated by psychodynamic psychotherapy.

B. Clinical Skills

1. The resident will demonstrate an ability to effectively interview a patient to elicit dynamically useful data.
2. The resident will be able to develop and communicate a dynamic case formulation based on all available data.
3. The resident will be able to recognize and effectively deal with transference and counter transference.
4. The resident will develop the skills necessary to recognize dynamic themes and then develop clinical interventions including interpretations and clarifications.
5. The resident will be able to effectively deal with resistance, confrontation and patient withdrawal.
6. The resident will develop skills in establishing and maintaining a therapeutic alliance.
7. The resident will develop skills in dealing with out of session crises, phone calls, missed appointments, and termination issues.
8. The resident will be able to evaluate the capacity of the patient to engage in and utilize psychodynamic psychotherapy.

C. Clinical Attitudes

1. The resident will be comfortable and non-judgmental with patients of all ages, sexes, sexual orientation, cultures, religions, and ethnicities.
2. The resident will be able to maintain a level of compassion and perspective in the face of confrontation, acting out and non-compliance.
3. The resident will become introspective enough to recognize when counter transference is interfering with or influencing responses to the patient.
4. The resident will respect the confidentiality of all patient and professional communications.
5. The resident will strictly limit all interactions with patients to professional contact in line with the highest ethical standards of the profession both during and after formal therapy sessions.
6. The resident will always remain the patient's advocate.

Methods of Evaluation:

A. By participation in didactic lectures
B. Psychodynamic "mock oral"
C. PRITE Exam
D. Columbia Psychotherapy Skills Test
E. Individual supervision/instruction – longitudinal outpatient and clinical rotations
F. Psychodynamic case write-up including psychodynamic formulation

PSYCHOTHERAPY COMPETENCY EVALUATION FORM
BRIEF THERAPY

Skill Apparent - The resident consistently shows an ability to implement the skill

Methods of Evaluation - **R**: Participation in Rounds/Didactics **T**: Test Scores
S: Individual Supervision **M**: "Mock Oral" Exam
C: Review of Patient Chart **F**: Case Write-Ups/Formulations

A. Knowledge

	Skill Apparent (initial as attained)	Method of Evaluation
1. The resident will demonstrate understanding of the use of a focus and time limit as therapeutic tools.		
2. The resident will demonstrate understanding of the course of brief therapy, including phases of the treatment.		
3. The resident will demonstrate understanding of the use of brief therapy in the overall treatment needs of the patient.		
4. The resident will demonstrate understanding that continued education in brief therapy is necessary for further skill development.		

B. Clinical Skills

1. The resident will be able to identify the specific achievable goals and objectives in the treatment plan amenable to treatment with brief therapy.		
2. The resident will be able to set parameters for brief therapy (i.e. appropriate patient selection, length of therapy, etc.).		
3. The resident will be able to effectively use crisis intervention, psychoeducation and/or community resources during brief therapy.		
4. The resident will be able to select suitable patients for the particular model chosen for brief therapy.		
5. The resident will be able to establish and maintain a therapeutic alliance.		
6. The resident will be able to establish and adhere to a time limit.		
7. The resident will be able to establish and adhere to a focus.		
8. The resident will be able to utilize at least one well-defined model of brief therapy.		
9. The resident will be able to educate the patient about the goals, objectives, and time frame of brief therapy.		

C. Clinical Attitudes

1. The resident will be empathic, respectful, curious, open, nonjudgmental, collaborative, able to tolerate ambiguity and display confidence in the efficacy of brief therapy.		
2. The resident will be sensitive to sociocultural, socioeconomic, and educational issues that arise in the therapeutic setting.		

Comments:

Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____

PSYCHOTHERAPY COMPETENCY EVALUATION FORM
COGNITIVE-BEHAVIORAL THERAPY

Skill Apparent - The resident consistently shows an ability to implement the skill

Methods of Evaluation - **R**: Participation in Rounds/Didactics
S: Individual Supervision
C: Review of Patient Chart
T: Test Scores
M: "Mock Oral" Exam
F: Case Write-Ups/Formulations

A. Knowledge

	Skill Apparent (initial as attained)	Method of Evaluation
1. The resident will know how to apply the techniques of CBT in the treatment of anxiety and depressive disorders.		
2. The resident will demonstrate understanding of the basic principles of the cognitive model including the relationship of thoughts to emotion, behavior and physiology; the concept of automatic thoughts and cognitive distortions; the common cognitive errors; the significance and origin of core beliefs and relationship of schemas to dysfunctional thoughts and assumptions, behavioral strategies and psychopathology.		
3. The resident will demonstrate understanding of the basic principles underlying the use of behavioral techniques including activity scheduling, exposure and response prevention, relaxation training, graded task assignment, exposure hierarchies/systematic desensitization.		
4. The resident will demonstrate understanding of the basic principles underlying the use of cognitive techniques including identifying automatic thoughts, cognitive restructuring, problem solving, advantage/disadvantage analyses, examining the evidence, thought recording, and modification of core beliefs.		
5. The resident will demonstrate understanding that continued education in cognitive behavioral therapy is necessary for further skill development.		

B. Clinical Skills

1. The resident will be able to apply cognitive techniques to psychiatric disorders.		
2. The resident will be able to establish and maintain a therapeutic alliance.		
3. The resident will be able to educate the patient about the cognitive model including the centrality of core beliefs/schemas, and the responsibilities of the patient in actively engaging in treatment.		
4. The resident will be able to educate the patient about the core beliefs/schemas most relevant to the presenting problem, and help him/her understand the basic origin of these beliefs.		
5. The resident will be able to structure and focus the therapy sessions including collaboratively setting the agenda, bridging from the previous session, reviewing homework and assigning appropriate new homework, working on key problems, summarizing and closing the session, and eliciting and responding to feedback.		
6. The resident will be able to utilize relaxation techniques, exposure and response prevention, and graded exposure to feared situations as the clinical situation indicates.		
7. The resident will be able to employ the dysfunctional thought record and measure the impact this has on mood and behavior.		
8. The resident will be able to present a cognitive behavioral formulation		

C. Clinical Attitudes

1. The resident will appreciate the usefulness and application of cognitive-behavioral therapy to specific psychiatry disorders.		
2. The resident will be empathic, respectful, curious, open, nonjudgmental, collaborative, able to tolerate ambiguity and display confidence in the efficacy of cognitive behavioral therapy.		
3. The resident will be sensitive to sociocultural, socioeconomic, and eductional issues that arise in the therapeutic relationship.		

Comments:

Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____

PSYCHOTHERAPY COMPETENCY EVALUATION FORM
COMBINED PSYCHOPHARMACOLOGY AND PSYCHOTHERAPY

Skill Apparent - The resident consistently shows an ability to implement the skill

Methods of Evaluation - **R**: Participation in Rounds/Didactics **T**: Test Scores
S: Individual Supervision **M**: "Mock Oral" Exam
C: Review of Patient Chart **F**: Case Write-Ups/Formulations

A. Knowledge

	Skill Apparent (initial as attained)	Method of Evaluation
1. The resident will understand how the use of psychotherapy and psychoactive medication combined can lead to improved outcomes.		
2. The resident will demonstrate knowledge of the diagnoses and clinical conditions which warrant consideration of psychopharmacological treatment in addition to psychotherapy, and psychotherapy in addition to psychopharmacology.		
3. The resident will demonstrate knowledge of the specific indications for a recommendation of psychotherapy and psychopharmacology and the rationale for the type of psychotherapy and medication recommended.		
4 The resident will demonstrate knowledge that taking medication may have multiple psychological and sociocultural meanings to a patient.		
5. The resident will demonstrate understanding that continued education in combined psychotherapy and psychopharmacology is necessary for further skill development.		

B. Clinical Skills

1. The resident will be able to provide psychoeducation about diagnosis and the use of therapeutic options of psychotherapy and psychopharmacology.		
2. The resident will be able to integrate biological and psychological aspects of a patient's history.		
3. The resident will be able to identify factors leading to non compliance with medication.		
4. The resident will be able to use both medication and therapy according to accepted treatment practice patterns.		
5. The resident will be able to monitor the patient's condition and modify the psychotherapeutic or psychopharmacologic approach when necessary.		
6. The resident will be able to understand the influences of other factors on combined psychotherapy and psychopharmacology such as conscious and unconscious aspects of the doctor-patient relationship, placebo effects, and concurrent medical conditions.		
7. The resident will be able to use psychotherapeutic techniques to diminish resistance to and facilitate use of medication when appropriate.		
8. The resident will be able to understand and explore the psychological and sociocultural meaning to a patient of taking medication.		
9. The resident will be able to collaborate effectively with non-psychiatric psychotherapists and respond to conflicts and problems in the three-person treatment as the clinical situation dictates.		

C. Clinical Attitudes

1. The resident will be empathic, respectful, curious, open, nonjudgmental, collaborative, able to tolerate ambiguity and display confidence in the efficacy of combined psychotherapy and psychopharmacology.		
2. The resident will be sensitive to sociocultural, socioeconomic, and educational issues and belief systems that arise in the therapeutic setting.		
3. The resident will understand that treatment is integrated such that the individual components of combined psychotherapy and psychopharmacology constitute the whole treatment and are not divisible into independent parts.		
4. The resident will be open to review of audio or videotapes or direct observations of treatment sessions.		

Comments:

Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____

PSYCHOTHERAPY COMPETENCY EVALUATION FORM
SUPPORTIVE THERAPY

Skill Apparent - The resident consistently shows an ability to implement the skill

Methods of Evaluation - **R**: Participation in Rounds/Didactics **T**: Test Scores
S: Individual Supervision **M**: "Mock Oral" Exam
C: Review of Patient Chart **F**: Case Write-Ups/Formulations

	Skill Apparent (initial as attained)	Method of Evaluation
A. Knowledge		
1. The resident will demonstrate knowledge that the principle objectives of supportive therapy are to maintain or improve the patient's self-esteem, minimize or prevent recurrence of symptoms, and to maximize the patient's adaptive capacities.		
2. The resident will demonstrate understanding that the practice of supportive therapy is commonly utilized in many therapeutic encounters.		
3. The resident will demonstrate knowledge that the patient-therapist relationship is of paramount importance.		
4. The resident will demonstrate knowledge of indications and contraindications for supportive therapy.		
5. The resident will demonstrate understanding that continued education in supportive therapy is necessary for further skill development.		
B. Clinical Skills		
1. The resident will be able to use the major techniques of supportive therapy (i.e. communication, confrontation, explanation, clarification and interpretation)		
2. The resident will be able to give sound directive interventions when appropriate.		
3. The resident will be able to use psychoeducation when indicated.		
4. The resident will be able to effectively support the individual in a crisis situation.		
5. The resident will be able to establish and maintain a therapeutic alliance.		
6. The resident will be able to establish treatment goals.		
7. The resident will be able to be responsive to the patient and give feedback and advice when appropriate.		
8. The resident will be able to determine which interventions are in the best interest of the patient and exercise caution about basing interventions on his/her own beliefs and values.		
9. The resident will be able to confront in a collaborative manner behaviors that are dangerous or damaging to the patient.		
10. The resident will be able to provide strategies to manage problems with affect regulation, thought disorders, and impaired reality testing.		
11. The resident will be able to provide education and advice about the patient's psychiatric condition, treatment and adaptation while being sensitive to specific community systems of care and sociocultural issues.		

C. Clinical Attitudes

1. The resident will appreciate the usefulness and application of supportive psychotherapy to specific psychiatric disorders.		
2. The resident will be empathic, respectful, curious, open, nonjudgmental, collaborative, able to tolerate ambiguity and display confidence in the efficacy of supportive therapy.		
3. The resident will be sensitive to sociocultural, socioeconomic, and educational issues that arise in the therapeutic relationship.		
4. The resident will be open to review of audio or videotapes or direct observations of treatment sessions.		

Comments:

Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____

PSYCHOTHERAPY COMPETENCY EVALUATION FORM
PSYCHODYNAMIC THERAPY

Skill Apparent - The resident consistently shows an ability to implement the skill

Methods of Evaluation - **R**: Participation in Rounds/Didactics
S: Individual Supervision
C: Review of Patient Chart
T: Test Scores
M: "Mock Oral" Exam
F: Case Write-Ups/Formulations

A. Knowledge

	Skill Apparent (initial as attained)	Method of Evaluation
1. The resident will understand the core concepts of psychodynamic theory including the tenets of topographical and structural theory.		
2. The resident will understand the basic principles behind the object relations theory.		
3. The resident will be knowledgeable about the dynamics of symptom formation and the neurotic process.		
4. The resident will be familiar with dream theory and its clinical applications.		
5. The resident will demonstrate understanding of the indications and contraindications for the psychiatric disorders and problems treated by psychodynamic psychotherapy.		

B. Clinical Skills

1. The resident will demonstrate an ability to effectively interview a patient to elicit dynamically useful data.		
4. The resident will develop the skills necessary to recognize dynamic themes and then develop clinical interventions including interpretations and clarifications.		
5. The resident will be able to effectively deal with resistance, confrontation and patient withdrawal.		
6. The resident will develop skills in establishing and maintaining a therapeutic alliance.		
7. The resident will develop skills in dealing with out of session crises, phone calls, missed appointments, and termination issues.		
8. The resident will be able to evaluate the capacity of the patient to engage in and utilize psychodynamic psychotherapy.		

C. Clinical Attitudes

1. The resident will be comfortable and non-judgmental with patients.		
2. The resident will be able to maintain a level of compassion and perspective in the face of confrontation, acting out and non-compliance.		
3. The resident will become introspective enough to recognize when counter transference is interfering with or influencing responses to the patient.		
4. The resident will respect the confidentiality of all patient and professional communications.		
5. The resident will strictly limit all interactions with patients to professional contact in line with the highest ethical standards of the profession both during and after formal therapy sessions.		

Comments:

Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____
Supervisor's Signature (initials) _____ Date: _____
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Compact Between Resident Physicians and Their Teachers

January 2006

www.aamc.org/residentcompact

The *Compact Between Resident Physicians and Their Teachers* is a declaration of the fundamental principles of graduate medical education (GME) and the major commitments of both residents and faculty to the educational process, to each other and to the patients they serve. The Compact's purpose is to provide institutional GME sponsors, program directors and residents with a model statement that will foster more open communication, clarify expectations and re-energize the commitment to the primary educational mission of training tomorrow's doctors.

The Compact was originated by the AAMC and its principles are supported by the following organizations:

Accreditation Council for Graduate Medical Education
American Academy of Allergy, Asthma and Immunology
American Academy of Dermatology
American Academy of Family Physicians
American Academy of Physical Medicine and Rehabilitation
American Association for Thoracic Surgery
American Board of Medical Specialties
American College of Obstetricians and Gynecologists
American College of Physicians
American Gastroenterological Association
American Hospital Association, Committee on Health Professions
American Medical Women's Association
American Orthopaedic Association
American Osteopathic Association
American Pediatric Society
American Society for Reproductive Medicine
Association of Academic Health Centers
Association of Academic Physiatrists
Association of American Medical Colleges
Association of Departments of Family Medicine
Association of Medical School Pediatric Department Chairs
Association of Professors of Dermatology
Association of Professors of Gynecology and Obstetrics
Association of University Anesthesiologists
Association of University Professors of Ophthalmology
Association of University Radiologists
Council of Medical Specialty Societies
Federation of State Medical Boards
National Board of Medical Examiners®
National Resident Matching Program
Society of Chairmen of Academic Radiology Departments
Society of Teachers of Family Medicine
Society of University Otolaryngologists-Head and Neck Surgeons

Compact Between Resident Physicians and Their Teachers

Residency is an integral component of the formal education of physicians. In order to practice medicine independently, physicians must receive a medical degree and complete a supervised period of residency training in a specialty area. To meet their educational goals, resident physicians must participate actively in the care of patients and must assume progressively more responsibility for that care as they advance through their training. In supervising resident education, faculty must ensure that trainees acquire the knowledge and special skills of their respective disciplines while adhering to the highest standards of quality and safety in the delivery of patient care services. In addition, faculty are charged with nurturing those values and behaviors that strengthen the doctor-patient relationship and that sustain the profession of medicine as an ethical enterprise.

Core Tenets of Residency Education

Excellence in Medical Education

Institutional sponsors of residency programs and program faculty must be committed to maintaining high standards of educational quality. Resident physicians are first and foremost learners. Accordingly, a resident's educational needs should be the primary determinant of any assigned patient care services. Residents must, however, remain mindful of their oath as physicians and recognize that their responsibilities to their patients always take priority over purely educational considerations.

Highest Quality Patient Care and Safety

Preparing future physicians to meet patients' expectations for optimal care requires that they learn in clinical settings epitomizing the highest standards of medical practice. Indeed, the primary obligation of institutions and individuals providing resident education is the provision of high quality, safe patient care. By allowing resident physicians to participate in the care of their patients, faculty accept an obligation to ensure high quality medical care in all learning environments.

Respect for Residents' Well-Being

Fundamental to the ethic of medicine is respect for every individual. In keeping with their status as trainees, resident physicians are especially vulnerable and their well-being must be accorded the highest priority. Given the uncommon stresses inherent in fulfilling the demands of their training program, residents must be allowed sufficient opportunities to meet personal and family obligations, to pursue recreational activities, and to obtain adequate rest.

Commitments of Faculty

1. As role models for our residents, we will maintain the highest standards of care, respect the needs and expectations of patients, and embrace the contributions of all members of the healthcare team.

2. We pledge our utmost effort to ensure that all components of the educational program for resident physicians are of high quality, including our own contributions as teachers.

3. In fulfilling our responsibility to nurture both the intellectual and the personal development of residents, we commit to fostering academic excellence, exemplary professionalism, cultural sensitivity, and a commitment to maintaining competence through life-long learning.

4. We will demonstrate respect for all residents as individuals, without regard to gender, race, national origin, religion, disability or sexual orientation; and we will cultivate a culture of tolerance among the entire staff.

5. We will do our utmost to ensure that resident physicians have opportunities to participate in patient care activities of sufficient variety and with sufficient frequency to achieve the competencies required by their chosen discipline. We also will do our utmost to ensure that residents are not assigned excessive clinical responsibilities and are not overburdened with services of little or no educational value.

6. We will provide resident physicians with opportunities to exercise graded, progressive responsibility for the care of patients, so that they can learn how to practice their specialty and recognize when, and under what circumstances, they should seek assistance from colleagues. We will do our utmost to prepare residents to function effectively as members of healthcare teams.

7. In fulfilling the essential responsibility we have to our patients, we will ensure that residents receive appropriate supervision for all of the care they provide during their training.

8. We will evaluate each resident's performance on a regular basis, provide appropriate verbal and written feedback, and document achievement of the competencies required to meet all educational objectives.

9. We will ensure that resident physicians have opportunities to partake in required conferences, seminars and other non-patient care learning experiences and that they have sufficient time to pursue the independent, self-directed learning essential for acquiring the knowledge, skills, attitudes, and behaviors required for practice.

10. We will nurture and support residents in their role as teachers of other residents and of medical students.

Commitments of Residents

1. We acknowledge our fundamental obligation as physicians—to place our patients' welfare uppermost; quality health care and patient safety will always be our prime objectives.
2. We pledge our utmost effort to acquire the knowledge, clinical skills, attitudes and behaviors required to fulfill all objectives of the educational program and to achieve the competencies deemed appropriate for our chosen discipline.
3. We embrace the professional values of honesty, compassion, integrity, and dependability.
4. We will adhere to the highest standards of the medical profession and pledge to conduct ourselves accordingly in all of our interactions. We will demonstrate respect for all patients and members of the health care team without regard to gender, race, national origin, religion, economic status, disability or sexual orientation.
5. As physicians in training, we learn most from being involved in the direct care of patients and from the guidance of faculty and other members of the healthcare team. We understand the need for faculty to supervise all of our interactions with patients.
6. We accept our obligation to secure direct assistance from faculty or appropriately experienced residents whenever we are confronted with high-risk situations or with clinical decisions that exceed our confidence or skill to handle alone.
7. We welcome candid and constructive feedback from faculty and all others who observe our performance, recognizing that objective assessments are indispensable guides to improving our skills as physicians.
8. We also will provide candid and constructive feedback on the performance of our fellow residents, of students, and of faculty, recognizing our life-long obligation as physicians to participate in peer evaluation and quality improvement.
9. We recognize the rapid pace of change in medical knowledge and the consequent need to prepare ourselves to maintain our expertise and competency throughout our professional lifetimes.
10. In fulfilling our own obligations as professionals, we pledge to assist both medical students and fellow residents in meeting their professional obligations by serving as their teachers and role models.

This compact serves both as a pledge and as a reminder to resident physicians and their teachers that their conduct in fulfilling their obligations to one another is the medium through which the profession perpetuates its standards and inculcates its ethical values.

For more information about the Compact, go to www.aamc.org/residentcompact