ACGME Requirements
Review and Comment Form

Title of Requirements	Common Program Requirements, Section VI

Organizations submitting comments should indicate whether the comments represent a consensus opinion of its membership or whether they are a compilation of individual comments.

Select [X] only one	
Organization (consensus opinion of membership)	X
Organization (compilation of individual comments)	
Review Committee	
Designated Institutional Official	
Program Director in the Specialty	
Resident/Fellow	
Other (specify):	

Name	Art Walaszek, MD
Title	President and Chair of the ACGME Liaison Committee
Organization	American Association of Directors of Psychiatric Residency Training

As part of the ongoing effort to encourage the participation of the graduate medical education community in the process of revising requirements, the ACGME may publish some or all of the comments it receives on the ACGME website. By submitting your comments, the ACGME will consider your consent granted. If you or your organization does not consent to the publication of any comments, please indicate such below.

The ACGME welcomes comments, including support, concerns, or other feedback, regarding the proposed requirements. For focused revisions, only submit comments on those requirements being revised. Comments must be submitted electronically and must reference the requirement(s) by both line number and requirement number. Add rows as necessary.

	Line Number(s)	**Requirement Number**	**Comment(s)/Rationale**
1	68-70 101-109 117-122	VI.A.1.a).(1).(a) VI.A.1.a).(3).(a) VI.A.1.a).(3).(c)	We do not believe that program directors have the authority to require faculty to participate in patient safety systems. Rather this should be responsibility of each service, department, or sponsoring institution.
2	110-115	VI.A.1.a.(3).(b)	We are concerned that this requirement overlaps with or duplicates similar requirements elsewhere in the CPR (e.g., IV.A.5.c.4, IV.A.5.f.6) and the milestones (Psychiatry SBP 4.1/A). We recommend that all requirements related to patient safety and quality

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			improvement be listed in just one section of the CPR and synchronized with the milestones.
3	107-108	VI.A.1.a).(3).(a).(ii)	Many residencies have residents rotating at many different clinical sites. It is unreasonable to expect that residents will know the patient safety reporting procedures at all of these sites. We recommend that this requirement be limited to the principal site for each residency.
4	150-153	VI.A.1.b).(1).(a)	The responsibility for this requirement should rest at the level of the Sponsoring Institution rather than each individual residency. Also, attention to health care disparities may merit its own requirement, rather than being listed as an example of a QI process.
5	161-163	VI.A.1.b).(2).(a)	We feel this requirement is problematic for various reasons. First, in Psychiatry we have not yet reached consensus regarding quality metrics and benchmarks. Second, electronic medical record systems pose challenges in extracting resident-specific outcomes. Third, residencies may not have the ability to require the systems in which their residents work to provide such data.
6	228-229 255-257	VI.A.2.b).(1) VI.A.2.c).(3)	A critical component of the development of psychiatry residents is receiving weekly supervision of their case loads from faculty, a much more in-depth process than the word "oversight" suggests. The CPR should allow for flexibility in what RCs can specify with respect to supervision, and the Psychiatry RC should continue to require this sort of supervision.
7	264-267	VI.A.2.d).(1)	In the absence of valid and reliable evaluation tools, it will be difficult for program directors to evaluate residents' ability to take on progressive responsibility.
8	323	VI.B.2.c)	While we agree that it is important to address issues of workload and work compression, we would hope that RCs will not be overly prescriptive and that residencies will have some flexibility in determining case loads. Residents are sometimes relied on to do social work, and so we ask that "social workers" be added to the list of staff with non-physician obligations (box prior to line 322).
9	381-385	VI.C.1.a)	The reference to "administrative support" in this context is somewhat vague – does it refer to program coordinators, clinical support staff, or someone else? Residencies may have limited ability to dictate the provision of support staff at the various sites where residents rotate.
10	394-395	VI.C.1.d)	We agree that there should be programs in place to improve resident and faculty well-being. However, we

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			note that residencies do not have the ability to develop such program for faculty – rather, this responsibility lies with departments or sponsoring institutions. We also wonder where the financial responsibility for implementation of programs to improve well-being lies.
11	398-400	VI.C.1.d).1	We agree that residents must be given the opportunity to attend appointments during working hours. We would that this is also an opportunity for residents to demonstrate appropriate professionalism and communication, including ensuring coverage for patient care during those times and both providing and receiving handoffs.
12	403-410	VI.C.1.e)	With respect to services for physicians who are burnt out, depressed, etc., we recommend that the ACGME be more specific than "means to assist those who experience these conditions"; services should include "resources for routine and urgent assessment and treatment."
13	Box between 412 and 413	N/A	The instruments should include the Maslach Burnout Inventory, which is the gold standard in burnout research. The General Health Questionnaire is the GHQ-12, not GHQ-13. The most prevalent psychiatric disorder is anxiety, and none of the instruments listed screen for anxiety; we would recommend the GAD-7 or PHQ-4. Consider the AUDIT-C to screen for an alcohol use disorder.
14	414-419	VI.C.1.e).(1)	We have several concerns about this requirement. First, it cannot be the responsibility of the program director to monitor the well-being of faculty members; this responsibility lies with departments or sponsoring institutions – this should be made clear in the requirement. Second, we do not think people should be encouraged to report residents who may be burned out, depressed, etc., to program directors – after all, this would not be appropriate for other medical conditions; rather, the goal is fostering a climate where residents who are burned out, depressed, etc., can receive appropriate services. Monitoring of residents' well-being would help address the concern that residents may be reluctant to seek help on their own. Third, we note that once a program director becomes aware of such problems, s/he may have an obligation to report them on licensing and credentialing forms for residents; unfortunately, the stigmatizing and discriminatory practice of licensing boards and credentialing bodies asking for this information continues.

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15	425-427	VI.C.1.e).(3)	It should be made clear this this is the responsibility of the sponsoring institution, as no residency has the ability to create such a service. Similar to LCME requirements, no faculty member or resident should provide care to a resident they have supervised or could potentially supervise. We note that residencies and sponsoring institutions in less resourced communities may be less able to fulfill this requirement. "Mental health counseling and treatment" is redundant, and should be replaced with "mental health assessment and treatment." We ask that the ACGME clarify whether this requirement applies only to residents, or to faculty as well.

General Comments:

We appreciate the explanations provided in Dr. Nasca's letter to the community and in the "Background and Intent" boxes in the revised Common Program Requirements. We also appreciate the aspirational quality of these revisions, and the attention to the meaning of our work, and "joy in curiosity, problem-solving, intellectual rigor and discovery." We applaud the focus on resident well-being and we hope that it leads to the development of a culture of wellness in medicine. We would note that in Dr. Nasca's letter, it may be more accurate to state that physician depression and burnout **can** impair a physician's ability to provide excellent care; we would not want to imply that someone who is depressed is inherently a clinical risk, nor that someone who provides excellent care cannot be depressed or burnt out.

Our method for developing the consensus opinion of our membership was as follows: We asked the members of our Executive Committee and our Regional Representatives to review the proposed revisions. We then identified common themes from their feedback and proposed a consensus statement. We then surveyed our general membership (resident program directors and associate program directors, fellowship directors), asking them if they agreed with the consensus or if they had recommendations for revising the consensus statement. Our Steering Committee used feedback from our general membership to finalize the consensus statement.

With respect to the proposed changes to the duty hours, we support this move towards greater flexibility. We surveyed our membership in January 2016 and summarized our recommendations in a letter to the ACGME on January 24, 2016. We have attached this letter for your reference.