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Psychiatry Residency Training Organizational Chart

- **Adult Program Director:** Sidney Zisook
- **Outpatient Site Director:** David Janowsky
- **CAPS Site Director:** Christopher Rich
- **VA Site Director:** Sanjai Rao
- **UCSD Hospital Site Director:** Louisa Steiger
- **Psychotherapy Director:** Alana Igelwicz
- **Curriculum Committee Chair:** Nicole Lanouette
- **Combined Program Director:** David Folsom
- **Research Track Director:** Neal Swerdlow
- **Community Psychiatry Fellowship:** David Folsom
- **Child Program Director:** Ellen Heyneman
- **Geriatric Program Director:** Daniel Sewell
- **Associate Training Directors:** Kristin Cadenhead, Sanjai Rao
- **Psychotherapy Director:** Alana Igelwicz
Introduction

The primary objective of our residency training program is to train academically knowledgeable, clinically astute and caring psychiatrists. Our clinically based program offers experiences in inpatient, outpatient, consultation-liaison, geriatric, community, forensic, substance abuse, and child and adolescent psychiatry. Throughout training, biological, psychological and sociocultural factors are integrated so that the resident becomes adept at selecting and utilizing the most current methods of biotherapy, psychotherapy and sociotherapy. While emphasizing clinical psychiatry, the residency program provides ample opportunity for the resident to learn and develop administrative, teaching and research skills.

Our departmental faculty is deeply committed to the intellectual growth and emotional well-being of our residents. Learning is reinforced through careful supervision of all clinical work; comprehensive didactic seminars that build on each other and are integrated with the clinical program, case conferences, grand rounds, journal clubs and the mentorship program. Residents actively participate in all levels of training and planning. Evaluation of the program, its trainees and its faculty, receives the highest departmental priority.

Our four-year residency in adult psychiatry is seen as part of a continuum from medical school, through further fellowship training and/or a career in psychiatry. We expect a high level of clinical competence and a thorough understanding of the principles continued excellence and growth. Upon completion of the program, residents are expected to be competent in the core areas of patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, professionalism, and systems-based practice. In addition, all graduates should be well grounded in sophisticated psychiatric diagnosis and balanced, state-of-the-art treatment. The program takes into account differences in each resident’s prior training, clinical skills, and future interests, and is flexible in tailoring the program to individual needs. Each resident will have the same core clinical and educational experience, as well as some “elective” time in PG Years 3 and 4 to pursue special areas of interest.

The UC San Diego Department of Psychiatry is fully accredited by the Accreditation Council for Graduate Medical Education and offers both a four and three-year residency program. Applicants from medical schools throughout the country are selected in a highly personal way. A limited number of applicants are accepted in order to insure close, personal contact between faculty and residents. Our program has up to 40 residents and 16 fellows. In addition to formal postgraduate psychiatry training, the Department of Psychiatry participates in the training of medical students, primary care physicians, neurology residents, social workers, registered nurses, vocational rehabilitation counselors, psychologists, psychiatric technicians and paraprofessional drug abuse counselors enrolled in affiliated training programs.
## Rotations

<table>
<thead>
<tr>
<th>Year</th>
<th>7 4-Week Blocks</th>
<th>2 4-Week Blocks</th>
<th>4 4-Week Blocks</th>
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<tbody>
<tr>
<td>Inpatient Psychiatry*</td>
<td>Neurology</td>
<td>Primary Care</td>
<td></td>
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*Includes 2 weeks night float (which provides experience in both Emergency and Consultation-Liaison Psychiatry)

<table>
<thead>
<tr>
<th>Year</th>
<th>6 4-Week Blocks</th>
<th>2 4-Week Blocks</th>
<th>2 4-Week Blocks</th>
<th>1 4-Week Block</th>
<th>1 4-Week Block</th>
<th>1 4-Week Block</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Psychiatry*</td>
<td>Inpatient Addiction Psychiatry (ADTP)</td>
<td>Inpatient Child Psychiatry (CAPS)</td>
<td>Consultation Liaison Psychology (C/L)</td>
<td>Inpatient Geriatric Psychiatry (Geropsychiatry)</td>
<td>Emergency Psychiatry Clinic (PEC)</td>
<td></td>
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- One afternoon weekly Mental Health Primary Care or other Specialty Clinic (10%)
- Forensic experience including commitment, assessment of potential to harm self or others, written forensic reports and providing testimony.
- Experiences in evaluation, crisis evaluation, management, and triage of emergency psychiatric patients
- Up to 2 4-week blocks research elective for research track residents may replace 1 block of Inpatient Psychiatry and 1 block of Addiction Psychiatry
- *Includes 4 weeks night float (which provides experience in both Emergency and Consultation-Liaison Psychiatry)

<table>
<thead>
<tr>
<th>Year</th>
<th>12 Months</th>
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<tr>
<td>Outpatient Psychiatry (including experience in Community Psychiatry, exposing residents to persistently and chronically-ill patients in the public sector and providing 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).</td>
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(90-100%)

- On half day weekly elective specialty continuity clinic and / or research for all residents (0-10%) and up to 2-days weekly research elective for research track residents (0-40%)
- Additional addiction, geriatric, forensic, community and emergency psychiatry clinical outpatient experiences.

<table>
<thead>
<tr>
<th>Year</th>
<th>12 Months</th>
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<tr>
<td>Chief or Senior Resident (Outpatient Service, VA Medical Center General Inpatient or Addiction Service or Research (for Research Track Resident)*</td>
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*All General Residents - *2-3 half days weekly for Independent Study Project, Outpatients and/or Specialty Clinics (20-30%)
*Research Track Residents – At least 1½ days for Outpatients and/or Outpatient Specialty Clinics (30%)
Training Goals and Objectives

A. Introduction and Philosophy
The Adult Psychiatry Residency Training Program (RTP) at UCSD provides a four-year educational and training program in general adult psychiatry. The General Adult RTP is fully integrated to the Child & Adolescent, Geriatric Psychiatry, and Combined Family Medicine and Psychiatry RTPs at UCSD.

Residents join staff in providing superb comprehensive and coordinated care for adult patients. This care is based on best practices and evidence-based treatments framed within the view that no single conceptual framework is sufficient to understand human behavior. Residents are taught to approach patients and their families from a bio-psycho-social perspective that integrates biological, psychodynamic, cognitive-behavioral, sociological, and anthropological models and tools. They are challenged to understand clinical issues in depth and to attempt formulations that integrate conceptual models.

Our RTP recognizes that adequate training for the current and future practice of general adult psychiatry is, of necessity, demanding. Beyond attaining essential knowledge, skills and attitudes, residents need to develop a sense of professional identity that includes being a secure physician, an advocate for patients, a sensitive therapist, and a thoughtful participant or consultant within healthcare teams and systems of care. A primary goal of the RTP is to produce leaders in the field of adult psychiatry.

We have designed this program to foster the development of well-rounded, competent adult psychiatrists. Above all we value a serious and passionate commitment to the highest standards of patient care. Our philosophy emphasizes that fact that first and foremost, we are clinicians, dedicated and available to the needs of our patients. Training in brief and long-term individual therapy, couples, family and group therapy as practiced in various orientations (supportive, psychodynamic, pharmacotherapy, cognitive behavioral, systems, motivational interviewing) along with biological therapies (pharmacotherapy, electroconvulsive therapy, light treatment, sleep deprivation) delivered in crisis intervention, emergency, inpatient and outpatient settings is provided through supervised direct patient care, theoretical and evidence-based seminars, and demonstrations by skilled clinical practitioners, consultants, teachers, and administrators. We specifically encourage pilot research protocols and other scholarly experiences. Our philosophy emphasizes the concept that research and scholarship are fundamental extensions of being a physician and a psychiatrist.

We understand that residents will come to our program with different strengths and needs. Our overriding objective is to insure clinical competence in adult psychiatric diagnosis and treatment, while being flexible enough to support learning opportunities according to a resident’s particular strengths and interests. Ample elective time is provided to encourage exploration and acquisition of skills in specific psychiatric subspecialties.

Clinically based, the RTP offers experiences in inpatient, outpatient, consultation-liaison psychiatry, geriatric psychiatry, community psychiatry, substance abuse, emergency psychiatry, and child and adolescent psychiatry. Throughout the training, biological, psychological and sociocultural factors are integrated so that residents become versatile in selecting and utilizing all current methods of biotherapy, psychotherapy, and sociotherapy. While emphasizing clinical psychiatry, the residency program provides ample opportunity and expects the resident to learn and develop clinical,
administrative, teaching, and research skills. The RTP is under the direction and supervision of the Training Director, Sidney Zisook, M.D. The RTP is approved by the Accreditation Council of Graduate Medical Education’s (ACGME) Residency Review Committee for four years of training.

B. General Goals and Objectives
The major goals of the RTP at UCSD are to graduate psychiatrists who have mature clinical judgment; extensive knowledge about diagnosis, etiology, and treatment of all psychiatric disorders and common neurological disorders; competence to render effective professional care to patients; awareness of personal limitations; and recognition of the necessity of continuing their development throughout their professional careers.

The six ACGME general competencies as well as the psychiatry-specific competencies are an organizing principle for the training curriculum and assessment. Thus, we have developed goals and objectives that identify educational outcomes for each competence domain, broken down further into knowledge, skills, and attitudes. In addition, each clinical rotation in the RTP has specific educational objectives in the areas of knowledge, skills and attitudes. Each rotation is designed to provide a balanced mixture of clinical service, didactics, and supervision, which enable residents to attain those educational objectives. We also have identified educational outcomes for goals and objectives in the didactic components of the RTP.

Residents are supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience. The level of responsibility afforded to each resident must be determined by the teaching staff. By the time of graduation, all residents must demonstrate sufficient competence to enter practice without direct supervision and maintain lifelong learning.

C. Didactics Goals and Objectives

1. Crash Course

Knowledge

- Practical and systematic approach to the evaluation and treatment of psychiatric emergencies
- Practical and systematic approach to the evaluation and treatment of acute psychiatric conditions
- Familiarity with goals and objectives of training program
- Acquaintance with classmates and inpatient faculty
- Basic pharmacology that pertains to psychiatric emergencies and acute psychiatric conditions
- Culture of inpatient unit
- Community resources
- Third party payer system (i.e., HMO, Medical, Medicare, unfunded/indigent)
- Medical causes of delirium and acute psychosis
- Suicide and homocidal risk assessment
- Grave disability assessment and conservatorship
- Legal issue related to inpatient psychiatry
- Clinical pearls
Skills

- Initiate inpatient assessment procedures
- Initiate diagnostic assessment
- Initiate acute psychiatric treatment
- Perform mental status evaluation
- Ability to obtain informed consent from patients

Attitudes

- On time attendance, preparation for class, and participation in discussions
- Enthusiasm for learning psychiatry
- Enthusiasm for practicing psychiatry
- Desire to increase medical and psychiatric knowledge based on current literature and standards of practice
- Interest in seeking appropriate supervision regarding patient care
- Desire to maintain the highest standards of ethical and professional behavior in the care of patients

2. Psychiatric Interviewing and Supportive Psychotherapy

Knowledge

- Recognize how childhood maltreatment and adverse experiences underlie psychopathology in the adult.
- Understand how genetic load, neurodevelopmental abnormalities, medical morbidity, substance use, social support, and culture influence the clinical presentation, treatment plan, and prognosis of mental disorders commonly seen in inpatient settings.
- Discuss research evidence of non-conscious brain processes relevant to psychiatric interviewing and supportive psychotherapy.

Skills

- Elicit reliably the most common symptoms of psychopathology in acute inpatients.
- Use summarizing, reflective listening, empathic statements, and nonverbal communication to establish rapport with patients.
- Monitor affect changes during interactions with patients, and patients conscious and unconscious ways to avoid experiencing those changes.
- Demonstrate at least 3 techniques commonly used in supportive psychotherapy.
- Gather data from and educate family members and significant others effectively.
- Formulate treatment plans that consider the patient’s preference, current degree of motivation, and anticipated barriers to adherence.

Attitudes

- On time attendance, preparation for class, and participation in discussions
• Awareness of own emotional reactions to patients, and demonstrate curiosity and appreciation for patients’ backgrounds and life circumstances.
• Value the contribution of psychosocial and behavioral interventions to a comprehensive treatment plan.

3. **Psychopharmacology Crash Course**

**Knowledge**

• Basic and clinical psychopharmacology of mood stabilizers, antidepressants, antipsychotics
• Basic and clinical aspects of electroconvulsant treatment

**Skills**

• Ability to initiate inpatient treatment with mood stabilizers, antidepressants, antipsychotics
• Assess patients’ capacity to consent to treatment, obtain informed consent from patients who are able to, and obtain consent from pertinent others when patients are unable to consent (e.g., patient’s conservator)

**Attitudes**

• On time attendance, preparation for class, and participation in discussions
• Interest in learning more about biological treatments
• Interest in seeking appropriate supervision regarding medication treatment
• Awareness of limitations of current state of knowledge

4. **Introduction to Psychopathology and Psychiatric Treatment**

**Knowledge**

• Epidemiology, diagnostic issues and treatment of major psychiatric conditions
• Uses and limitations of key neuropsychological tests
• Reading evidence-based literature
• Ethical and legal issues relevant to acute inpatient care
• Principles of teaching medical students
• Human development through the life cycle

**Skills**

• Perform psychiatric assessment
• Initiate evidence-based psychiatric treatment in the context of relevant developmental and cultural issues

**Attitude**

• On time attendance, preparation for class, and participation in discussions.
• Desire to increase medical and psychiatric knowledge based on current literature and standards of practice.
• Desire to maintain the highest standards of ethical and professional behavior in care of patients.

**PGY 2**

1. **Cognitive Behavioral Therapy**

   **Knowledge**
   
   • Principles of patient selection, treatment principles and procedures of cognitive and other time limited therapies
   • Indications and limitations for cognitive and other time limited therapies

   **Skills**
   
   • Ability to utilize techniques of individual cognitive-behavioral therapy and other time-limited psychotherapies in work with patients.

   **Attitudes**
   
   • On time attendance, preparation for class, and participation in discussions.
   • Desire to increase medical and psychiatric knowledge based on current literature and standards of practice
   • Desire to maintain the highest standards of ethical and professional behavior in the care of patients
   • Participate actively in didactic, making relevant comments during discussions

2. **Foundations of Psychodynamic Psychotherapy**

   **Knowledge**
   
   • Principles of patient selection, treatment principles and procedures of psychodynamic psychotherapy
   • Indications and limitations for psychodynamic psychotherapy

   **Skills**
   
   • Ability to utilize techniques of individual psychodynamic psychotherapy

   **Attitudes**
   
   • On time attendance, preparation for class, and participation in discussions.
   • Desire to increase medical and psychiatric knowledge based on current literature and standards of practice
   • Desire to maintain the highest standards of ethical and professional behavior in the care of patients
• Participate actively in didactic, making relevant comments during discussions
• Appreciation of therapeutic alliance and countertransference in all therapeutic interactions.

3. **Psychopathology and Psychiatric Treatments - Part 2**

**Knowledge**

• Epidemiology, diagnostic issues and treatment of major psychiatric conditions
• Evidence based psychiatry and the Internet
• Suicidality – identification, treatment and prevention
• Key public health relevant effectiveness trials
• Ethical and legal issues relevant to hospital care
• Teaching skills -II
• Intensive Short term Dynamic Psychotherapy
• Alternative medicine and spirituality
• Death and dying
• Gender orientation and identity
• Research methodology
• Diversity
• Introduction to neuroscience
• Introduction to research methodology

**Skills**

• Perform psychiatric assessment
• Initiate evidenced based psychiatric treatment in the context of relevant developmental and cultural issues
• Critically read the literature
• Conduct focused searches of best available evidence and practices

**Attitude**

• On time attendance, preparation for class, and participation in discussions.
• Desire to increase medical and psychiatric knowledge based on current literature and standards of practice.
• Desire to maintain the highest standards of ethical and professional behavior in care of patients.
• Recognize the need for life-long learning and monitoring of one’s own practice

**PGY 3**

1. **Advanced Psychopharmacology**

**Knowledge**

• How to account for the developmental expression of psychopathology in evaluations
• How to use DSM-IV categories in selecting pharmacologic treatment disorders
• How to use the pathophysiology of psychiatric disorders to guide diagnostic hypotheses
• How to use mechanism of action and side effects of psychotropic medications to guide treatment
• How to prescribe psychotropics for psychiatric disorders
• Basic mechanism of pharmacologic actions
• Most common drug-drug interactions
• Evidence-based treatment guidelines and algorithms

Skills

• Ability to select appropriate medications using DSM-IV and prevailing evidence
• Ability to diagnose and treat co-occurring disorders
• Ability to design a first line psychotropic treatment
• Ability to communicate a diagnosis to parents and significant others with tact, compassion and sensibility to culture, health literacy level, and preparedness
• Ability to work with patients on a psychotropic treatment plan over the course of chronic psychiatric disorders
• Ability to evaluate and monitor patients being prescribed medications
• Ability to use medications in the most effective and safe manner consistent with current knowledge
• Work collaboratively to enhance patients’ adherence, and identify and problem-solve barriers to adherence
• Ability to manage appropriately side effects, adverse effects, and drug-drug interactions

Attitudes

• On time attendance, preparation for class, and participation in discussions.
• Ability to maintain an analytic and investigatory approach to pharmacologic treatment
• Desire to increase pharmacologic knowledge based on current literature and standards of practice
• Recognize the need for life-long learning and monitoring of one’s own practice
• Be willing to pursue continuing education and supervised experiences to keep one’s own practice commensurate with the community standard of care
• Desire to obtain information from electronic data bases and scientific literature in child and adolescent psychiatry and related fields.
• Will to remain abreast on scientific advances, new clinical approaches and investigation of clinical outcomes
• Recognize that the scientific literature is constantly evolving, that no one report or idea is necessarily true for all situations, and that the literature should be critically judged for its methodology and applicability

2. Forensics and Ethics

Knowledge

• How to detect and who must report abuse and neglect.
• Types of interventions and interview techniques to use when abuse is suspected but not obvious.
• Basic knowledge of the many legal issues involving psychiatric practice such as custody, parental rights, delinquency, protective services, malpractice, and confidentiality.
• Legal rights of children, adults, older adults, parents, foster parents, state agencies, hospitals and health care providers.
• Legal duties of hospitals, health care providers, teachers and others likely to be involved in abuse situations, and other situations involving the legal system and psychiatric patients
• Systems of protective services and other systems of care to call upon in emergency abuse situations as well as non-emergency situations.
• Basic understanding of the laws affecting the practice of clinical psychiatry including the administration of medications to special populations of children.
• Familiarity with APA and AMA Principles of Ethical Behavior.

Skills

• Ability to evaluate adults who might have been abused as children and adolescents.
• Ability to make decisions regarding the need to file for protective services.
• Ability to work with systems of care including schools, hospitals, clinics, community health care providers and others in the care of abused and neglected persons.
• Ability to seek appropriate consultation in regard to medical legal matters.
• Ability to testify in court if required in a professional and thorough manner.
• Ability to begin to conceptualize and write reports which might have bearing on legal proceedings.
• Ability to recognize normative and deviant sexual behavior.
• Ability to provide ethical care.
• Ability to analyze clinical conundrums using ethical principles.

Attitudes

• On time attendance, preparation for class, and participation in discussions.
• Ability to evaluate patients who might have been abused, or who have other legal issues, without counter-transference interference.
• Ability to work with the legal system, state agencies, systems of care and others involved with patients while bearing in mind the applicable laws, legal duties and ethical obligations.
• Ability to discuss observations of abuse / neglect, or of other legal complications, with colleagues and others in an effective and appropriate manner.
• Ability to discuss legal and ethical issues affecting the psychiatric care of patients with colleagues and others in an effective and appropriate manner.
• Recognize importance of maintaining professional boundaries with colleagues, patients, institutes, industry.

3. Advanced Psychodynamic Psychotherapy

Knowledge
• Principles of patient selection, treatment principles and procedures of psychodynamic psychotherapy
• Indications and limitations for psychodynamic psychotherapy
• Definitions and descriptions of therapeutic alliance, transference, resistance, countertransference, working through, object relations, narcissism and attachment theory

Skills

• Ability to utilize techniques of individual psychodynamic psychotherapy

Attitudes

• On time attendance, preparation for class, and participation in discussions.
• Desire to increase medical and psychiatric knowledge based on current literature and standards of practice
• Desire to maintain the highest standards of ethical and professional behavior in the care of patients
• Participate actively in didactic, making relevant comments during discussions
• Appreciation of therapeutic alliance and countertransference in all therapeutic interactions.

4. Other Evidence-Based Psychotherapies

Knowledge

• How to prepare for and pass patient interview part of oral board examinations
• New findings in neuroscience
• Various academic, fellowship and practice opportunities post residency
• Principles of family, couples and group psychotherapy

Skills

• Ability to pass patient interview part of oral board examinations in psychiatry
• Integrate neuroscience into psychiatric care
• Provide effective leadership on multidimensional treatment team
• Begin to plan for life after residency
• Provide family, couples and group psychotherapy

Attitudes

• On time attendance, preparation for class, and participation in discussions.
• Appreciate the profound responsibility of physicians for patients’ welfare and needs.
• Communicate honestly.
• Recognize one’s limitations.
• Dedication to self-improvement.
• Seek guidance whenever appropriate.
• Provide ethical and moral care.
• Sensitivity to, and acceptance of, diversity.
• Commitment to teaching others.

PGY 4

1. Research Skills and Independent Study

Knowledge

• Research methodology.
• How to competently use all available sources to master a topic.
• How to complete an IRB application.

Skills

• Receive IRB approval.
• Carry out a research study.
• Present results to faculty and others.
• Write a publishable research report.

Attitudes

• On time attendance, preparation for class, and participation in discussions.
• Residents will recognize the need for life-long learning and monitoring of one’s own practice.
• Willing to remain abreast on scientific advances, new clinical approaches and investigation of clinical outcomes.

2. Professional Development

Knowledge

• Understand how senior faculty and clinicians have overcome challenges in meeting career goals.
• Learn the breadth of career trajectories available to graduating residents.
• Learn methods of preparing for “life after residency.”

Skills

• Competently negotiate for academic faculty or private practice positions.
• Be better prepared to overcome challenges to career goals.
• Make informed choices about career path.

Attitudes

• On time attendance, preparation for class, and participation in discussions.
• Openness to new ideas.
• Willingness to seek out advice and mentorship from colleagues and faculty.
3. **History of Psychiatry**

**Knowledge**

- Learn the historical origins of modern psychiatry.
- Be familiar with contributions of Hippocrates, Aristotle, the Greek philosophers, the Inquisition, Asylum, Bethlehem, Pinel, Rush, Dix, Wernicke, Morel, Kalbaum, Krepelin, Bleur, Mesmer, Charcot, Freud and Rush.

**Skills**

- Describe several significant advances in psychiatry over the last several hundred years.

**Attitudes**

- On time attendance, preparation for class, and participation in discussions.
- Value previous contributions to modern psychiatry.
- Appreciate that what we now “know” will soon go by the way of “animal magnetism” and leeches.

4. **Intensive Short term Dynamic Psychotherapy**

**Knowledge**

- Indication for, and components of, short term dynamic psychiatry.
- “Triangle of conflict” (impulse-anxiety-defense) and “triangle of persons” (figure from the past-person in the present-transference with therapist)
- Inter-relations of current, past and transference relationships.
- Role of therapist pressure, challenge on defenses, and “head-on collision” with maladaptive personality structure in facilitating insight and change

**Skills**

- Ability to provide focused, dynamic psychotherapy.
- Ability with tolerate intense negative affect, both from and toward patients
- Ability to confront defenses while maintaining a strong therapeutic alliance

**Attitudes**

- On time attendance, preparation for class, and participation in discussions.
- Desire to increase medical and psychiatric knowledge based on current literature and standards of practice.
- Desire to maintain the highest standards of ethical and professional behavior in the care of patients.
- Participate actively in didactic, making relevant comments during discussions.
- Appreciation of therapeutic alliance and countertransference in all therapeutic interactions.
5. **Written Board Examination Review**

**Knowledge**

- Review all areas covered in National Board of Psychiatry and Neurology written examination.
- Review areas needing improvement from old PRITE examinations.

**Skills**

- Improved test taking ability.
- Improved knowledge base in areas of relative weakness.

**Attitudes**

- On time attendance, preparation for class, and participation in discussions.
- Recognize the need for life-long learning and monitoring of one’s own practice.
- Be willing to pursue continuing education and supervised experiences to keep one’s own practice commensurate with the community standard of care.
- Willing to obtain information from electronic databases and scientific literature in clinical psychiatry and related fields.
- Desire to remain abreast on scientific advances, new clinical approaches and investigation of clinical outcomes.
- Recognize that the scientific literature is constantly evolving, that no one report or idea is necessarily true for all situations, and that the literature should be critically judged for its methodology and applicability.

6. **The “Art” of Psychotherapy**

**Knowledge**

- Understanding how to integrate various models of effective psychotherapy
- How to conduct an initial behavior assessment of presenting problem
- Therapeutic use of the self
- Understanding of the major techniques employed in different psychotherapies

**Skills**

- Ability to perform functional analysis of presenting behavior problems
- Ability to design treatment plans relying upon empirically-validated strategies and/or strategies based upon experimentally-verifiable principles
- Ability to teach patients relaxation techniques
- Ability, with ongoing supervision, to implement behavioral and psychological interventions for a variety of behavior disorders

**Attitudes**

- On time attendance, preparation for class, and participation in discussions.
• Ability to recognize when consultation is needed in complicated cases
• Empathetic, respectful, curious, open-minded, nonjudgmental, collaborative, able to tolerate ambiguity
• Confidence in the efficacy of therapy
• Sensitive to the sociocultural and socioeconomic issues arising in the therapeutic relationship
• Open to supervision and review of patient progress
• Desire to continue improving therapeutic skills

All Residents

1. Grand Rounds

Knowledge

• Residents will learn about a wide variety of topics including basic and clinical research, social and community psychiatry, developmental psychiatry, ethical and legal issues in psychiatry as well as clinical presentations from a variety of orientations.

Skills

• Ability to present a formal lecture in a large group setting.

Attitudes

• Residents will recognize the need for life-long learning and monitoring of one’s own practice.
• Willing to remain abreast on scientific advances, new clinical approaches and investigation of clinical outcomes.

2. Journal Club

Knowledge

• Learn the psychiatric literature in a wide variety of topics, including basic and clinical research, social and community psychiatry, developmental psychiatry, and ethical and legal issues

Skills

• Gain literacy in using medical literature to inform the treatment of patients
• Learn to present a journal article in a concise and informative way
• Be able to critically evaluate the strengths and weakness of a study or analysis, and determine applicability to one’s own patient population

Attitudes

• On time attendance, preparation for class, and participation in discussions.
• Desire to remain abreast on scientific advances, new clinical approaches and investigation of clinical outcomes
Recognize that the scientific literature is constantly evolving, that no one report or idea is necessarily true for all situations, and that the literature should be critically judged for its methodology and applicability.

3. Six 4-year Coordinated Curricula

The overall goals are to develop a 4-year coordinated curriculum that builds on itself, is appropriate to level of training, is consistent with clinical experiences at each training level and provides a comprehensive body of useful information, skills and values by graduation from the program. The curriculum is comprised of six threads, each of which has its own coordinator who oversees the respective didactics taught throughout the four years of residency education. The objectives of each thread are described below.

3.1 Psychotherapy Thread:

Knowledge

- Principles of patient selection, theory, and the clinical practice of supportive, psychodynamic, cognitive behavioral, group, couples, family, and other evidence-based psychotherapies taught throughout an integrated curriculum which builds on itself over all four years of residency
- Indications and limitations for different modalities of psychotherapy
- Understanding of referral and payment processes for psychotherapy in different clinical systems

Skills

- Ability to utilize techniques of different forms of psychotherapy, both in individual therapy with patients as well as during medication management visits

Attitudes

- On time attendance, preparation for class, active participation in discussions, and writing psychotherapy case formulations
- Desire to maintain the highest standards of ethical and professional behavior in the care of patients
- Appreciation for the life-long pursuit of learning the art and practice of psychotherapy
# Psychotherapy Didactics and Experiences

<table>
<thead>
<tr>
<th>Training Year</th>
<th>Experiences</th>
<th>Didactics</th>
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<tbody>
<tr>
<td><strong>PGY 1</strong></td>
<td>• Inpatients</td>
<td>• Seminars - Psychiatric Interviewing and Supportive Psychotherapy (Iglewicz and Casmar), Introduction to Clinical Psychiatry (Rao) and Introduction to Psychodynamic Psychiatry (Zetumer)</td>
</tr>
</tbody>
</table>
| **PGY 2**     | • Weekly experiential group  
• Two Outpatients (one with CBT)  
• Continuity Clinic (30 patient case load) with CBT patients and supervision  
• Two supervisors weekly - At least one dynamically oriented  
• Co-lead ADTP group 2 months | • Weekly CBT Seminar (Rodgers)  
• Weekly Seminar - Foundations of Psychodynamic Psychotherapy (Hintz)  
• Group CBT Supervision Weekly |
| **PGY 3**     | • 4-6 hours Individual Therapy  
• Case load of patients for medical management, collaborative treatment, and variety of psychotherapies  
• Co-facilitate at least one outpatient group  
• Continue experiential group (optional)  
• Continue Primary Care Psychiatry (optional)  
• Three hours of supervision weekly | • Couples – 4 hrs (Shaevitz)  
• Family Therapy – 6 hrs (Shaevitz)  
• Psychoanalytic Therapy – 37.5hrs (Corrin)  
• Group Therapy – 10 hrs (Koutzenok)  
• Other evidence-based therapies – 12 hrs (Nappi, Espejo, Casmar, Judd, Rodgers)  
• Logotherapy (Khatami) |
| **PGY 4**     | • Recommend 4-6 hours psychotherapy  
• Other experiences (including Primary Care Psychiatry Continuity Clinic, other Clinics, etc.) – optional  
• Experiential Group (optional)  
• 1-3 hours supervision | • Short-term Dynamic Psychotherapy – 8 sessions (Neborsky)  
• Integrative Psychotherapy – 20 hrs (Phillips)  
• Advanced Psychodynamic Therapy – 12 sessions (Jaffe and Suskind) |

### 3.2 Pharmacotherapy Thread:

**Knowledge**

- Principles of patient selection, theory, and the clinical practice of pharmacological treatments taught throughout an integrated curriculum which builds on itself over all four years of residency
• Indications and limitations for different modalities of pharmacotherapy
• Use of evidence based as well as emerging treatments

Skills

• Ability to utilize pharmacotherapy in individuals with the broad spectrum of mental disorders while monitoring for effectiveness, adherence and safety.

Attitudes

• On time attendance, preparation for class, active participation in discussions
• Desire to maintain the highest standards of ethical and professional behavior in the care of patients
• Appreciation for the life-long pursuit of learning the art and practice of pharmacotherapy

3.3 Neuroscience Thread:

Knowledge

• Principles of new and emerging findings in neurobiology genomics, imaging and neuropsychiatry taught throughout an integrated curriculum which builds on itself over all four years of residency

Skills

• Ability to integrate scientific advances into clinical care
• Ability to critically read the scientific literature

Attitudes

• On time attendance, preparation for class, active participation in discussions.
• Desire to maintain lifelong learning

3.4 Geriatric Psychiatry Thread:

Knowledge

• Principles of diagnostic and treatment issues specific to individuals in late life.
• Knowledge of what it means to ‘age successfully’.
• Knowledge about legal issues and reporting requirements regarding ‘elder abuse’
• Principles of end of life care, death, dying and bereavement.
• Understanding of referral and payment processes for psychotherapy in different clinical systems for the elderly
Skills

- Ability to utilize techniques of different forms of psychotherapy and pharmacotherapy for treatment and prevention of mental illness in late life.
- Ability to work with patients and their families, utilizing all available resources in the care of older persons and their families.

Attitudes

- On time attendance, preparation for class, active participation in discussions.
- Desire to maintain the highest standards of ethical and professional behavior in the care of aging and older patients.
- Appreciation for the life-long pursuit of learning the art and practice of caring for the elderly with mental illness.

3.5 Community and Cultural Psychiatry Thread:

Knowledge

- Working knowledge of community resources, recovery models, health disparities, alternative health systems and programs, entitlements and mental health financing and research taught throughout an integrated curriculum which builds on itself over all four years of residency.
- Cross cultural psychiatry
- Components of quality assurance and quality improvement programs
- Understanding of referral and payment processes for psychotherapy in different clinical systems

Skills

- Ability to effectively diagnose and treat patients from diverse cultural, ethnic, racial and psychosocial backgrounds.
- Plan and complete a group quality improvement project.

Attitudes

- On time attendance, preparation for class, active participation in discussions.
- Desire to maintain the highest standards of ethical, culturally sensitive and professional behavior in the care of all patients.
- Appreciation for the life-long pursuit of learning.

3.6 Ethics Thread:

Knowledge
• Principles of forming a professional identity, accountability, altruism, excellence, humanism, setting personal goals and overcoming roadblocks.
• Ethical principles relevant the practice of medicine

Skills

• Ability to utilize knowledge of principles of professional behavior in one’s professional life
• Ability to transfer knowledge of ethical principles to case vignettes of ethical conundrums and to real-life practice.

Attitudes

• On time attendance, preparation for class, active participation in discussions.
• Desire to maintain the highest standards of ethical and professional behavior in the care of patients and in relationships with others in the health care system
• Appreciation for the life-long pursuit of learning.

D. Competency Based Clinical Goals and Objectives by Year and Rotation

In each of the four years of training, residents have day-to-day responsibilities for the care of psychiatric patients. These experiences, along with the corresponding supervision and didactics, comprise the materials around which our core competencies are taught. Specifically, these experiences include:

PGY 1

Introduction to Inpatient Psychiatry

Patient Care

• Ability to obtain information from the patient interview, family contact, old charts, and outpatient providers to compile a thorough assessment.
• Ability to complete a comprehensive mental status examination.
• Ability to assess for dangerousness to self and/or others.
• Ability to use precautions appropriately, including close observation, suicide precautions, and one-to-one.
• Ability to appropriately apply criteria for inpatient hospitalization.
• Ability to determine if a patient is medically stable enough for psychiatric hospitalization.
• Ability to formulate a basic treatment plan including: acute stabilization, medication management, psychosocial interventions, group and individual therapy, psycho education, physical and occupational therapy, discharge planning.
• Ability to practice basic individual, group and family psychotherapy as it relates to inpatient psychiatry.
• Ability to document the full history, mental status examination, hospital course, basic differential diagnosis, basic diagnostic formulation and basic treatment plan in the discharge summary.
• Ability to place patients on 5150, Riese and Conservatorship, assess Competency and testify in court under supervision.

Medical Knowledge

• Understanding of criteria for inpatient hospitalization.
• Ability to make a reasonable differential diagnosis based on a basic understanding of DSM-IV criteria to include all 5 axes.
• Display basic familiarity with at least one high, medium, and low potency typical neuroleptic.
• Display basic familiarity with all non-Clozapine atypical neuroleptics.
• Understanding of basic principles of Clozapine use including when to consider a Clozapine trial.
• Understanding of indications and dosing of long acting neuroleptic preparations.
• Display familiarity with major side-effects of all neuroleptics (EPS, anticholinergic, orthostasis, etc.).
• Understanding of 3 major forms of acute EPS and basic treatments.
• Display a basic understanding of tardive dyskinesia including proper use of the AIMS test and treatments for TD.
• Ability to name receptors responsible for orthostasis, sedation, weight gain, and sexual dysfunction.
• Ability to name at least 5 anticholinergic symptoms.
• Display a basic understanding of NMS and its treatment.
• Display basic familiarity with all classes of antidepressants including dosing, major side effects, and contraindications.
• Display basic familiarity with lithium and the anticonvulsant mood stabilizers including dosing, pre-treatment testing, follow-up monitoring, major contraindications, and side effects.
• Display basic familiarity with the benzodiazepines and other anxiolytics including dosing, major side effects and contraindications.
• Display an awareness of both potentially common and lethal drug interactions (Paxil and NTP; Demerol and Phenelzine; CBZ and Clozapine; and the like).
• Demonstrate an understanding of basic drug mechanisms of action, receptor blockade profiles, and indications for selection and use of specific agents.
• Ability to use sedative-hypnotics and neuroleptics for acute behavioral control.

Interpersonal and Communication Skills

• Ability to co-lead community and team meetings on the unit.
• Ability to be emphatic and develop rapport with patients.
• Ability to work effectively as part of a multidisciplinary team.
• Ability to work effectively as a team player with peers.
• Ability to communicate effectively with supervisors.
• Ability to be effective and emphatic working with families
• Ability to effectively liaison with professional colleagues in other fields.
• Ability to adapt his/her style of interaction specific to age and cognitive capacity.

Professionalism

• Personal and intellectual integrity and an understanding of the ethical values and codes of a member of the medical profession.
• Ability to obtain and provide cross coverage as needed.
• Ability to assist with and ask for assistance in emergencies as appropriate.
• Ability to do appropriate sign-outs, addressing pertinent issues for patients.
• Commitment to ethical principles when dealing with patients and families
• Respect for patients and colleagues in interactions.
• Sensitivity to and awareness of the patient’s culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
• Respect towards patients and family members.
• Respect towards physician and non-physician colleagues.
• Ability to follow through with patient care recommendations.
• Ethical behavior with respect for patient confidentiality.
• Ability to establish and maintain professional boundaries.
• Maintains a professional appearance appropriate to clinical site.

Practice-Based Learning

• Ability to facilitate medical students’ learning.
• Ability to use information technology to access on-line medical information and support his/her own education.
• Ability to locate, critique, and assimilate evidence from scientific studies as it relates to patients’ health problems.
• Ability to analyze practice experience and perform practice-based improvement activities.
• Ability to incorporate material discussed in supervision into clinical work.
• Motivation and eagerness to learn.

Systems Based Practice

• Understanding of how types of medical practice and delivery systems differ from one another.
• Awareness of different costs of health care for different services.
• Ability to advocate for quality patient care and assist patients in dealing with system complexities.
• A basic understanding of medical-legal issues as it relates to inpatient psychiatry including: voluntary and involuntary admission procedures, testifying at hearings, court ordered patients, issues of confidentiality, forced medications/medication panels.
PGY 1 Neurology

The primary goal of the PGY1 rotation on Neurology Residency Training Program is to train psychiatrist to diagnose and treat patients with neurological disorders and conditions.

Medical Knowledge

- Know the characteristic presentations, methods of diagnosis, and treatments of common neurologic disorders.
- Know the indications, contraindications, efficacy, common and important side effects, and necessary patient monitoring/follow-up for several medications from each of the major categories of neurologic drugs.
- Know the indications, contraindications, and side effects of lumbar puncture.
- Know the use, reliability, and validity of the other generally accepted neurodiagnostic tests, including neuropsychological testing, CT and MRI scanning of the brain, spinal cord and roots, neuropathologic evaluation, BEG, evoked potentials and EMG/nerve conduction studies.
- Know healthcare delivery systems, including patient and family counseling.
- Know the application of ethical principles in delivering medical care, including consent for diagnostic tests and procedures.
- Know the use, reliability, and validity of genetic testing and be aware of the ethical and practical issues involved.
- Have the ability to reference and use electronic systems to access medical, scientific, and patient information.
- Know the basic neuroscience that is critical to the practice of neurology.
- Know the pathophysiology of the major neurological disorders and be familiar with the scientific basis of these disorders.
- Know the characteristic presentations methods of diagnosis, and treatments (including side effects of these treatments) of the common psychiatric disorders.
- Know how to localize neurological lesions.

Patient Care

- Ability to obtain a complete and accurate neurologic history from patients, and from their family members or friends when necessary.
- Ability to perform a complete and accurate neurologic examination.
- Ability to present effectively orally and in writing the results of the neurologic history and examination. Ability to perform a competent lumbar puncture.
- Ability to perform and interpret a competent bedside caloric test in a patient who has an abnormal level of consciousness.
- Ability to identify and describe abnormalities seen in common neurological disorders on radiographic testing including CT and MRI.
- Ability to recognize ethical issues in the care of neurologic patients and to respond to them appropriately.
• Ability to perform and interpret competent electromyogram/nerve conduction studies examination.
• Ability to identify and describe the CSF abnormalities seen in common neurological disorders.
• Ability to formulate orally and in writing a complete differential diagnosis, select the correct diagnosis, and plan for cost effective evaluation and treatment for patients with neurologic disorder.
• Ability to know when to employ neurodiagnostic tests including electroencephalogram, motor and sensory nerve conduction studies, electromyography, evoked potentials, polysomnography, electronystagmogram, audiometry, perimetry, psychometry, CSF analysis, vascular imaging (duplex, transcranial Doppler), and radiographic studies including plain films, myelography, angiography, CT, isotope studies and MRI.
• Ability to write timely, competent, and legible neurologic notes, using computerized record systems when needed.
• Ability to dictate competent and timely discharge summaries for neurologic patients.

Interpersonal and communication skills

• Ability to form and maintain a professional relationship with neurologic patient, their families, and their caregivers.
• Ability to relate to neurologic patients and their families with compassion, respect, and integrity.
• Ability to relate well to other members of the health care team.
• Develop and improve upon teaching skills for medical students, patients and families, and other residents. Develop an ethical and compassionate approach to interactions with patients, coworkers, staff and trainees.

Professionalism

• Demonstration of responsibility for their patients' care.
• Demonstration of ethical behavior, integrity, honesty, and compassion in all aspects of their training and practice.
• Demonstration of respect for patients and their families, and their colleagues.
• Demonstration of understanding of and sensitivity to end of life care issues.
• Ability to review their own professional conduct and remediate when appropriate.
• Participation in the review of the professional conduct of their colleagues.
• Ability to be aware of safety issues, including acknowledging and remediating medical errors, should they occur.

Practice-Based Learning

• Ability to know when one's own neurological base or clinical skill is insufficient, and then to seek assistance from a more senior neurology resident or from a neurology faculty member.
• Ability to accept and integrate constructive criticism pertaining to clinical skills, fund of neurologic knowledge, and interpersonal skills.
• Demonstration of appropriate skills for obtaining and evaluating up-to-date information from scientific and practice literature and other sources to assist in the care of patients.
• Ability to design self-improvement plans to improve performance in each of the six core competencies.

Systems-Based Practice

• Ability to work with and make optimum use of the skills of nonphysician professional colleagues including ward and clinic clerks and secretaries, nurses, occupational and physical therapists, pharmacists, social workers, and psychologists.
• Ability to know when and how to obtain consultations on neurologic patients.
• Ability to form appropriate and constructive professional relationships with colleagues.
• Ability to have a working knowledge of the systems involved in treating patients, and understand how to use the systems as part of a comprehensive system of care in general and as part of a comprehensive, individualized treatment plan.

PGY1 Primary Care: Medicine

In the PGY1 year, psychiatry residents spend 4 months at Scripps Mercy Hospital, VA Urgent Care Medicine, Scripps Chula Vista and/or St Vincent de Paul Clinic. In general, residents have 2 months of inpatient and 2 months of ambulatory medicine. Core goals and objectives for these experiences include:

Patient Care

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

• Become competent in taking an appropriate history. This includes knowing how to use the “Blue Phone Translation Service” for patients and families who are not fluent in English and reviewing old charts for pertinent data.
• Become competent in performing an accurate physical examination.
• Formulate an assessment to the highest level of resolution and a differential diagnosis that reflects appropriate synthesis of available clinical data and applied knowledge of relevant basic and clinical science at a PGY-1 level and document this on the admission H&P/A&P.
• Develop and implement appropriately prioritized, evidence based, diagnostic and therapeutic management plans under supervision.
• Compose admission orders and daily orders under supervision.
• Formulate appropriate daily progress notes.
• Appropriately perform Internal Medicine procedures under supervision to become “certified” in these procedures (see Procedure Summary Sheet).
• Perform appropriate daily handoffs using the I-SWITCH format.
• Develop proficiency in providing cross-coverage under supervision to patients on other teams.
• Competently dictate appropriate discharge summaries using a standardized format within 3 days of discharge (Dictate on the “stat line” on the day of discharge if transferred to another facility).

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. Specifically, they will:

• Learn how to access and interpret the medical literature in a time-efficient fashion.
• Acquire/enhance medical knowledge of the pathophysiology, presentation, workup and treatment of acute internal medicine diseases at a PGY-1 level.
• Demonstrate procedural knowledge (informed consent, indications, contraindications, interpretation of results, etc) during the performance of supervised procedures and by passing the procedure quizzes.
• Demonstrate EKG interpretation skills while providing supervised patient care and by passing the weekly EKG quizzes.
• Learn how to use a medical literature abstract service (Journal Watch, ACP Journal Club) to remain current in a time-efficient fashion.

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. Specifically, they will:

• Demonstrate compassion and respect when communicating with patients and families.
• Know how to use the “blue phones” (a medical translation service) to communicate with patients who do not speak English.
• Demonstrate proficiency and empathy in communicating “bad news” and in discussing end-of-life issues with patients and families.
• Communicate effectively with other physician and non-physician members of the health care team by presenting information concisely and clearly with an awareness of the relative clinical priorities to ensure comprehensive and timely care of hospitalized patients.
• Maintain medical records that are timely and appropriate in content. Create a timely discharge summary using the Scripps Mercy Med Ed Discharge Summary Format that accurately reflects events during the patient’s admission, and clearly reconciles medications prior to admission with those prescribed at time of discharge, and matches the list provided to the patient and to subsequent care providers.
- Perform timely, pertinent, and accurate handoffs of information to the next in-hospital caregiver using the I-SWITCH methodology, and provide feedback to the caregiver of record about changes that occurred during overnight call.
- The PGY-1 ward resident should promptly notify the appropriate Continuity Clinic resident about the admission and discharge of one of his/her Clinic patients to facilitate continuity of care.

Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population. Specifically, they will:

- Demonstrate a willingness to assume responsibility for behavior and accountability to patients and colleagues, including but not limited to, meeting assigned responsibilities in a timely and complete manner and taking initiative in accomplishing the work of the health care team.
- Demonstrate adherence to ethical principles of patient care, with particular attention to integrity, confidentiality and informed consent.
- Demonstrate sensitivity and responsiveness to patients’ and colleagues’ gender, age, culture, religion, sexual preferences, socioeconomic status, personal beliefs and disabilities.
- Demonstrate a SELF-MOTIVATED commitment to on-going professional development through regular attendance at conferences and reading the medical literature.
- Take responsibility for investigating reported changes in a patient’s condition, and insure that patients are adequately examined and appropriately stabilized before turning over responsibility to the next caregiver.

Systems Based Practice and Improvement

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. Specifically, they will:

- Acquire/enhance skill in using medical technology to access and manage information.
- Practice cost-effective health care and resource allocation that does not compromise the quality of care. Utilize resources that compare the cost of various modalities which can be used to evaluate/treat the same condition, and know how to choose which modality is most cost-effective.
- Learn how to optimize the use of paramedical personnel such as nurses, case managers, pharmacists, dieticians, physical therapists/speech therapists/occupational therapists, librarians, discharge planners and home health care providers in the management of patients.
- Learn how to appropriately consult medical/surgical subspecialists and palliative care services. (PGY-2/PGY-3 residents will provide the initial communication to surgeons per the request of our surgical departments).
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. Specifically, they will:

- Locate, appraise, assimilate and apply current medical information to answer questions that arise in the care of patients. Read about each of the patients you encounter in your day-to-day care of them.
- Reflect on all aspects of your patient care to identify areas for personal improvement and implement strategies for this improvement.
- Demonstrate a willingness to incorporate formative feedback into daily practice and to acknowledge errors and learn from them.
- It is expected that knowledge and skills (including physical exam techniques) taught to a resident during the evaluation and management of a patient will be applied by the resident WITHOUT PROMPTING to the care of subsequent patients with similar problems.
- All residents complete a formal self-evaluation using a standardized format biannually. These self-evaluations are reviewed with the resident’s faculty advisor.

PGY-2

Advanced Inpatient Psychiatry

Patient Care

- Ability to perform an independent patient interview exploring all aspects of a patient’s history and including a complete mental status examination.
- Ability to develop an accurate differential diagnosis and pertinent treatment plan.
- Ability to perform an accurate acute and chronic suicide risk assessment for a potentially suicidal patient.
- Ability to perform an accurate violence risk assessment for a potentially violent patient.
- Ability to provide comprehensive and accurate documentation in the written record including documentation of the effect of clinical interventions.
- Ability to detoxify patients from alcohol, sedatives, and opiates when necessary.
- Ability to recognize and manage the side effects of psychotropic medications.
- Ability to perform individual supportive psychotherapy in the treatment of acute inpatients including utilizing crisis intervention techniques.
- Ability to provide effective and therapeutic structure for patients with personality disorders including appropriate limit setting.
- Ability to use support and psychoeducation techniques when working with families.
- Understanding of the indications for using time-out, quiet room, restraint and seclusion. Be able to utilize alternative modalities to minimize use of these procedures.
- Understanding of the indications for ECT in acute psychiatric inpatients.
• Ability to effectively lead community meetings and/or other patient group meetings.
• Understanding of the effective use of the milieu for optimum patient benefit in the inpatient setting.
• Ability to utilize the voluntary admission process and a voluntary admission agreement for an inpatient.
• Understanding of the certification process. This will include a working knowledge of the paperwork involved, including an emergency petition.
• Understanding of the mechanics of a hearing for a certified patient.
• Understanding of the indication for a clinical review panel.
• Provide basic management of medical problems for psychiatric inpatients including the appropriate use of consultation from other medical specialties.

Medical Knowledge

• Knowledge of phenomenology of and diagnostic criteria for various psychiatric disorders and be able to elicit those criteria clinically from the patient, and obtain relevant data from family and treatment professionals. At a minimum, the resident should have an in-depth understanding of the phenomenology and diagnostic criteria for the following disorders: schizophrenia and other psychotic disorders, mood disorders, adjustment disorders, substance-related disorders, and personality disorders.
• Ability to develop a basic psychodynamic formulation for an inpatient. This includes a discussion of prominent defense mechanisms as well as areas of conflict for the patient.
• Ability to reliably perform the AIMS reliably and be familiar with the BPRS, PANSS, Young Mania Scale, BDI and Ham-D.

Interpersonal and Communication Skills

• Ability to take a leadership role for patient care.
• Ability to express findings in coherent, orderly oral and written presentations including a discussion of the differential diagnosis and biopsychosocial treatments.
• Ability to engage with a family and perform an assessment of family functioning.
• Ability to effectively work with a multidisciplinary treatment team utilizing the abilities of all the mental health professionals for the benefit of the patient.
• Ability to be empathic and develop rapport with patients and families.
• Ability to work effectively as a team player with peers.
• Ability to communicate effectively with supervisors.
• Ability to effectively liaison with professional colleagues in other fields (i.e., primary care physician).
• Ability to adapt his/her style of interaction specific to age and cognitive capacity.
Professionalism

- Personal and intellectual integrity and an understanding of the ethical values and codes of a member of the medical profession.
- Ability to obtain and provide cross coverage as needed.
- Ability to assist with and ask for assistance in emergencies as appropriate.
- Ability to do appropriate sign-outs, addressing pertinent issues for patients.
- Commitment to ethical principles when dealing with patients and families.
- Respect for patients and colleagues in interactions.
- Sensitivity to and awareness of the patient’s culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
- Respect towards patients and family members.
- Respect towards physician and non-physician colleagues.
- Ability to follow through with patient care recommendations.
- Ethical behavior with respect for patient confidentiality.
- Ability to establish and maintain professional boundaries.
- Maintains a professional appearance appropriate to clinical site.

Practice-Based Learning

- Ability to facilitate medical students’ learning.
- Ability to use information technology to access on-line medical information and support his/her own education.
- Ability to locate, critique, and assimilate evidence from scientific studies as it relates to patients’ health problems.
- Ability to analyze practice experience and perform practice-based improvement activities.
- Ability to incorporate material discussed in supervision into clinical work.
- Motivation and eagerness to learn.

Systems Based Practice

- Understanding of the vocational needs of patients and will know how to access such resources with help from members of the treatment team.
- Understanding of how types of medical practice and delivery systems differ from one another.
- Awareness of different costs of health care for different services.
- Ability to advocate for quality patient care and assist patients in dealing with system complexities.

Inpatient Drug and Alcohol Treatment Program

Patient Care

- Ability to conduct a thorough interview with substance abusing patients that will detail drug using histories, prior treatment, patient motivation for treatment and co-morbidity.
• Demonstrate an understanding of the principles of motivational interviewing and patient-centered care.
• Ability to apply the chronic illness model of treatment in attending to their addicted patients on this rotation.
• Ability to assist addicted patients in moving through the different levels of treatment in this system.
• Ability to treat patients with co-morbid disorders both psychotherapeutically and pharmacologically.
• Ability to function as a primary therapist, co-therapist and family or couples therapist with addicted patients.

Medical Knowledge

• Demonstrate understanding of the recovery environments and the roles played by families and collaterals in the treatment process.
• Demonstrate an understanding of all aspects of the DSM IV Criteria for Substance-Related Disorders, Substance-Induced Disorders and Remission Stages.
• Demonstrate understanding of psychopharmacological adjunctive agents for the treatment of alcoholism, including Naltrexone and Disulfiram.
• Demonstrate an understanding of the pharmacokinetics of all major categories of drugs.
• Demonstrate an understanding of basic principle of intoxication withdrawal and detoxification of major categories of drug abuse.

Interpersonal and Communication Skills

• Demonstrate an understanding of his/her own attitudes towards substance abusing patients and the ability to differentiate between recovering versus practicing addicts and alcoholics.
• Ability to be empathic and develop rapport with patients.
• Ability to work effectively as part of a multidisciplinary team.
• Ability to work effectively as a team player with peers.
• Ability to communicate effectively with supervisors.
• Ability to work effectively and empathically with families.
• Ability to effectively liaison with professional colleagues in other fields.
• Ability to adapt his/her style of interaction specific to age and cognitive capacity.

Professionalism

• Demonstrate personal and intellectual integrity.
• Demonstrate an understanding of the ethical values and codes of a member of the medical profession when dealing with patients and families.
• Ability to obtain and provide cross coverage as needed.
• Ability to assist with and ask for assistance in emergencies as appropriate.
• Ability to do appropriate sign-outs addressing pertinent issues for patients.
• Demonstrate respect for patients, families and colleagues in interactions, including a sensitivity and awareness of the patient’s culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
• Ability to follow through with patient care recommendations.
• Demonstrate respect for patient confidentiality.
• Ability to establish and maintain professional boundaries.
• Maintains a professional appearance appropriate to clinical site.

Practice-Based Learning

• Ability to facilitate medical students’ learning.
• Ability to use information technology to access on-line medical information and support his/her own education.
• Ability to locate, critique, and assimilate evidence from scientific studies as it relates to patients’ health problems.
• Ability to analyze practice experience and perform practice-based improvement activities.
• Ability to incorporate material discussed in supervision into clinical work.
• Demonstrate motivation and eagerness to learn.

Systems Based Practice

• Demonstrate understanding of the complicated medical, dental, vocational, financial, and psychosocial needs of addicted patients. This includes dealing with a high percentage of homeless patients.
• Demonstrate understanding of peer-support recovery programs such as 12 Step Programs and SMART recovery.
• Ability to participate as a member of an interdisciplinary team and be able to learn treatment perspectives provided from team members from Social Work, Psychology, Pharmacy, Nursing and Certified Addiction Counselors.
• Demonstrate an understanding of the rationale for placement of patients internally and in community programs.
• Ability to be an advocate for addicted patients and facilitate proper placement by accurately representing information to collaborating programs.
• Demonstrate an understanding of how types of medical practice and delivery systems differ from one another.
• Demonstrate an understanding of the different costs of health care for different addiction services.
• Ability to advocate for quality patient care and assist patients in dealing with system complexities.

Consultation-Liaison Psychiatry

Patient Care
• Ability to gather data from appropriate sources, including chart, hospital staff, family, and other relevant individuals.
• Ability to adapt his/her interview style in medically ill patients in a variety of settings (i.e., adapt to patients on ventilators, recognize stress and fatigue in patients, prioritize questions and do multiple, brief interviews).
• Ability to formulate a good HPI, including psychiatric symptoms and recent stressors precipitating hospitalization, as well as acute medical issues and their relationship to psychiatric symptoms.
• Ability to formulate a complete psychiatric work-up, including history of present illness, past medical history, past psychiatric history, substance abuse history, family history, social history, developmental history and mental status examination.
• Ability to do a comprehensive assessment of cognitive capacity in medically ill patients using MMSE, and either the HIV Dementia Scales or the CAM (confusion assessment method).
• Ability to evaluate for psychopathologic processes in patients with concomitant medical and surgical conditions.
• Ability to assess for suicidality and dangerousness and evaluate risk factors and need for sitter/hospitalization.
• Ability to assess for homicidality and dangerousness and evaluate risk factors and need for sitter/hospitalization.
• Ability to evaluate for decision making capacity in medically ill patients.
• Ability to monitor the patient’s course during hospitalization and provide continuing input as needed.
• Ability to manage time, including appropriate length of notes with increased number of consults.
• Ability to do complete and adequate documentation addressing medico-legal risks.

Medical Knowledge

• Understanding of the indications for a variety of somatic therapies in medical and surgical patients.
• Understanding of the use of psychotropic medications and ECT in medical/surgical patients and appreciate physiologic effects, contraindications, drug interactions and dosing concerns.
• Understanding of the use of psychosocial treatments, including brief psychotherapy, behavioral management techniques, family therapy and psycho education.
• Knowledge of diagnostic criteria, common and emergent etiologies, medical work-up and biopsychosocial treatment for delirium.
• Knowledge of dosing strategies and indications for the use of haloperidol and lorazepam in delirious patients.
• Knowledge of the organic work-up for psychiatric symptoms.
• Knowledge of medications that have psychiatric symptoms as side effects.
• Knowledge of drug interactions between psychotropics and non-psychotropic medications.
- Knowledge of the appropriate indications and dosing strategies for psychostimulants in the medically ill.
- Knowledge of the use, risks and benefits, and dosing strategies of psychotropics in pregnancy.
- Knowledge of the diagnostic criteria, evaluation, work-up and management of neuroleptic malignant syndrome.
- Knowledge of the diagnostic criteria and differences between factitious disorder, malingering, and conversion disorder.
- Knowledge of the core concepts of decision making capacity and the process once a patient has been deemed 'incompetent'.
- Knowledge of supportive psychotherapy techniques utilized in the context of psychological response to medical illness.
- Knowledge of the biopsychosocial management of personality disorders in medical settings.

Interpersonal and Communication Skills

- Ability to formulate the Impression and Plan so that it consists of concrete recommendations and delineates clearly the role of the consultant and the role of the consulting team in the plan.
- Ability to present concise and relevant data to supervisors and use supervision appropriately.
- Understanding of the stressors the consulting team faces and be clear about the discharge date as recommendations are being made.
- Ability to advise and guide consultees about the role of the medical disease and medications in the patient’s presenting symptoms.
- Ability to work as a member of a multidisciplinary staff to maximize the care of complex medically ill patients.
- Ability to provide appropriate direction to consultees regarding management of dangerous or psychotic patients who must be treated on general hospital units.
- Ability to engage in effective interactions with a variety of consultees, including determination of consultation questions, and reporting of findings and recommendations.
- Ability to maintain verbal contact with the consulting team.
- Ability to develop a therapeutic alliance with respect for privacy in medically ill patients.
- Ability to work cooperatively as part of a multidisciplinary team, utilizing input from other members of the team.
- Ability to be empathic and develop rapport with patients.
- Ability to work effectively as a team player with peers.
- Ability to be effective and empathic working with families.
- Ability to effectively liaison with professional colleagues in other fields (i.e., primary care physician).
- Ability to adapt his/her style of interaction specific to age and cognitive capacity.
Professionalism

- Personal and intellectual integrity and an understanding of the ethical values and codes of a member of the medical profession.
- Ability to obtain and provide cross coverage as needed.
- Ability to assist with and ask for assistance in emergencies as appropriate.
- Ability to do appropriate sign-outs, addressing pertinent issues for patients.
- Commitment to ethical principles when dealing with patients and families
- Respect for patients and colleagues in interactions.
- Sensitivity to and awareness of the patient’s culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
- Respect towards patients and family members.
- Respect towards physician and non-physician colleagues.
- Ability to follow through with patient care recommendations.
- Ethical behavior with respect for patient confidentiality.
- Ability to establish and maintain professional boundaries.
- Maintains a professional appearance appropriate to clinical site.

Practice-Based Learning

- Ability to facilitate medical students’ learning.
- Ability to use information technology to access on-line medical information and support his/her own education.
- Ability to locate, critique, and assimilate evidence from scientific studies as it relates to patients’ health problems.
- Ability to analyze practice experience and perform practice-based improvement activities.
- Ability to incorporate material discussed in supervision into clinical work.
- Motivation and eagerness to learn.

Systems Based Practice

- Knowledge of how types of medical practice and delivery systems differ from one another.
- Knowledge of different costs of health care for different service.
- Ability to advocate for quality patient care and assist patients in dealing with system complexities.

Psychiatric Emergency Clinic

Patient Care

- Ability to assess and begin to manage crisis situations with appropriate supervision as needed.
- Ability to effectively accept and prioritize the sign-out of cases at the beginning of a shift.
• Ability to efficiently and appropriately acquire clinical information in a variety of ways including: patient interview, family interview, calling collateral sources of information, reviewing old records.
• Ability to effectively manage the violent or agitated patient through the judicious use of verbal de-escalation, medications, restraints.
• Ability to make a complete suicide risk assessment including lethality of method, details of planning, level of hopelessness, risk of rescue ratio, and social support as well as document the assessment.
• Ability to make a complete homicide risk assessment including prior history, legal history, presence of paranoia as well as document the assessment.
• Ability to assess and manage psychotic patients in the emergency setting.
• Ability to integrate biopsychosocial constructs into formulation of cases.
• Ability to check levels of psychiatric medications (including Lithium, Depakote, Tegretol, Pamelor) and assess how these levels relate to the last dose.
• Understanding of the psychosocial aspects of treatment with patients, including crisis counseling, psycho education, community referrals.
• Ability to effectively document patient history as well as the decision-making process and justification for professional judgment.
• Ability to assess a patient medically through history and physical exam and ability to recognize and manage uncomplicated medical needs.
• Ability to develop initial treatment plans including safety and biopsychosocial aspects.
• Obtain appropriate history and physical for the patient in detox.
• Ability to recognize complicating medical factors in the patient with an addiction.
• Ability to monitor a patient in detox and be familiar with symptoms and signs of alcohol and heroin withdrawal.
• Understanding of informed consent and ability to document risk/benefit discussion of treatment options with patients.
• Ability to work as independently as possible but know when to seek supervision.

Medical Knowledge

• Ability to formulate a comprehensive differential diagnosis including medical causes for psychiatric presentations.
• An evolving knowledge of the indications and pharmacologic properties of psychotropic medications commonly used in the emergency setting.
• Ability to assess for and treat the following pharmacologic emergencies: anticholinergic toxicity, NMS, serotonin syndrome, dystonic reactions.
• Knowledge of medication interactions and major side effects of medications.
• Knowledge of the indications for various methods of detox, including for heroin, alcohol and benzodiazepines.
• Ability to appropriately dose medications for alcohol and heroin withdrawal.
Interpersonal and Communication Skills

- Ability to effectively collaborate and liaison with a multidisciplinary team in delivering psychiatric emergency services.
- Ability to effectively work with non-psychiatric staff in the education and management of patients in crisis.
- Ability to give thorough, clear, concise sign-outs for patients at the end of a shift.
- Ability to rapidly form and foster effective therapeutic relationships with patients in crisis.
- Ability to efficiently summarize and present the results and conclusions of data collected, including labs and collateral information.
- Ability to effectively work with addictions treatment personnel.
- Ability to be emphatic and develop rapport with patients.
- Ability to work effectively as part of a multidisciplinary team.
- Ability to work effectively as a team player with peers.
- Ability to communicate effectively with supervisors.
- Ability to effectively liaison with professional colleagues in other fields.
- Ability to adapt his/her style of interaction specific to age and cognitive capacity.

Professionalism

- Personal and intellectual integrity and an understanding of the ethical values and codes of a member of the medical profession.
- Ability to obtain and provide cross coverage as needed.
- Ability to assist with and ask for assistance in emergencies as appropriate.
- Ability to do appropriate sign-outs, addressing pertinent issues for patients.
- Commitment to ethical principles when dealing with patients and families.
- Respect for patients and colleagues in interactions.
- Sensitivity to and awareness of the patient’s culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
- Respect towards patients and family members.
- Respect towards physician and non-physician colleagues.
- Ability to follow through with patient care recommendations.
- Ethical behavior with respect for patient confidentiality.
- Ability to establish and maintain professional boundaries.
- Maintains a professional appearance appropriate to clinical site.

Practice-Based Learning

- Ability to facilitate medical students’ learning.
- Ability to use information technology to access on-line medical information and support his/her own education.
• Ability to locate, critique, and assimilate evidence from scientific studies as it relates to patients’ health problems.
• Ability to analyze practice experience and perform practice-based improvement activities.
• Ability to incorporate material discussed in supervision into clinical work.
• Motivation and eagerness to learn.

Systems Based Practice

• Ability to formulate and access an appropriate disposition with appropriate assistance: assessment of hospitalization vs. discharge with appropriate safety assessment, referrals for treatment, including day hospital, addictions treatment, etc., community resources, referrals for living situations (i.e., shelters, halfway houses, etc).
• Ability to perform sufficient documentation and liaison effectively with insurance companies.
• Knowledge of how types of medical practice and delivery systems differ from one another.
• Knowledge of different costs of health care for different service.
• Ability to advocate for quality patient care and assist patients in dealing with system complexities.

Inpatient Geriatric Psychiatry

Patient Care

• Ability to perform appropriate testing and work-up of newly admitted elderly patients.
• Ability to make a broad differential diagnosis of psychiatric disorders including medical causes.
• Ability to use collateral information appropriately to obtain a thorough history.
• Ability to appropriately use neuroimaging and EEG in the differential diagnosis of psychiatric illness in the elderly.
• Ability to distinguish between dementia and delirium.
• Ability to make a differential diagnosis of delirium and dementia, including iatrogenic causes.
• Ability to evaluate the patient’s decisional competency.
• Ability to recognize and treat substance use (especially alcohol and prescription drug abuse) including withdrawal protocols, psychoeducation, and appropriate outpatient referrals.

Medical Knowledge

• Knowledge of neuropsychological testing used to assess geriatric patients.
• Ability to make a broad differential diagnosis for mania and late onset psychosis.
• Knowledge of the interaction of medical and psychiatric illness.
• Understanding of indications and benefits and risks of cholinesterase inhibitors and NMDA receptor antagonists.
• Understanding of indications and benefits and risks of typical and atypical antipsychotics, anxiolytics, mood stabilizers and antidepressants in the treatment of behavioral complications of dementia.
• Understanding of anticholinergic side effects of psychotropics and other medications.
• Ability to manage a complex regimen of medications, including knowledge of potential drug interactions
• Ability to use age-appropriate dosing strategies and be aware of pharmacokinetic and pharmacodynamic differences in the elderly.
• Knowledge of the indications and special considerations for ECT in the elderly.

Interpersonal and Communication Skills

• Ability to take a leadership role for patient care.
• Ability to express findings in coherent, orderly oral and written presentations including a discussion of the differential diagnosis and biopsychosocial treatments.
• Ability to engage with a family and perform an assessment of family functioning.
• Ability to effectively work with a multidisciplinary treatment team utilizing the abilities of all the mental health professionals for the benefit of the patient.
• Ability to be empathic and develop rapport with patients and families.
• Ability to work effectively as a team player with peers.
• Ability to communicate effectively with supervisors
• Ability to effectively liaison with professional colleagues in other fields (i.e., primary care physician).
• Ability to adapt his/her style of interaction specific to age and cognitive capacity.

Professionalism

• Personal and intellectual integrity and an understanding of the ethical values and codes of a member of the medical profession.
• Ability to obtain and provide cross coverage as needed.
• Ability to assist with and ask for assistance in emergencies as appropriate.
• Ability to do appropriate sign-outs, addressing pertinent issues for patients.
• Commitment to ethical principles when dealing with patients and families
• Respect for patients and colleagues in interactions.
• Sensitivity to and awareness of the patient’s culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
• Respect towards patients and family members.
• Respect towards physician and non-physician colleagues.
• Ability to follow through with patient care recommendations.
• Ethical behavior with respect for patient confidentiality.
• Ability to establish and maintain professional boundaries.
• Maintains a professional appearance appropriate to clinical site.

Practice-Based Learning

• Ability to facilitate medical students’ learning.
• Ability to use information technology to access on-line medical information and support his/her own education.
• Ability to locate, critique, and assimilate evidence from scientific studies as it relates to patients’ health problems.
• Ability to analyze practice experience and perform practice-based improvement activities.
• Ability to incorporate material discussed in supervision into clinical work.
• Motivation and eagerness to learn.

Systems Based Practice

• Ability to plan appropriate follow-up care, including medication management, therapy and day program.
• Understanding of indications for nursing home placement vs. assisted living or board and care placements.
• Knowledge of the regulations governing nursing home placement, including the role of Adult Evaluation Review Service.
• Knowledge of regulations governing psychotropic prescriptions and restraints in nursing homes.

Continuity Clinics

Patient care

• Undertake the initial evaluation of patients with broad psychopathology.
• Diagnose a broad range of psychiatric disorders and common medical disorders and their suitability for ambulatory management.
• Formulate a treatment plan.
• Establish a psychotherapeutic contract and form a therapeutic alliance.
• Formulate interventions following cognitive and psychodynamic principles.
• Treat at least one patient with formal, manualized, cognitive behavioral psychotherapy

Knowledge

• Understand pathophysiology of general diseases most commonly seen clinical practice
• Understand key diagnostic criteria for most common l conditions.
• Understand differential diagnosis of most common conditions.
• Understand preventive and treatment principles of most common conditions.
• Be cognizant of drug interactions among psychiatric medications and between commonly used medical agents and psychiatric ones.
• Understand techniques of conducting therapeutic interviews in outpatient clinic.
• Understand techniques of developing therapeutic alliances.
• Understand methods of taking comprehensive histories.
• Understand methods of using ancillary means for patient assessment, including laboratory tests, psychological tests, and medical and neurological examinations.
• Understand biological therapies including psychopharmacological agents and other somatic therapies.
• Understand principles of supportive psychotherapy for patients with psychiatric and general medical conditions.
• Be cognizant of treatment methods for the full range of psychopathology including substance use disorders.
• Understand importance of preventive medical care.

Interpersonal and Communication Skills

• Ability to collaborate with other treatment and care providers, including multidisciplinary team members, psychosocial rehabilitation staff, case managers and somatic providers around treatment of severely mentally ill individuals.
• Ability to effectively liaison with professional colleagues in other fields (i.e., primary care physician).
• Ability to work with patients and their families utilizing approaches including psychoeducation, outreach and liaison with community services.
• Ability to express findings in coherent, orderly oral and written presentations including a discussion of the differential diagnosis and biopsychosocial treatments.
• Ability to communicate effectively with supervisors.

Professionalism

• Appreciate the profound responsibility of physicians for patients’ welfare and needs.
• Communicate honestly.
• Provide ethical and moral care.
• Sensitivity to, and acceptance of, diversity.
• Commitment to teaching others.
• Ability to obtain and provide cross coverage as needed.
• Ability to assist with and ask for assistance in emergencies as appropriate.
• Ability to do appropriate sign-outs, addressing pertinent issues for patients.
• Respect for patients and colleagues in interactions.
• Respect towards patients and family members.
• Respect towards physician and non-physician colleagues.
• Ability to follow through with patient care recommendations.
• Ethical behavior with respect for patient confidentiality.
• Ability to establish and maintain professional boundaries.
• Maintains a professional appearance appropriate to clinical site.

Practice-Based Learning

• Dedication to self-improvement.
• Recognize one’s limitations.
• Seek guidance whenever appropriate

System Based Learning

• Understanding of VA and other community resources relating to individuals with severe mental illness, including psychosocial rehabilitation programs, employment programs, day hospitals, crisis beds, and residential programs.
• Ability to advocate for quality patient care and assist patients in dealing with system complexities

**Inpatient Child and Adolescent Psychiatry**

**Patient Care**

• Master techniques and strategies for diagnostic assessment of preschool, school age and adolescent patients.
• Gain experience with behavior modification techniques, parent management techniques, brief therapy and longer term psychodynamic therapy.
• Develop competency and appropriately prescribe and manage stimulant medication for ADHD.
• Develop competency and appropriately prescribe and manage non-stimulant medication for ADHD.
• Develop competency and appropriately prescribe and manage medications for depression and anxiety in children and adolescents.
• Be aware of the various structured diagnostic tests (CBCL, Conners, CDI etc.).

**Medical Knowledge**

• Understand normal growth and development.
• Be familiar with the various diagnostic conditions seen during childhood and adolescence including ADHD, Conduct Disorder, Anxiety Disorders, Optional Deficit Disorder, Autism, Spectrum Disorders, Objective Disorders, Obsessive-Compulsive Disorders, Substance Abuse Disorders and Learning Disabilities.
• Understand the difference in symptom manifestation between children, adolescents and adults.
• Understand the occurrence of commonalities in children and adolescents.
• Understand the importance and impact of family dynamics among children and adolescents.
• Understand the importance and impact of school experiences and peer relationships.
• Become familiar with the various classifications of medications and their appropriate uses with child and adolescent patients.
• Learn the appropriate use of antipsychotics in children and adolescents.
• Learn the appropriate use of mood stabilizers children and adolescents.
• Be familiar with techniques and applications of play therapy.
Interpersonal and Communication Skills

- Ability to be empathic and develop rapport with patients.
- Ability to work effectively as part of a multidisciplinary team.
- Ability to work effectively as a team player with peers.
- Ability to communicate effectively with supervisors.
- Ability to be effective and empathic working with families.
- Ability to effectively liaison with professional colleagues in other fields (i.e., primary care physician).
- Ability to adapt his/her style of interaction specific to age and cognitive capacity.

Professionalism

- Personal and intellectual integrity and an understanding of the ethical values and codes of a member of the medical profession.
- Ability to obtain and provide cross coverage as needed.
- Ability to assist with and ask for assistance in emergencies as appropriate.
- Ability to do appropriate sign-outs, addressing pertinent issues for patients.
- Commitment to ethical principles when dealing with patients and families
- Respect for patients and colleagues in interactions.
- Sensitivity to and awareness of the patient’s culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
- Respect towards patients and family members.
- Respect towards physician and non-physician colleagues.
- Ability to follow through with patient care recommendations.
- Ethical behavior with respect for patient confidentiality.
- Ability to establish and maintain professional boundaries.
- Maintains a professional appearance appropriate to clinical site.

Practice-Based Learning

- Ability to facilitate medical students’ learning.
- Ability to use information technology to access on-line medical information and support his/her own education.
- Ability to locate, critique, and assimilate evidence from scientific studies as it relates to patients’ health problems.
- Ability to analyze practice experience and perform practice-based improvement activities.
- Ability to incorporate material discussed in supervision into clinical work.
- Motivation and eagerness to learn.

Systems Based Practice

- Knowledge of how types of medical practice and delivery systems differ from one another.
• Knowledge of different costs of health care for different service.
• Ability to advocate for quality patient care and assist patients in dealing with system complexities.

PGY 3

Outpatient Psychiatric Clinic

Patient Care

• Learn to utilize a biopsychosocial approach in the outpatient treatment of individuals with severe mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder, recurrent major depression, anxiety disorders, impulse control disorders, substance abuse/dependence, and severe personality disorders.
• Learn to treat severe mental illness pharmacologically and to manage medications, including antipsychotics, mood stabilizers, antidepressants, anxiolytics, and adjunctive medications, in an outpatient clinic.
• Learn to perform supportive psychotherapy and combined psychotherapy and psychopharmacological treatment of patients with severe mental illnesses.
• Learn to manage crises in outpatient treatment with patients with severe mental illnesses and demonstrate an understanding of criteria for more intensive treatment.
• Learn to perform recommended physical and laboratory assessments for initial outpatient treatment and continuing follow-up of patients with severe mental illness.
• Learn to address, at a basic level, somatic issues relevant to patients with severe mental illness (such as smoking cessation, diabetes, and hypertension) and facilitate and support appropriate somatic care.
• Learn to perform family therapy through supervised patient/family sessions.
• Learn to perform group therapy through a longitudinal, supervised experience as a group co-leader.
• Learn to perform individual psychodynamic psychotherapy and cognitive-behavioral therapy with appropriate patients through supervised, longitudinal psychotherapy experience.

Medical Knowledge

• Understand the concepts of recovery and consumer empowerment and how to utilize these concepts in the treatment of patients with severe mental illness.
• Develop advanced skill in selecting specific antidepressants for specific patient presentations (e.g. anxious depression, obsessive-compulsive disorder, post-traumatic stress disorder, other anxiety disorders, atypical depression, elderly patients, etc.).
• Develop advanced skill in combining antidepressants, using augmenters and other treatment strategies to address treatment-refractory depression.
• Develop advanced skill in treating refractory bipolar disorder and impulse control disorders using combination mood stabilizer therapies in addition to other somatic treatments (antipsychotics, thyroid augmentation, ECT, etc.).
• Learn treatment options for refractory psychotic disorders.
• Develop advanced proficiency in appropriately using antipsychotics to treat special populations and illnesses which lack a psychotic component.
• Develop advanced skill in treating common and serious antidepressant-induced side-effects (sexual dysfunction, insomnia, central serotonin syndrome, etc.).
• Develop advanced skill in treating common and serious mood stabilizer-induced side-effects (weight gain, alopecia, hypothyroidism, creatinine elevations, ataxia, etc.).
• Gain advanced knowledge of most CYP 450 mediated drug interactions pertinent to antidepressant and mood stabilizer therapy.
• Gain detailed knowledge of specific and special properties of various benzodiazepines (use of Clonazepam or alprazolam in panic disorder; conversion to clonazepam for BZD tapers; etc.).
• Develop basic skill in atypical uses of mood stabilizers (topiramate for binge eating or migraine, gabapentin for neuropathic pain, etc.).
• Learn the 3 antidepressants that don't produce sexual dysfunction when used as monotherapy.
• Develop advanced skill in treating a variety of anxiety disorders with syndrome-specific medications and cognitive-behavioral therapies.
• Develop proficiency in diagnosis and treatment of patients with comorbid psychiatric and substance abuse/dependence disorders.

Interpersonal and Communication Skills

• Ability to collaborate with other treatment and care providers, including multidisciplinary team members, psychosocial rehabilitation staff, case managers and primary care providers around treatment of severely mentally ill individuals.
• Ability to liaison effectively with professional colleagues in other fields (i.e., primary care physician).
• Ability to work with patients and their families utilizing approaches including psychoeducation, outreach and liaison with community services.
• Ability to express findings in coherent, orderly oral and written presentations, including discussion of the differential diagnosis and biopsychosocial treatments.
• Ability to communicate effectively with supervisors.

Professionalism

• Personal and intellectual integrity and an understanding of the ethical values and codes of a member of the medical profession.
• Ability to obtain and provide cross coverage as needed.
• Ability to assist with and ask for assistance in emergencies as appropriate.
• Ability to do appropriate sign-outs, addressing pertinent issues for patients.
• Commitment to ethical principles when dealing with patients and families
• Respect for patients and colleagues in interactions.
• Sensitivity to and awareness of the patient’s culture, ethnicity, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
• Respect towards patients and family members.
• Respect towards physician and non-physician colleagues.
• Ability to follow through with patient care recommendations.
• Ethical behavior with respect for patient confidentiality.
• Ability to establish and maintain professional boundaries.
• Maintaining a professional appearance appropriate to clinical site.

Practice-Based Learning

• Ability to facilitate medical students’ learning.
• Ability to use information technology to access on-line medical information and support his/her own education.
• Ability to locate, critique, and assimilate evidence from scientific studies as it relates to patients’ health problems.
• Ability to analyze practice experience and perform practice-based improvement activities.
• Ability to incorporate material discussed in supervision into clinical work.
• Motivation and eagerness to learn.

Systems Based Practice

• Understanding of community resources relating to individuals with severe mental illness, including psychosocial rehabilitation programs, employment programs, day hospitals, crisis beds, and residential programs.
• Understanding of how types of medical practice and delivery systems differ from one another.
• Awareness of different costs of health care for different services.
• Ability to advocate for quality patient care and assist patients in dealing with system complexities

PGY 4

Senior Inpatient Psychiatry

Patient Care

• Ability to model to junior residents skills in patient interviewing, chart review, and medical record documentation.
• Ability to model to junior residents presenting patients in rounds and completing a mental status exam.
• Ability to oversee junior residents' patient risk assessment skills in terms of safety of patients as well as safety of staff.
• Ability to review junior residents' assessments of patient medical stability and ongoing management of any medical issues related to inpatient care.
• Ability to review and critique junior residents' treatment plans.
• Ability to model the practice of basic individual, group and family psychotherapy as it relates to inpatient psychiatry.
• Ability to review and critique junior residents' discharge summary documentation.
• Ability to model culturally and spiritually sensitive approaches to patient care.
• Provide psychotherapy to selected outpatients.
• Provide evidence based and compassionate care to psychiatric inpatients, and emergency room/urgent care patients.
• Comfortable with appropriate referral and consultation with other medical specialties when appropriate in patient management.

Medical Knowledge

• Ability to provide a more extended differential and assessment of junior residents' admission workups.
• Display an easy familiarity with all psychotropic medication classes including SSRIs, TCAs, MAOIs, first and second generation antipsychotics, mood stabilizers, benzodiazepines, anticholinergic medications, and drugs used in the treatment of substance dependence.
• Display working ease with use of Clozapine, long acting injectable neuroleptics, and short acting injectable neuroleptics (including long and short term side effect concerns and monitoring).
• Ability to name receptors responsible for orthostasis, sedation, weight gain, and sexual dysfunction.
• Demonstrate an understanding of complex drug mechanisms of action, receptor blockade profiles, and indications for selection and use of specific agents.
• Familiarity with the indications, uses, and side effects of Electroconvulsive Therapy.
• Familiarity with using the medical literature to review and assess pharmacologic and nonpharmacologic interventions.
• Familiarity with the routine treatments of medical issues routinely encountered on psychiatric inpatient services including hypertension, hypotension, dyslipidemias, tachycardia, urinary tract infections, screening for tuberculosis, evaluation of fevers, and workup of chest pain.
• Familiarity with medical screening labs tests appropriate to given diagnoses and medications.

Interpersonal and Communication Skills

• Ability to co-lead community and team meetings on the unit.
• Ability to be emphatic and develop rapport with patients.
• Ability to work effectively as part of a multidisciplinary team.
• Ability to work effectively as a team player with peers.
• Ability to communicate effectively with supervisors.
• Ability to be effective and empathic working with families.
• Ability to effectively liaise with professional colleagues in other fields.
• Ability to adapt his/her style of interaction specific to age and cognitive capacity.
• Ability to model these abilities to junior residents and medical students including the ability to provide appropriate positive and negative feedback to them.

Professionalism

• Personal and intellectual integrity and an understanding of the ethical values and codes of a member of the medical profession.
• Ability to obtain and provide cross coverage as needed.
• Ability to assist with and ask for assistance in emergencies as appropriate.
• Ability to do appropriate sign-outs, addressing pertinent issues for patients.
• Commitment to ethical principles when dealing with patients and families.
• Respect for patients and colleagues in interactions.
• Sensitivity to and awareness of the patient’s culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
• Respect towards patients and family members.
• Respect towards physician and non-physician colleagues.
• Ability to follow through with patient care recommendations.
• Ethical behavior with respect for patient confidentiality.
• Ability to establish and maintain professional boundaries.
• Maintains a professional appearance appropriate to clinical site.
• Ability to provide specific and accurate professional feedback to junior residents, medical students, staff, and colleagues in a mature and empathic manner.

Practice-Based Learning

• Ability to facilitate medical students’ learning.
• Ability to use information technology to access on-line medical information and support his/her own education.
• Ability to locate, critique, and assimilate evidence from scientific studies as it relates to patients’ health problems.
• Ability to analyze practice experience and perform practice-based improvement activities.
• Ability to incorporate material discussed in supervision into clinical work.
• Motivation and eagerness to learn.

Systems Based Practice

• Understanding of how types of medical practice and delivery systems differ from one another.
• Awareness of different costs of health care for different services.
• Ability to advocate for quality patient care and assist patients in dealing with system complexities.
• A basic understanding of medical-legal issues as it relates to inpatient psychiatry including: voluntary and involuntary admission procedures, testifying at hearings, court ordered patients, issues of confidentiality, forced medications/medication panels.

**Senior Alcohol and Drug Abuse Inpatient Unit**

**Patient Care**

• Ability to model a thorough interview with substance abusing patients that will detail drug using histories, prior treatment, patient motivation for treatment and co-morbidity to junior residents and medical students.
• Ability to match patients with addictive disorders to proper levels of treatment utilizing objective recommendations according to the American Society of Addiction Medicine categories.
• Ability to use treatment methods focusing on patient denial, such as motivational interviewing and supportive confrontation, to convert involuntary patients into voluntary patients involved in their own care.
• Ability to model to junior residents skills in patient interviewing, chart review, and medical record documentation.
• Ability to oversee junior residents' patient risk assessment skills in terms of safety of patients as well as safety of staff.
• Ability to review junior residents' assessments of patient medical stability and ongoing management of any medical issues related to inpatient care.
• Ability to review and critique junior residents' treatment plans.
• Ability to model the practice of basic individual, group and family psychotherapy as it relates to inpatient psychiatry.
• Ability to review and critique junior residents' discharge summary documentation.
• Ability to model culturally and spiritually sensitive approaches to patient care.
• Provide psychotherapy to selected outpatients.
• Provide evidence based and compassionate care to psychiatric inpatients, and emergency room/urgent care patients.
• Comfortable with appropriate referral and consultation with other medical specialties when appropriate in patient management.
• Ability to engage in short and long term planning for disposition of patients with complicated psychosocial situations.

**Medical Knowledge**

• Ability to provide a more extended differential and assessment of junior residents' admission workups. Demonstrate understanding of the stages of recovery with addicted patients from
emergency care, withdrawal from various drugs (including heroin, cocaine and alcohol), stabilization and early recovery.

- Ability to apply several informational and diagnostic tools in diagnosing addictive disorders such as: CAGE, AUDIT, DAST, SMAST, ASI.
- Demonstrate understanding of the several models of addictive disorders and international strategies for highly resistant patients.
- Ability to treat patients for opiate agonist treatment based on an understanding of the complexities of Methadone, Buprenorphine and its varieties.
- Ability to use specific detoxification regimens both for alcohol and heroin.
- Ability to judiciously use antagonist medication (Naltrexone) used in the treatment of heroin dependence.
- Display an easy familiarity with all psychotropic medication classes including SSRIs, TCAs, MAOIs, first and second generation antipsychotics, mood stabilizers, benzodiazepines, anticholinergic medications, and drugs used in the treatment of substance dependence. Display working ease with use of benzodiazepines, suboxone, naltrexone, disulfiram, and antabuse.
- Familiarity with the withdrawal syndromes of the addictive substances and psychotropic management of that withdrawal.
- Ability to name receptors responsible for orthostasis, sedation, weight gain, and sexual dysfunction. Demonstrate an understanding of complex drug mechanisms of action, receptor blockade profiles, and indications for selection and use of specific agents.
- Familiarity with using the medical literature to review and assess pharmacologic and nonpharmacologic interventions.
- Familiarity with the routine treatments of medical issues routinely encountered in patients with drug/alcohol dependencies, including hypertension, hypotension, dyslipidemias, tachycardia, urinary tract infections, screening for tuberculosis, evaluation of fevers, and workup of chest pain.
- Familiarity with medical screening labs tests appropriate to given diagnoses and medications.

Interpersonal and Communication Skills

- Ability to co-lead community and team meetings on the unit.
- Ability to be empathic and develop rapport with patients.
- Ability to work effectively as part of a multidisciplinary team.
- Ability to work effectively as a team player with peers.
- Ability to communicate effectively with supervisors.
- Ability to be effective and emphatic working with families
- Ability to effectively liaison with professional colleagues in other fields.
- Ability to adapt his/her style of interaction specific to age and cognitive capacity.
- Ability to model these abilities to junior residents and medical students including the ability to provide appropriate positive and negative feedback to them.
Professionalism

- Personal and intellectual integrity and an understanding of the ethical values and codes of a member of the medical profession.
- Ability to obtain and provide cross coverage as needed.
- Ability to assist with and ask for assistance in emergencies as appropriate.
- Ability to do appropriate sign-outs, addressing pertinent issues for patients.
- Commitment to ethical principles when dealing with patients and families.
- Respect for patients and colleagues in interactions.
- Sensitivity to and awareness of the patient’s culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
- Respect towards patients and family members.
- Respect towards physician and non-physician colleagues.
- Ability to follow through with patient care recommendations.
- Ethical behavior with respect for patient confidentiality.
- Ability to establish and maintain professional boundaries.
- Maintains a professional appearance appropriate to clinical site.
- Ability to provide specific and accurate professional feedback to junior residents, medical students, staff, and colleagues in a mature and empathic manner.

Practice-Based Learning

- Ability to facilitate medical students’ learning.
- Ability to use information technology to access on-line medical information and support his/her own education.
- Ability to locate, critique, and assimilate evidence from scientific studies as it relates to patients’ health problems.
- Ability to analyze practice experience and perform practice-based improvement activities.
- Ability to incorporate material discussed in supervision into clinical work.
- Motivation and eagerness to learn.

Systems Based Practice

- Understanding of how types of medical practice and delivery systems differ from one another.
- Awareness of different costs of health care for different services.
- Ability to advocate for quality patient care and assist patients in dealing with system complexities.
- A basic understanding of medical-legal issues as it relates to Addiction psychiatry including: Tarasoff warnings, court ordered treatment, issues of confidentiality, appropriate medication consent.
Senior Outpatient Psychiatric Clinic

Patient Care

- Learn to supervise PGY 3 residents in utilizing a biopsychosocial approach in the outpatient treatment of individuals with severe mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder, recurrent major depression, anxiety disorders, impulse control disorders, substance abuse/dependence, and severe personality disorders.
- Learn to supervise PGY 3 residents to treat severe mental illness pharmacologically and to manage medications, including antipsychotics, mood stabilizers, antidepressants, anxiolytics, and adjunctive medications, in an outpatient clinic.
- Learn to supervise PGY 3 residents in performing supportive psychotherapy and combined psychotherapy and psychopharmacological treatment of patients with severe mental illnesses.
- Learn to supervise PGY 3 residents in managing crises in outpatient treatment with patients with severe mental illnesses and demonstrate an understanding of criteria for more intensive treatment.
- Teach PGY3 residents to perform recommended physical and laboratory assessments for initial outpatient treatment and continuing follow-up of patients with severe mental illness.
- Learn to supervise PGY3 residents in adhering to, at a basic level, somatic issues relevant to patients with severe mental illness (such as smoking cessation, diabetes, and hypertension) and facilitate and support appropriate somatic care.
- Facilitate opportunities for PGY 3 residents to perform group therapy through a longitudinal, supervised experience as a group co-leader.
- Facilitate opportunities for PGY 3 residents to perform individual psychodynamic psychotherapy and cognitive-behavioral therapy with appropriate patients through supervised, longitudinal psychotherapy experience.
- Transition to independent care of outpatients and the ability to practice without supervision

Medical Knowledge

- Supervise PGY 3 residents in understanding the concepts of recovery and consumer empowerment.
- Supervise PGY 3 residents in developing advanced skill in selecting specific antidepressants for specific patient presentations (e.g. anxious depression, obsessive-compulsive disorder, post-traumatic stress disorder, other anxiety disorders, atypical depression, elderly patients, etc.).
- Supervise PGY 3 residents in developing advanced skill in following areas: combining antidepressants, using augmenters and other treatment strategies to address treatment-refractory depression, treating refractory bipolar disorder and impulse control disorders using combination mood stabilizer therapies in addition to other somatic treatments (antipsychotics, thyroid augmentation, ECT, etc.), treatment options for refractory psychotic disorders, proficiency in appropriately using antipsychotics to treat special populations and illnesses which lack a psychotic component, treating common and serious antidepressant-induced side-effects (sexual dysfunction, insomnia, central serotonin syndrome, etc.), advanced skill in treating
common and serious mood stabilizer-induced side-effects (weight gain, alopecia, hypothyroidism, creatinine elevations, ataxia, etc.).

- Facilitate understanding of most CYP 450 mediated drug interactions pertinent to antidepressant and mood stabilizer therapy.
- Supervise PGY 3 residents in obtaining detailed knowledge following: specific and special properties of various benzodiazepines (use of Clonazepam or alprazolam in panic disorder; conversion to clonazepam for BZD tapers; etc.), atypical uses of mood stabilizers (topiramate for binge eating or migraine, gabapentin for neuropathic pain, etc.)
- Supervise PGY 3 residents in developing advanced skill in treating a variety of anxiety disorders with syndrome-specific medications and cognitive-behavioral therapies.
- Supervise PGY 3 residents in developing proficiency in diagnosis and treatment of patients with comorbid psychiatric and substance abuse/dependence disorders.

Interpersonal and Communication Skills

- Enhance ability to collaborate with other treatment and care providers, including multidisciplinary team members, psychosocial rehabilitation staff, social work staff, administrative staff, PGY 3 residents, case managers and primary care providers around treatment of severely mentally ill individuals.
- Enhance ability to liaison effectively with professional colleagues in other fields (i.e., primary care physician).
- Enhance ability to work with patients and their families utilizing approaches including psychoeducation, outreach and liaison with community services.
- Enhance ability to supervise oral and written presentations, including discussion of the differential diagnosis and biopsychosocial treatments.
- Enhance ability to communicate effectively with supervisors.

Professionalism

- Personal and intellectual integrity and an understanding of the ethical values and codes of a member of the medical profession.
- Ability to obtain and provide cross coverage as needed.
- Ability to assist with and ask for assistance in emergencies as appropriate.
- Ability to do appropriate sign-outs, addressing pertinent issues for patients.
- Commitment to ethical principles when dealing with patients and families
- Respect for patients and colleagues in interactions.
- Sensitivity to and awareness of the patient’s culture, ethnicity, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
- Respect towards patients and family members.
- Respect towards physician and non-physician colleagues.
- Ability to follow through with patient care recommendations.
- Ethical behavior with respect for patient confidentiality.
• Ability to establish and maintain professional boundaries.
• Maintaining a professional appearance appropriate to clinical site.

Practice-Based Learning

• Ability to facilitate medical students’ learning.
• Ability to use information technology to access on-line medical information and support his/her own education.
• Ability to locate, critique, and assimilate evidence from scientific studies as it relates to patients’ health problems.
• Ability to analyze practice experience and perform practice-based improvement activities.
• Ability to incorporate material discussed in supervision into clinical work.
• Motivation and eagerness to learn.

Systems Based Practice

• Understanding of community resources relating to individuals with severe mental illness, including psychosocial rehabilitation programs, employment programs, day hospitals, crisis beds, and residential programs.
• Understanding of how types of medical practice and delivery systems differ from one another.
• Awareness of different costs of health care for different services.
• Ability to advocate for quality patient care and assist patients in dealing with system complexities.

Supervision Guidelines

A. UCSD Guidelines

Purpose: To ensure proper and consistent supervision of house officers in delivery of patient care.

Communication and collaboration between attending physicians and housestaff is required. Identification of the respective duties and responsibilities of attendings and housestaff provides the foundation upon which supervision is based. Housestaff must be supervised by attending faculty in such a way that the housestaff assume progressively increasing responsibility for patient care according to their level of training, ability and experience.

Ambulatory Sites:
• Housestaff will be able to identify an available supervising attending at all times during patient care.
• Attending faculty will be available to housestaff during the entire ambulatory clinic session or outpatient procedure.
• Attending faculty or licensed housestaff physician will personally supervise and appropriately document the care of all patients under the care of unlicensed housestaff.
A faculty attending member will be responsible for service in each specific ambulatory site. This individual will be responsible for insuring compliance with ACGME policies.

**Urgent Care, Emergency Department Sites:**
- Housestaff will be able to identify an available supervising attending at all times during patient care.
- Attending faculty will be available to housestaff.
- Compliance with requirements regarding the supervision of housestaff and the care of patients.
- A specific attending faculty member will be assigned to be responsible for compliance with ACGME policies.
- At the request of the emergency medicine faculty, a consulting attending faculty member will personally see the patient and document recommendations for care. Alternatively, licensed resident-level consultation may suffice in some cases. In these cases, supervision by specialist faculty will be routinely expected by telephone.

**Inpatient Sites:**
- Housestaff will be able to identify an available supervising attending at all times during patient care. Attendings must be available to housestaff and must be able to provide direct consultation patient care when necessary.
- Admissions will be discussed with an attending supervisor on the day of admission.
- Transfers and discharges will be discussed with an attending prospectively.
- As often as medically appropriate, attending faculty (or his/her attending faculty back-up) will personally supervise the care of all hospitalized patients assigned to his/her service, will document as appropriate and will see patients daily.
- An attending faculty will personally see and supervise inpatient consultations referred to his/her service and insure appropriate documentation.
- Compliance with ACGME requirements regarding the supervision of housestaff and the care of inpatients.
- A specific attending faculty member will be responsible for compliance with ACGME policies in the inpatient setting.

**B. ACGME Regulations**

**Components of Attending Supervision:**
- Educational objectives are defined.
- The supervisor assesses the skill level of the housestaff by direct observation.
- The supervisor authorizes independent action by the housestaff.
- The supervisor defines the course of progressive independence from performing functions together with decreasing frequency of review. This process starts with close supervision, progressing towards independence as skills are observed.
- Written evaluation and feedback are considered in the progression levels. At all times, the housestaff has access to advice and direction from the supervisor.

**Defining Levels of Supervision:**
- Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. Other portions of care provided by the
resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities.

- To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following levels of supervision:
  - Direct Supervision – the supervising physician is physically present with the resident and patient.
  - Indirect Supervision:
    - With direct supervision immediately available – the supervising physician is physically within the other site of patient care, provide Direct Supervision.
    - With direct supervision available – the supervising physician is not physically present within the other site of patient care, but is immediately available to provide Direct Supervision.
    - Oversight – The supervising physician is available to review care delivered.

- The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty member.

  - The program director must evaluate each resident’s abilities based on specific criteria.
  - Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
  - Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence.

C. USCD Psychiatry: Certifying PGY1s:

PGY-1 residents may progress to being supervised indirectly with direct supervision available only after demonstrating competence in:

a) The ability and willingness to ask for help when indicated;
b) Gathering an appropriate history;
c) The ability to perform an emergent psychiatric assessment; and,
d) Presenting patient findings and data accurately to a supervisor who has not seen the patient.

Inpatient Psychiatry

- a-d above are taught in the Crash Course and reinforced in didactics and daily clinical activities
- Each PGY1 observes 1 new patient evaluation done by a senior resident or attending level psychiatrist before being observed doing at least 1 complete intake evaluation.
- After the PGY1 passes at least one 'CSV-like*' evaluation (doing a new patient diagnostic assessment and presenting the case and mental status exam) on the appropriate form and supervised by an attending level psychiatrist, the resident may graduate to performing new patient evaluations with "direct supervision immediately available".
- Thereafter, new patients will be presented to a senior resident or attending level psychiatrist the same day and interviewed by an attending psychiatrist at rounds within 24 hours of admission
• Follow-up and daily interviews can be completed with "direct supervision immediately available" with daily supervision either individually and/or at rounds and sign outs until residents are certified by at least 3 psychiatrists - (1) senior resident, 2) supervising or attending psychiatrist and 3) site director - as competent in a, b and d above. After that, they may see patients "with direct supervision available".

Call (evenings, nights and week-ends)
• On call with senior (PGY3 and 4 residents) up to 10 pm initially with Direct Supervision until
• At least 4 (short or long) calls, and
• Pass at least 1 CSV (testing patient relationship, history and presentation)
• At least 1 residents and 1 faculty certify competence in a-d above
• Progress to call with senior (PGY3 and 4 residents) up to 10 pm with direct supervision immediately available until
• Total of 6 calls (long or short), and
• Pass at least 1 CSE (CSV + differential diagnosis and treatment plan)
• At least 2 residents and 2 faculty certify competence in a-d above
  a. Progress to call (in-house without senior or attending psychiatrist) with Indirect Supervision available
     o Not until > 4 months training, including > 1 month medicine, 1 month inpatient psychiatry and at least 6 short calls and 1 long call with direct supervision immediately available
        ▪ Pass at least 1 CSE (as above)
        ▪ Certified competent on a-d above by 2 residents and 3 faculty attendings, including site director
     o *'CSV like' = can be full CSV or even CSE, but not necessarily fulfilling all requirements of ABPN. Goal is assessing competency to take call with supervision available - not necessarily to practice psychiatry independently

D. Clinical Supervision Policy for Call at the Medical Center:

Purpose: To ensure proper and consistent supervision to the interns, who take primary call at the university, with senior residents and attendings serving as backup.

• Prescribing Medications: In general, this should not be done while on-call. Interns are expected to manage patient’s medications on the unit, and make recommendations when consulting in the ED or on the floor, and should get senior resident input whenever needed. Rarely, an intern may want to prescribe medications to someone who is leaving the ED. The case will be discussed with the senior anyway, and the question of medications can be addressed then. Phone call requests for refills are not in the scope of on-call duties, but in the rare case that it is indicated, the senior will need to call in the Rx with their own license and DEA numbers.

• Patients Sent Out Of The Emergency Department: Every patient that leaves the ED to return home (including board and cares, shelters, and others) will be presented in full to the senior resident prior to them leaving. This is important not only for the protection of the patient, but to the intern as well. If need be, the university attending will be called to review the case
in addition. The intern will document in the notes who the case was discussed with (e.g. the case was discussed with and treatment plan approved by Dr. Jones).

- **Outside Phone Calls From Patients**: The intern will use their discretion regarding calling the senior backup. Outside calls tend to be straight forward, but can produce a lot of anxiety since you will only get a small part of the picture. In general, situations that require a change in medication or treatment also necessitate a formal evaluation in person. The patient can be asked to come to the ED, or 911 can be called to dispatch assistance to them. Feel free to ask for someone’s number, and call then back with your final decision after talking to the senior resident. All calls will be reviewed in sign-ins the following morning.

- **Floor Consults**: These need to be staffed by an attending within 24 hours. If an intern has concerns that can’t wait until morning sign-ins, they will call the senior resident. On weekends, the intern will inform the oncoming person of the consult so that they can present to the attending during weekend rounds (a copy of the consult note should be given to the oncoming person as well).

- **Patients Admitted To The Unit**: The intern will call the senior for questions about admission orders and medications overnight. If a problem particular to the unit comes up, call the university attending, or chief resident.

- **Patients Sent To Another Facility**: When someone is being admitted to CMH, another hospital, or a crisis house, they are being transferred to a safe environment, and a psychiatrist there will be in charge of treatment. Therefore, unless there are specific concerns these patients can be presented in sign-ins the following day.

- **Patients Being Discharged From the Unit**: Any unscheduled discharge from the unit needs to be cleared by the university attending on-call. This includes AMA discharges for people who are not detainable.

- **Study Patients**: For questions related to patients enrolled in a research study, calls should go to Dr. Feifel. If any patient in a research study conducted by Dr. Feifel presents to the ED, he should be contacted immediately. If the patient is enrolled in an outside study, they should have a number for the study coordinator, and if not, attempts should be made to reach the attending involved in the study.

- **Patients With Outpatient Doctors**: When a patient with an outpatient doctor presents to the ED or calls, attempts should be made to coordinate care as much as possible. For patients getting care at the UCSD Outpatient Clinic, leave a voicemail with their doctor. For a patient followed by one of our attendings, consider paging the attending or calling them at home, but at the minimum leave a voice mail informing them of the events. For patients with private doctors, the task of getting information and providing appropriate disposition can be expedited by getting in touch with their office. The patient may have the number of their office or answering service, and frequently the private doctor can assist with admitting patients to one of the hospitals they service.
When To Call The Attending: Anytime the intern believes it is necessary! Whenever a resident would like to discontinue a hold prior to discharging a patient. Whenever suicide risk is a concern. Serious or potentially serious adverse events. Prior to discharging a patient from the inpatient service or emergency room. If a resident is unable to reach the faculty attending who is on-call, they will try to reach the attending in charge of that patient’s care, the Site Director or the Residency Training Director, they will try the university chief resident first, then call the attending if needed.

E. Supervision Guidelines (for residents): Policy for Graded Supervision and Transition of Care on Inpatient Psychiatry Service

Effective July 1, 2011, the following policy will be in effect for resident’s duties/responsibilities on the 2-5 Inpatient Psychiatric unit at the VA and the NBMU Inpatient unit at the UCSD medical center.

1. PGY-1 Residents
   - PGY-1 residents on Inpatient Psychiatry will carry no more than six patients at any given time.
   - The PGY-1 resident will see their patients under direct supervision (physical presence) of a senior resident (PGY-4) or the attending physician assigned to the patient.
   - An individual determination of PGY-1 residents will determine if they can move to indirect supervision at the end of the first week. When it is determined that they are able to see patients with indirect supervision, an in-house direct supervisor must be immediately available to discuss each patient seen by PGY-1 residents until they are certified as capable of caring for patients with indirect supervision and “supervision available”.

2. PGY-2 Residents
   - PGY-2 residents will carry no more than eight inpatient patients at a given time.
   - PGY-2 residents will be able to provide direct supervision to PGY-1 residents as long as documentation has been completed attesting to an individual PGY-2 resident’s ability to provide supervision to junior resident colleagues.

3. PGY-4 Residents
   - PGY-4 residents will provide direct/indirect supervision to PGY-1 and PGY-2 residents on the unit at any given time. When PGY-1s and PGY-2s under their supervisions have reached their maximum (up to 6 and 8 patients respectively), PGY-4 residents will carry the additional patient assigned to that team.
   - When PGY-4 residents are providing direct supervision to PGY-1 residents, the maximum number of inpatients being followed by a PGY-4 resident will be one or two.

F. Lines of Supervisory Responsibility:
   - The attending Physician will have the final responsibility for the care of each patient admitted under his/her name or accepted for transfer to his/her care.
   - Each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for the patient’s care. This information will be available to residents, faculty, and staff members, and patients. Residents and faculty members will inform patients of their respective roles in each patient’s care.
G. Resident Progression in Responsibility for Patient Care:

A resident will progress through the levels of supervision according to individual ability, based on observation of patient care in the hospital and subsequent evaluation by faculty members. All PGY-1 resident and new residents to the program will begin providing patient care under Direct Supervision. Each resident will be evaluated for progression to Indirect Supervision with Direct Supervision Immediately Available (Level A Supervision) by an assessment form; assessment forms by 2 different faculty members must attest that the resident is capable of providing patient care with Indirect Supervision if Direct Supervision is available within the hospital complex. It is expected that residents might be able to progress to this level of supervision within the first week assigned to an Indirect Supervision with Direct Supervision Available (Level B Supervision), which would permit the resident to provide patient care if phone supervision is available.

H. Resident Supervision of Junior Trainees

A resident who requires Direct Supervision will not be able to independently supervise medical students. Once a resident has progressed to Level A Supervision, he/she will be able to supervise medical students. Subsequently, a resident who has advanced to Level B supervision will be able to supervise junior psychiatric and non-psychiatric residents. These advanced residents will be able to serve in a supervisory role on the Inpatient, Consultation/Liaison, Emergency, Geriatric, and Outpatient Psychiatry rotations.

I. In-house (Attending)

- Each clinical rotation site must assign residents one or more attending supervisors who assume overall responsibility for the clinical care and management of all patients assigned to each resident at a given site (e.g. VA, UCSD).

- These attending supervisors generally are responsible for supervising residents on all administrative matters (e.g. monitoring and/or medical records) during the assigned rotation.

- Although residents frequently will be reviewing their cases with other teaching faculty and education supervisors (e.g. psychotherapy supervisors, case conferences, psychopharmacology rounds), any patient care recommendations generated from those sources should be reviewed and approved as directed by management decisions for that individual patient. Each individual attending supervisor should inform the resident under what clinical circumstances and within what time frame he/she needs to be consulted (e.g. evaluation of suicidality, hospitalization decisions, medication changes, discharge plans).

- Assigned attending supervisors will review and co-sign all required clinical documentation as per individual site/location administrative policies and requirements.

- Frequency of contact will be determined by the assigned attending supervisor in consideration of the specific residency education requirements for a particular clinical rotation. In general, the assigned attending supervisor will lead rounds 3-5 times weekly as well as weekly supervision.
• Attending supervisors generally are required to complete an electronic or written evaluation on each resident supervised. This should be reviewed by the supervisor with the assigned resident. The Residency Training Office and the involved resident should be informed promptly regarding any problems with the resident’s performance on any rotation, so that remediation and improvement are possible.

J. Other Clinical Supervisors

• In addition to attending supervisors, residents may be expected to review patients with a variety of additional individual or group supervisors and teaching faculty for academic purposes. This may include supervisors of various types of psychotherapy, case conference and grand rounds discussants, diagnostic conference leaders, and long-term psychotherapy supervisors.

• These academic supervisors are responsible for teaching residents clinical management techniques, generally in a defined area of expertise (e.g. how to conduct psychodynamic psychotherapy). Although they may make specific clinical recommendations to assigned residents, such recommendations are still subject to review and approval by resident’s assigned attending supervisor.

• Frequency of contact will be based on residency education requirements. In general, each resident has 2 hours of clinical supervision weekly in addition to case conferences with grand rounds and their teaching didactics.

• Academic supervisors are also required to complete an electronic or written evaluation on each resident supervised. This should be reviewed by the supervisor with the assigned resident. The program director and the involved resident should be informed promptly regarding any problems with the resident’s performance, so that remediation and improvement are possible.

K. Long-Term Psychotherapy Supervisors and Clinical Experiences

Residents in the general Psychiatry residency training program are expected to have supervised long-term psychotherapy training experiences of a year or more in duration, beginning in the PGY-2 year. The following principles have been adopted:

• All residents must have at least four supervised long-term psychotherapy experiences of a year or more in duration.

• All residents should become introduced to supervised long-term psychotherapy no later than the second six months of the PGY-2 year.

• Service chiefs, supervisors, and residents should work together to develop schedules that will provide for up to 2 hours a week for psychotherapy cases and associated supervision during the PGY-2 year and 4-6 hours in the PGY-3 and PGY-4 year.
L. Individual Supervision

Each resident must be provided a minimum of 2 hours of direct supervision per week, at least 1 of which is individual.

M. Residents’ Personal Psychotherapy/Psychiatric Treatment

Residents are encouraged to pursue their own psychotherapy, but residents should arrange their schedule so as not to interfere with clinical or other teaching activities.

N. Patient Numbers

Each resident should be assigned a reasonable number of patients consistent with the individual resident’s skill level. The cap on inpatient numbers will be a maximum of 6 inpatients. A beginning PGY-1 resident may not be able to manage more than 4-5 patients initially, but he/she should be able to work up to the maximal 6 inpatients when Level A Supervision has been attained. PGY-4 residents provide direct patient care as needed (e.g. when beginning and intermediate residents have reached their cap, when they need help, when a junior resident on the team is ill or on vacation etc. PGY-4 inpatient duties also include assisting in morning report, evaluating proposed admission requests, providing didactic and clinical instruction to junior residents and medical student, learning to lead a multidisciplinary treatment team, and acquiring administrative skills.

In addition to Attending Supervision, all housestaff receive 2 hours of weekly additional Clinical Supervision from clinical faculty. Clinical supervisors will meet resident their offices and provide patient focused teaching and guidance, using patient interviews, videotaped interviews, progress notes and the psychiatric interview as resources.

In accordance with ACGME guidelines, each patient must have must have an identifiable, appropriately-credentialed and privileged attending physician or who is ultimately responsible for that patient’s care.

- This information should be available to residents, faculty members, and patients.
- Residents and faculty members should inform patients of their respective roles in each patient’s care.

O. Individual Supervision Guidelines for Residents

1. We believe supervision is one of the most important methods of teaching available and an integral part of your education. Any resident who is not receiving an adequate quality and quantity of supervision is being cheated. If you have problems connecting with, contacting, seeing or getting along with your supervisor, please let me know immediately.

2. During the first year, Interns should have at least one clinical supervisor from our volunteer faculty meeting with you either NMBU or 2-S, at least weekly. In addition, full-time faculty and senior residents from on your service will be supervising you in rounds as well as individually. Finally, each PGY-1 has been assigned a mentor who should meet with you as often as the 2 of you see fit. The role of the mentor is to guide you in any area relevant to your training.
3. During PGY-2 and PGY-3, the resident is assigned two clinical supervisors who meet with residents weekly in addition to teaching you receive from full-time faculty, senior residents and service chiefs. The two clinical supervisors should meet with the resident weekly whenever the resident is on a VA rotation (e.g. 2-S, ADTP, PEC, etc). Each of your supervisors can and will discuss in or out patients with you. If the resident and supervisor can arrange it, we encourage them to try to continue meeting during months away (e.g. CL or CAPS), though we know this isn’t always possible. Many other services (e.g. PEC, CL, ADTP, geriatric psychiatry) also supply additional service-oriented supervisors.

4. PGY-4s should receive supervision from mentors, service chiefs, administrative supervisors and at least one clinical supervisor. The nature and frequency of this supervision varies considerably from resident to resident. Supervision from other faculty on an “as needed basis” is always available at your initiation.

5. Any resident who would like additional supervision should contact Sidney Zisook, Alana Iglewicz, their site director (David Feifel, David Lehman or Sanjaya Saxena), or their clinical service chiefs immediately. If you are having problems with your supervisor and you can’t work it out with them (often a valuable exercise), contact one of us immediately. If you have a particular interest (e.g. forensics, molecular biology, ECT, etc.) and would like to meet with someone around those interest, either contact them directly, if you know who they are, or see me. We aim to please.

6. You and your supervisors should discuss mutual goals and expectations early on. There are no hard and fast rules on what to discuss, or how much personal issues may become the focus of supervision. However, learning about counter transference does get personal. Every resident-supervisor dyad is unique.

7. Many residents have found it useful to have supervisors interview selected patients with them, have the supervisor observe the resident interviewing, discuss detailed process notes from one or two patients, discuss clinical problems, discuss questions arising from seminars or reading, discuss areas of perceived weakness, etc. Taping is available at all clinical sites and the equipment to view with your supervisor is also available at each site. This is a greatly underutilized learning modality. I encourage you all to videotape at least some patients each year. Many of your supervisors will be happy to review the tapes with you.

8. The goals of supervision include 1) development of technical (including use of psychotherapy and of medications) and interpersonal skills; 2) support – examination and management of clinical work; 3) quality assurance; 4) transmission of professional values.

9. Although personal psychotherapy is not one of the goals, given the regular, structured, 1:1 contact between trainee and supervisor, development of rapport, disclosure of personal experiences, and power imbalance (features that are an integral part of both supervision and psychotherapy) the boundaries sometimes can blur. This is not to say that important personal insight and understanding cannot or should not occur during supervision. They should.

10. Some supervisors are better at teaching psychotherapy, some pharmacotherapy, and some are equally adept at helping with both. We try to balance your supervisors to give you both excellence in psychotherapy and psychopharmacological instruction. Try to maximize the unique skills and proficiencies of each of your supervisors. Sometimes you’ll get conflicting opinions
from different supervisors. This can be confusing. Learning to live with ambiguity and uncertainty while developing your own unique style, incorporating the best of your many supervisors and mentors, is part of becoming a psychiatrist.

11. There are as many types of supervision as there are supervisors. Some see patients with you, some talk and teach, some never say a word until you speak (dreaded silence!), others have a specific agenda and others are there for “whatever you need each and every week”. You may even feel that you “know more than your supervisor”, or you may feel you’ll never know as much. Chances are, you’re wrong on both counts.

12. Be creative and even efficient: Have your supervisor interview a new admission for you. Do you have a difficult patient? Watch how your supervisor handles the problems in real time (this can be more informative than hearing what you “should have said” before the patient refused to talk to you any further, left the room and is now permanently mute, glaring across the room at you). Have your supervisor watch you interview a new, difficult or interesting patient: get feedback on your style as well as patient management.

13. **Supervision is not an option.** It is our responsibility to provide it, and yours to make sure it happens. You will be presented the names and phone number and e-mails (if available) of your supervisors. In some cases, the first meeting will be already scheduled for you. In others, you will need to call their office to set up the first appointment. Please make sure you do this. Do not let more than one week ago by without setting up an appointment for your supervision. Each supervisor has agreed to meet with you on site. They have been pre-assigned on the basis of the geographical location most convenient for them. If you need to change or cancel an appointment with one of your supervisors, always let them know with as much lead-time as possible.

14. All residents will be supervised on the clinical service on which they are working and not in the offices of the supervisors.

15. If some problems arise in your supervisory experience, every attempt should be made to work it out with your supervisor since this can be a very meaningful part of the supervisory experience. If the problem cannot be resolved between you and your supervisor, please call Dr. Zisook for an appointment to discuss the matter.

16. The Graduate Education Committee will expect each supervisor to make a written report at the end of the rotation period describing the supervisory experience and an evaluation of the resident's work (please see sample form). This report should be shared with the resident, discussed and signed. In the same way, a report by the resident regarding his views of the supervision and the supervisor is expected (see sample form). Both resident and supervisor reports are to be sent to the Residency Training Office.

17. All supervisory assignments are made centrally in the Residency Training Office. Occasionally a resident may contact a supervisor about future supervision on his own initiative. This should be immediately reported to the Residency Training Office for review and coordination since it is the responsibility of the Residency Training Office to make all the assignments.
Your supervisor will be asked to evaluate you and to document that you have attended at least 70% of your weekly supervisory sessions. This is an important part of your training and important for your promotion. You will also be asked to evaluate them. We encourage supervisor and supervisee to share evaluations on an on-going basis and formally during the last session.

**Policies and Procedures for Residents' Duty Hours and Work Environment**

**Working Hours:** Duty hours are defined as all clinical and academic activities related to the residency program, including inpatient and outpatient care, administrative duties relative to patient care, 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.

a. Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. All moonlighting hours, either external or internal, must be logged and included in the 80 hour maximum per week.

b. Residents are provided with at least 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties. At-home call cannot be assigned on these free days.

c. PGY-1 and PGY-2 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

d. Residents in the final years of education, PGY-3 and PGY-4 residents, must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. (a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

e. Duty periods of PGY-1 residents must not exceed 16 hours in duration. (There is no 4 hour transition period).
f. PGY-2-4 residents must be scheduled for in-house call no more frequently than every-third-night. Averaging is not allowed.

g. Duty periods of PGY-2-4 residents may be scheduled to a maximum of 24 hours of continuous duty in the hospital. It is essential for patient safety and resident education that effective transitions in care occur. This period of time must be no longer than an additional four hours.

h. PGY-2 residents must have at least 14 hours free of duty after 24 hours of in-house duty.

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

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

k. At-home call (or pager call): At-home call is not so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call are provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

l. When residents are asked to assume patient care responsibility as part of the “on-call back up system” (that is, to assume the clinical assignment of another resident because of that resident’s inability to assume that assignment for any reason), the above restrictions on clinical assignment are applied, and the hours worked for the absent resident are included in the “back-up” resident’s duty hours tally.

m. The Program Director and Site Directors will monitor the clinical demands of all residents and will make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue, whatever the reason(s) for that fatigue.

On-Call Frequency: Residents, on average, are on-call no more than every 6th night.

Time Off: Residents, on average, have at least one full day off every week and at least 10 hours off between all scheduled daily duty shifts and often in-house call (see Working Hours for more details).

Annual Leave: Residents have a total of four weeks of vacation leave annually. Taking vacation leave will be subject to the following guidelines:

a. Forms are available from the Residency Training Office and must be submitted for approval at least 60 days in advance. This will allow adequate time for on-call scheduling and service coverage. Vacation requests will be reviewed on a first-come, first-serve basis.

b. Signatures from the appropriate rotation Attending, Chief Resident and Primary Care or other Specialty Clinic is mandatory prior to submitting vacation request to the RTO for approval.

c. Vacation leave must be taken in a minimum of one-week blocks and no more than a two-week block of time.
d. Vacation leave may not be carried over from one training year to the next.

e. **No terminal vacation leave will be paid.**

f. PGY I & II residents **must** take **two weeks of vacation in each six-month period** (July-December and January-June). Only one PGY-I/II year resident may be on vacation from any service at a time. Vacation will be allocated among the PGY I & II year clinical services according to the following schedule:

1. UCSD Medical Center Inpatient Service (West Wing): avoided whenever possible.
2. Mercy Hospital – 1 week (ALREADY ASSIGNED) *See Rotation Schedule.*
3. VAMC Inpatient Service (2-South): 1-2 weeks (only when 6 junior residents are on service).
4. VAMC Alcohol and Drug Treatment Program (ADTP): 1 week **required** from 2-3 month ADTP (only when 2 junior residents on service).
5. VAMC Psychiatric Emergency Clinic (PEC): none
6. Consultation/Liaison : none
7. Neurology: - 1 week **required,** generally last week of rotation.
8. Child Inpatient Service: - 1 week **strongly encouraged** at the beginning or end of rotation when two residents are on the rotation, 1 resident at a time. However when there is only one resident on the rotation, vacation must be cleared with Service Chief.
9. Geriatric Psychiatry: - 1 week **allowed.**
10. **No vacation last 2 weeks in June unless pre-assigned by RTO.**
11. UCSD Outpatient Psychiatric Services: no vacation in first two months of rotation or last two weeks of rotation.

g. Always remember to notify all of your clinical services of any time away (e.g., Primary Care Clinic) so that they can arrange for patient care. Clinic cancellations must be made at least 2 months in advance.

h. **USE IT OR loose IT!! VACATION MUST BE TAKEN ACCORDING TO THESE GUIDELINES.**

**Educational Leave:** up to 3 days yearly (PGY 2-4) with the approval of service chief and arrangement for adequate coverage. Up to 5 days if presenting a paper or an abstract or given an award. This is meant to provide residents the opportunity to attend continuing education meetings to supplement their training. To be excused without having to use your vacation time, the resident must provide the Residency Training Office with a conference brochure and request, signed by the service chief, at least 60 days before the scheduled conference.
**Supervision:** All residents meet at least weekly with at least one full time and one volunteer faculty supervisor. Supervision should be documented in the patient’s chart.

**On-Call Facilities:** In-house private and secure sleep and rest space with bathroom facilities is provided.

**Grievances:** Residents may bring grievances regarding working conditions to the Department of Psychiatry, Resident Training Committee (RTC), or to the Residency Training Director privately. Residents may also discuss any grievances privately and confidentially with the Executive Vice-Chair of the Department (Dr. Igor Grant), the UCSD Office of the Ombuds, or with the Institutional Director of Medical Education (Dr. Steve Hayden). In addition, residents may provide anonymous comments on the Department of Psychiatry Resident Training website and/or the institutional anonymous feedback folder on the UCSD GME website.

**Sexual Harassment:** No resident should never be sexually harassed, exploited, or intimidated by another house officer, instructor, or faculty member. Any such intrusion should be reported to the administrative supervisor and/or residency training director immediately. Please refer to the UCSD policy statement.

**Monitoring Working Conditions (including resident stress and fatigue):** In accordance with UCSD and ACGME guidelines, the faculty and Residency Training Office will ensure that resident working conditions are in compliance with the above and that the work environment should minimize undue stress and resident fatigue. To do this, we will:

- Ensure grievances are heard (see #7 above)
- Assign 2 mentors (a faculty and a resident) to each incoming resident to help ease their transition, help with personal issues and monitor well-being.
- Provide support group for all PGY2’s, elective thereafter.
- Provide no cost /low cost psychotherapy for all interested residents.
- Maintain availability of Associate Training Directors, Site Directors and Chief Residents who are available to all residents, in each year, and who meet regularly with each class
- Maintain meetings of each class with the Residency Training Director (Dr. Zisook) on a regular basis.
- Maintain an open door policy with the Residency Training Office. Residents are always welcome.
- Discuss residency issues, including stress, and working conditions and resident well-being at each monthly RTC meeting. Each class has at least 2 representatives on that committee. The representatives are given the responsibility of bringing information to and from the residents in their year.
- Require residents to regularly complete evaluations of each rotation and of the program which will be reviewed by the Residency Training Director.
• Semi-annual face-to-face meetings (Minimally every 6 months) to discuss resident evaluation of program, stress-levels and evaluation of resident.

• At monthly meetings of Associate Training Directors (ERTC) and Senior Residents (with Residency Training Director), resident performance will be discussed. If any resident’s performance seems to be falling, or if any resident appears overly stressed or fatigued, appropriate action will be taken.

• Empower resident call committee to maintain and update on-call lists, back-up systems, mechanism to relieve fatigued or stressed residents and develop fatigue mitigation policy (in consultation with Dr. Sonia Ancoli-Israel).

• Biannual resident retreats and quarterly “all residents” meetings to discuss work conditions and meet with training leadership as requested by residents.

• Regularly review residents’ anonymous feed-back on the training website and discuss responses at “all resident” meetings.

**Duty Hours for UCSD Psychiatry Residents**

Duty hours are defined as all clinical and academic activities related to the residency program, including inpatient and outpatient care, administrative duties relative to patient care, 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.

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

B. Residents are provided with at least 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties. At-home call cannot be assigned on these free days.

C. PGY-1 and PGY-2 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

D. Residents in the final years of education, PGY-3 and PGY-4 residents, must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

E. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. (a) Circumstances of return-to-hospital activities with fewer than eight
hours away from the hospital by residents in their final years of education must be monitored by the program director.

F. Duty periods of PGY-1 residents must not exceed 16 hours in duration. (There is no 4 hour transition period)

G. PGY-2-4 residents must be scheduled for in-house call no more frequently than every-third-night. Averaging is not allowed.

H. Duty periods of PGY-2-4 residents may be scheduled to a maximum of 24 hours of continuous duty in the hospital. It is essential for patient safety and resident education that effective transitions in care occur. This period of time must be no longer than an additional four hours.

I. PGY-2 residents must have at least 14 hours free of duty after 24 hours of in-house duty.

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

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

L. At-home call (or pager call): At-home call is not so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call are provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

M. When residents are asked to assume patient care responsibility as part of the “on-call back up system” (that is, to assume the clinical assignment of another resident because of that resident’s inability to assume that assignment for any reason), the above restrictions on clinical assignment are applied, and the hours worked for the absent resident are included in the “back-up” resident’s duty hours tally.

N. The Program Director and Site Directors will monitor the clinical demands of all residents and will make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue, whatever the reason(s) for that fatigue.

**Monitoring of Compliance with Duty Hour Restrictions**

Residents are required to maintain accurate records of their actual duty hours through use of New Innovations ‘Duty-hours Module’, an on-line, Web-based system for recording actual hours worked. Compliance with duty hour restrictions will be monitored by the Training Director and Training Administrator using the reports available through New Innovations as well as resident surveys, monthly Residency Training Committee (RTC) meetings, reports from Chief Residents’ meetings, semi-annual evaluation meetings and an encouragement for residents to bring any duty hour violations forward.
Faculty and Chief Residents are required to monitor adherence to duty hour policies. Residents will not be scheduled for clinical duties in excess of these policies, and residents must not be requested or required to remain on duty beyond the time periods stipulated below. When patient care needs exceed the availability of residents to care for those patients within the above duty hours restrictions, alternative staffing will be developed. Residents must notify responsible faculty, the Chief Residents and Program, Associate or Site Director if such circumstances exist. In the short term, however, duty hour restrictions should not serve as a reason to jeopardize patient safety.

**Failure to Comply:** Residents who fail to comply with duty hour restrictions will be reminded of the policies and, whenever possible, sent home. Repeated instances of non-compliance will be regarded as failure to adhere to accepted standards of professionalism.

**Protocol for Episodes When Residents Remain on Duty Beyond Scheduled Hours**

We take duty hours seriously and consider them as important patient care and resident wellness guides. It is the professional responsibility of each resident to avoid excessive fatigue and respect patient safety needs by adhering to duty hours restrictions. Our goal is to have as close as 100% adherence as possible, but we recognize that there might be occasions when this is not possible.

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must:

- Appropriately hand over the care of all other patients to the team responsible for their continuing care.
- Document the reasons for remaining to care for the patient in question on New Innovations and in a written note to the Training and Site Directors describing the nature and reasons for the event.
- The program and site directors will review each submission of additional service and tracks both individual resident and program-wide episodes of additional duty.

**Fatigue Policy of UCSD Psychiatry Residency**

A. First and foremost, we emphasize that adherence with each of the ACGME duty-hours requirements is consistent with good patient care as well as resident well-being. Thus, we make adherence with the requirements the professional responsibility of the training administration, chief residents and each and
every resident. We carefully monitor adherence and make adjustments to duty hours as necessary. We recognize that the duty hours don’t, in themselves, guarantee that residents will always be ‘fit for duty’ and are prepared to make accommodations (e.g., more rest time between scheduled activities or reduced call burden) as needed.

B. Faculty and residents are educated to recognize the signs of fatigue, starting with new Residency Orientation and reinforced at (almost) annual grand rounds with Dr. Sonia Ancoli Israel. In 2012-3, we added a PGY1 and 2 didactic sessions in the Crash Course on ‘fatigue management’.

C. The UCSD Office of Graduate Medical Education (OGME) provides a “Core Training Modules” which is available as a link on the OGME website (http://meded.ucsd.edu/gme) and meets ACGME requirements for education in sleep deprivation and fatigue. This module is mandatory for all House Officers at UCSD and participation will be tracked through the online delivery system and provided to program directors and coordinators. In addition, this module is available to all faculty. Faculty will be encouraged to view this training module annually, with particular reminders to those not able to attend the grand rounds presentation noted above.

D. The training program, at the level of both Chief Resident and Program Director, will adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and monitor the demands of call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. Residents are informed of this on arrival and orientation to the program. The Chief Resident and Program Director are charged to monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged.

E. Policies and procedures have been developed to prevent and counteract the potential negative effects of fatigue. If a resident feels fatigued and unable to drive home, he/she will be reimbursed the expense of a taxi/cab home and back to the assigned institution to retrieve their vehicle. We also maintain backup call systems to assist residents when the clinical demands become excessive or to relieve them if they become if they become unable to function effectively.

F. As role models, teaching faculty members must demonstrate an understanding and acceptance of their personal role in the following: assurance of the safety and welfare of patients entrusted to their care; provision of patient- and family–centered care; assurance of their fitness for management of their time before, during, and after clinical assignments; recognition of impairment, including illness and fatigue, in themselves and in their peers; attention to lifelong learning; the monitoring of their patient care performance improvement indicators; and, honest and accurate reporting of duty hours, patient outcomes and clinical experience data.

G. The departmental policy, communicated to residents at orientation, is that all residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.
H. **Alertness Management/Fatigue Mitigation:** The program educates all faculty members and residents to recognize the signs of fatigue and sleep deprivation, and it educates all faculty members and residents in alertness management and fatigue mitigation processes; the program has a fatigue mitigation process to manage the potential negative effects of fatigue on patient care and learning, such as strategic naps and back-up call schedules. The program has a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties. The sponsoring institution provides sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.

**On-Call Policy**

**On Call**
The frequency of call varies from time to time, depending on "person power", service needs and educational issues. As a department, we are committed to staying well within the UCSD and ACGME guidelines regarding call frequency. In general, interns (PGY-I’s) will have tandem call with a more senior resident for at least half of the year, and then all-night solo-call when ready, for about 2 weeks towards the end of the year. PGY-II’s can be expected to be on call at the VA, predominantly as week-long float rotations, approximately 4 weeks a year in addition to some week-end duty. PGY-III’s will have no more than 3-4 weeks of float-call and some week-end call. PGY-IV’s provide primarily back up supervisory call from home (see below) or week-end call no more than about one week-end every six to ten weeks, unless they elect to take more fee-for-service call. When senior residents are on home ‘back-up’ call, they are expected to be available to the junior residents for clinical and administrative questions (see below).

**Resident Call Committee**
The resident call committee sets policy, adjudicates disputes and ensures responsiveness to duty hour regulations and resident fatigue. It is comprised of resident representatives of each year of training and chaired by an elected senior resident (ideally not a chief resident).

**Faculty In Charge**
The faculty will be available by phone in a supervisory capacity on a rotating basis. Faculty are the physicians in charge’ with ultimate responsibility for patient care and outcome.

**Selling Call**
The Department expressly forbids selling of scheduled on-call assignments and such activity may serve as grounds for discontinuation of a resident in the program.
Trading Call
All call trades must be presented to the chief residents. It is the responsibility of the residents trading call and the chief resident to ensure there are no service conflicts and that all services (VA psych main office, UCSD Med Center operators, RTO) are informed at least 30 days prior to the change. Until this information is received, the resident originally scheduled is considered the responsible physician.

Back up System
The back up call calendar is listed and maintained on Google calendar. There are two second year residents on back up for every night, a primary back up and secondary back up.

Primary Back Up:
The role of the primary backup is to come in when: 1) someone on call at the VA or UCSD Medical Center becomes ill, has a conflicting clinical emergency, or has a personal emergency, or 2) if the person on call at either location gets overwhelmed with patients that have not been seen (overwhelmed is defined here as having more than 6 patients who are waiting to be evaluated without having been seen yet).

Primary backup should only be called in by a Chief Resident or their designate. If there are more than 6 patients who have yet to be seen in the ER, the Chief Resident should be called to arrange for the backup resident come in to help. Backup residents will be responsible for coming to the hospital to assist the person on call until midnight, at which time they will be expected to leave the on call resident to finish, or until the patient burden is reduced to less than 6, whichever occurs first. If the backup resident is being called in due to an overwhelming number of patients, he/she can only be called in prior to 10pm. Because the backup resident is expected to leave the hospital by midnight, they will be required to come to work the next day, but would not be expected prior to 9am the following day.

Should an overwhelming number of patients occur a second time in one week, it will be the responsibility of the senior backup person to come in to assist, again until midnight or until the burden of patients is reduced below 6 patients who have yet to be evaluated.

Secondary Back Up:
This person will likely (hopefully) not be utilized much. The role of secondary backup will be to 1) come in should both people at NBMU and VAMC have emergencies or are sick on the same night, 2) to come in the second night and thereafter should someone have extended illness while on night float.

Senior Back Up:
This resident should be available by phone or pager during all the nights (5 PM through 8 AM) of their senior backup week to assist with questions that the junior resident may have in terms of logistics or clinical issues. In addition, the senior backup is expected to physically go in to NBMU/Hillcrest on Saturday and Sunday from 8 AM to 5 PM for the first half of the year. After January, the senior back up does not come in to the hospital but is available by phone or pager. Additionally, if a senior backup responsibility is scheduled over a holiday, the senior back up will be expected to go in on those holidays from 8 AM to 5 PM. The senior back up would come in on call during the weekdays only if an overwhelming number of patients (>6) occurs a second time in one week.
***The person assigned to back up must be in town, available by pager or phone and respond to page or phone call within 30 minutes of being called. The backup person is then expected to be at the hospital within one hour of being called in.***

**Pay Back**
There is a payback system in place in case the backup resident gets called in to take a call. The resident will be “repaid” 2 calls for each call period worked by the person they relieved.

**Changing Back Up Call**
Residents may switch back up calls only after approval by the chief resident who will update Google calendar. Primary and secondary backup can be anyone on Gero, ADTP, CAPS, research, or other ‘optional’ rotation blocks. Backups cannot be on 2S, PEC or CL.

**Fatigue Mitigation:**
After 16 consecutive hours of duty and/or between the hours of 11pm and 7am, brief strategic napping is encouraged. Clinical judgment should be utilized. The call committee has been asked to recommend a policy and Dr Sonia Ancoli Israel has agreed to consult and advise. Any time a house officer is too fatigued to safely drive from any clinical duty, including in-hospital call, they should call a taxi and will be reimbursed by the department or hospital.

**Handoffs**

Transfers of patient care from one physician to another, a process known as "handoffs," are ubiquitous in healthcare. The frequency of handoffs has increased with the restriction of resident duty hours by the Accreditation Council on Graduate Medical Education (ACGME) in 2003 followed by additional restrictions scheduled for July, 2011. Handoffs are vulnerable to communication failures, which can lead to medical errors and harm to patients. The Joint Commission (JC) has found that two out of three sentinel events have communication errors as a contributing cause and that over half of these errors involve handoff failures. Communication failures during handoffs are characterized by omissions of important medical information and/or failure-prone communication processes. The failure prone communication processes include unstructured written and verbal communication, non face-to-face sign-out, poorly communicated rationale for the clinical plan, inadequate training of clinicians in handoffs communication, occurrence of handoffs in settings that are neither quiet, private, nor free of interruptions, and the lack of infrastructure to support handoffs such as protected time (overlapping shifts) or a structured electronic written template linked to the EMR.

**Purpose of Handoff**
The responsibility of patient care transferred from one physician to another is considered a handoff, and the information transferred to manage this discontinuity is referred to as the sign-
The purpose of any handoff is to establish a shared mental model about a patient in order to avoid unwarranted changes in goals, decisions, priorities, or plans.

**Regulatory Response**
The potential for harm during these transitions has led to regulatory and policy initiatives. The Institute of Medicine recommended and the ACGME began requiring, as of July, 2011, enhanced training for residents regarding handoffs. Similarly, the JC has mandated a standardized approach to handoff communications.

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<td>• Programs must design clinical assignments to minimize the number of transitions in patient care.</td>
<td>• Implement a standardized approach to “handoff” communications including an opportunity to ask and respond to questions</td>
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<td>• Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes that facilitate both continuity of care and patient safety.</td>
<td>Expectations:</td>
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<td>• Programs must ensure that residents are competent in communicating with team members in the hand-over process.</td>
<td>• Interactive communications: opportunity for questions</td>
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<td>• The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient’s care.</td>
<td>• Minimum content: Up-to-date information</td>
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<td>• Interruptions are limited</td>
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<td>• Process for verification: &quot;read-back&quot;</td>
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<td>• Opportunity to review prior care</td>
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<td>• Allocation of schedule for handoffs</td>
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Below are our current handoff procedures for the VA, UCSD Hospital and Outpatient Service.

**Sign Outs and Handoffs at the VA – 2S/ADTP/PEC Residents**

**Treating Resident to On-call Resident**

1. Residents should use the Shift Handoff Tool in CPRS under “Tools”, making sure to update the yellow areas at least once per week and the “To Do” area nightly. There should be a brief one-liner about the patient, a multiaxial diagnosis, and a “To Do” list filled out daily. Meds, allergies, code status and patient identifiers including name and location are auto-populated on this form.

2. If you leave before 5 pm you need to be available by pager and designate someone who knows your patients who you could call to assist with issues that may arise on the unit (ie your fellow resident on your team, your senior resident, etc) – it is **not** OK for the PEC resident to be getting
called about your patients at any time under any circumstances. The covering resident would need to be able to respond within 5 minutes to an urgent matter on the unit regarding your patient. Between 5 and 6:30 pm you may sign out directly to the PEC resident or the ‘on-call’ resident if they are available. After 6:30, sign out directly to the on call resident.

3. Sign out in person either to the person you would call from your team should an issue arise or to the PEC resident (if you leave prior to 6:30pm). If you sign out after 6:30 pm you will need to contact the overnight resident directly and sign out face-to-face. Sometimes you will need to wait until the PEC resident or overnight resident is done with what they are doing to sign out. It is not OK to interrupt them if they are in with a patient so that you may sign out.

4. Residents must sign out anything that the resident must follow up on that evening, and any concerns or other issues that the overnight person should be made aware of (ie what to use as prn in case of agitation or pain, allergies or adverse reactions to medications)

5. The PEC resident must sign out any patients in the ED to the incoming overnight resident and patients who had been ‘signed-out’ to them by other residents.

**On-Call Resident to Treating Resident**

1. In the morning, all treating residents, including the PEC resident must receive sign-out information from the overnight resident. It is expected that when 2S and ADTP residents arrive in the morning, that they find the overnight on call resident (ideally before 8 am or at sign-in rounds at 8 am) or to receive their updates on their patients. Residents should arrive at the VA by 8am. Receiving ‘sign-out’ information from the overnight resident is mandatory.

2. The overnight resident is tasked with both leaving a note in CPRS and making a notation on the paper sign-out if there is an issue with a patient.

3. The overnight resident will need to sign out any patients left in the ED to the PEC resident.

4. To facilitate this process, there will be morning ‘sign-in’ teaching rounds to review the previous night’s activities and ensure that all ‘sign-out’ information is conveyed and all questions answered and discussed. The ‘on-call’ and PEC residents are always expected to attend; other VA-based residents are encouraged to attend. The senior resident or Attending Psychiatrist leaders are:

   - Monday – Yang
   - Tuesday – Lanouette
   - Wednesday - Porras
   - Thursday – Porras
   - Friday – Iglewicz

**Off-Service Hand Offs**
5. At the end of a rotation residents must write off service notes which should include:
   a) a complete progress note from that day
   b) the entire clinical course from that hospital stay including all medication trials,
   c) the clinical rationale for the patient’s current treatment
   d) any adverse events or medical issues
   e) the expected future clinical course during that hospital stay so that the oncoming resident will have a general idea where to proceed with the patient
   f) an account of all legal proceedings that have taken place
   g) a summary of collateral information received by the team.

This should be submitted on the Friday before leaving service. Anything that does not belong in the official chart but that needs to be communicated regarding a particular patient should be done so prior to the new resident taking over.

Sign Outs and Handoffs at UCSD Hospital

Morning Hand Off
8 am. Attended by the on-call intern/resident, NBMU interns, NBMU chief, C/L resident, C/L attending and medical students.
Handing off resident provides written sign out detailing information on patients on the C/L service and in the Emergency Department. Details of sign out documentation below. Signing off resident also updates EMR as appropriate including EPIC, WebCharts and iShare.
The handing off resident also provides oral report of the following:
- Emergency Department: presents patients still in the ED. Also presents any pertinent learning cases that were discharged overnight. Presents any administrative problems.
- Consults: presents new consults on hospitalized patients seen overnight.
- NBMU: presents issues arising on the psychiatric unit. Include medical and administrative issues.
- Telephone calls: presents any calls from outside patients to the on-call pager.
- Admissions: are NOT presented until rounds unless there is something that requires emergent attention like a serious medical issue or a hold.

Evening Hand Off
5-6PM on weeknights. Attended by Night Float/overnight resident, a rotating NBMU intern, medical student, C/L resident.
The C/L resident provides updated written sign out. See details below. The NBMU interns provide written sign out of admitted patients. Signing off residents also updates EMR as appropriate including EPIC, Web Charts and iShare.
The C/L resident who is handing off care also provides oral report of the following:
- Emergency Department: presents patients still in the ED and awaiting disposition
- Consults: Presents any pending/new consults. Also provides information about issues that may come up overnight/over the weekend
The NBMU intern will provide an oral report of the following:

- NBMU: presents any ongoing issues with admitted patients. Also pending lab or examinations to follow up on. Proposed medication changes in response to possible lab results.

**NBMU Sign Out Documentation:**
Information should include:
Name, MRN, DOB, Date of Admission, Brief ID statement, Multi-axial diagnoses, target symptoms, All Medications (medical and PRN included), Allergies, Legal Status, pending issues (labs results, expiring holds, proposed medication changes, contraindications for medications); brief, relevant hospital course (focusing on any medication changes/trials or IM’s); History of Assault/Elopement.

**C/L Sign Out List:**
- You must record the following information on the CL list:
  - Patient Name
  - MRN
  - Requesting attending’s name
  - Requesting resident’s name and pager number
  - Patient's insurance
  - Bed/Floor
  - ID statement
  - Relevant Medications
  - Consult question
  - Legal Status
  - To Do list (issues/follow-up overnight or over the weekend, especially legal holds)

**Education:**
- Incoming interns are educated on the written, verbal and electronic hand off system during first week of residency.
- During first week of residency crash course, new interns have opportunity to observe hand offs. During the first month of residency, interns will also have the opportunity to perform hand offs under supervision of the Chief Resident
- Attending teaching hand offs are done Monday, Wednesday and Friday morning at 8am. Interns receive real time feedback/supervision regarding clinical work and hand off communication.

**Sign Outs and Handoffs at the Outpatient Service**

*Parting is all we know of heaven
And all we need of hell*- Emily Dickinson
The following are a few paragraphs of collective wisdom and guidance that will hopefully facilitate a good transition for you and your patients as you prepare to leave the Outpatient Service. Articles on transfer and termination will also be distributed that we have found helpful. You have made a significant impact on your patients’ lives and will become a part of their collective memory of obtaining help from mental health professionals. We trust that their memory of you will be one that provides encouragement and hope in their daily lives. The therapeutic experience with you will also instill a desire to continue treatment with a new clinician or to return when needed. Although the patient’s feelings at the end of the relationship are determined largely by how the relationship has been experienced over time, the last few months of treatment tend to act as a screened memory for the whole relationship. As you are also ending a significant and pivotal experience in your professional life it is important that you take time to reflect on your own feelings about leaving. These feelings will probably include a mixture of relief, pride, sadness, regret, disappointment, anxiety and excitement about the future. Your experience here and in your training program and your personal history with separation and loss will, of course, influence your own reactions. Also, consider your modus operandi when ending relationships or leaving prior places and former colleagues and friends. Awareness of your own responses will enable you to be available and open to your patients’ experience.

The anticipation of separation and loss often generates anxiety as it threatens our basic sense of safety and security maintained through attachment to significant others. Anxiety may be expressed directly but more often is expressed through actions. Patients may protest and cling, deny, appear unconcerned or become sad, anxious and disorganized. Some will escalate substance abuse, suicidal behaviors or start missing appointments. Our goal is to minimize the fear and anxiety surrounding the transition through assurance of continued services in the Outpatient Service (i.e. institutional transference or continued secure attachment), transfer to other services in the community or through their memory of the relationship with us and what they have gained. Remember that when loss and separation occur we retain the memory of “the way things were” in a relationship; the way we were treated and how the other person made us feel. The memory of being cared for serves as an anchor during the transition.

**General Guidelines**

If you have not yet done so, at the beginning of the next session, remind your patients that you are leaving and give them the approximate number of sessions that are left and the exact week you are leaving. Inform them of any intervening vacations. Observe their immediate reactions and those at subsequent sessions to determine their particular style of handling separation and loss.

The last few meetings should generally be conducted like all previous sessions. It is not a time for new techniques, new medications, new issues, confrontation or confessions. It is a time to consolidate the best aspects of the relationship, review what has been gained and establish future goals. A major objective during this period is to strengthen the patient’s self-esteem, convey a sense of work well done and instill hope in the future. Another important goal is to reinforce their feeling of security and trust that help, when needed, is available.
How you discuss termination and transfer depends upon your patients’ unique needs and capacities. Consider the form of attachment (secure, insecure dismissing, insecure anxious preoccupied or disorganized) that each patient exhibits in the context of their current psychiatric status, past history of loss, personality style and psychosocial support system. These factors will provide important information as to how your patient will handle your leaving. As some of our patients have been through the transfer process many times, each person will experience unique and common elements. Take time to review last year’s notes when appropriate to determine any patterns and ask your patient what his/her experience was. As you discuss the transition acknowledge when appropriate that the training rotation, not the patient’s needs, is forcing this termination. Follow your patient's non-verbal and verbal behavior as to what level of support they need from you.

While it is important to provide an opportunity for your patient to express and discuss his thoughts and feelings regarding the end of the therapeutic relationship with you, many patients have a limited capacity to do so. They may experience our exploration of feelings as pressure to "feel" or to "react" to our leaving. This can be interpreted as a demand to take care of the clinician and make the clinician feel good. A sense of inadequacy and guilt may be generated if the patient feels they are not ending according to the “book.” Others may experience anger at perceived pressure to meet our needs.

**Schizophrenia/Schizoaffective Disorder and Psychosis NOS**
A highly structured predictable transition is our goal for patients with these disorders. Change and the anticipatory anxiety it generates is extremely stressful and disorganizing for this patient group. They have minimal capacity to process feelings. Be concrete as you discuss this transition in order to reduce anxiety. Tell them when you are leaving, where you are going in generic terms, and who will be taking your place. If the patient misses an appointment call them to follow-up.

During the last meetings explicitly state what progress you feel they have made on whatever level it has been, e.g., stayed on medications, stayed out of the hospital or known when they needed a hospital admission, attended group regularly, developed a friendship, attended AA, kept their appointments. Be straightforward and matter of fact about the change and don’t press for "feelings" if they are not forthcoming. Reassurance that care will remain stable even though you leave is essential to preventing relapse and disorganization. Reinforce the continuity of attachment to the institution.

If there is any sign of a relapse reach out and provide additional support or arrange for hospitalization or a START program. Common signs of decompensation are medication noncompliance, increase in symptoms, and missed sessions. Remember that these individuals may not appear to be very attached to you but are highly dependent and will react through an increase in symptoms and decrease in functioning.

**Personality Factors**
The majority of our Gifford patients with mood and anxiety disorders have co-morbid personality disorders and, of course, all have unique personality styles. Under the stress of
change and loss our patients will respond with an exaggeration and amplification of their particular personality traits (as do we). The more disordered the personality structure the more extreme the maladaptive response may be depending upon their current psychiatric status, psychosocial stressors and support system. Remember that rigidity and impaired self-reflection are the key features of personality disorder. Under stress these features are amplified.

Those with Cluster A disorders and traits may appear unaffected but become increasingly disorganized, paranoid, eccentric, withdrawn and detached. Those with Cluster B disorders and traits are likely to become more disorganized behaviorally, more narcissistic, grandiose, demanding, labile and dramatic. Those with Cluster C disorders and traits may exhibit greater anxiety and become more avoidant or clinging, fearful, obsessional and compulsive. Those with severe personality disorders will often express a mixture of traits from each cluster. Their response set may become increasingly rigid and/or highly disorganized.

Respond with empathy to the underlying feelings e.g. fear, anxiety, hurt, anger rather than to the manifest behaviors or distorted cognitions. Work in supervision to understand the particular meaning and challenge to your patient of this transition. It is especially important to maintain steady involvement, provide kind and consistent structure and prevent premature termination.

**Borderline Personality Disorder**

This patient group is particularly vulnerable to loss of significant others. They require a highly predictable transition with a clear idea of whom they will be seeing and when their next appointment will be. Expect an emotional storm and vacillation between dismissing you and demanding more from you. You may also anticipate increased behavioral manifestations of anxiety i.e., suicidal threat, cutting or whatever the patient characteristically does when overwhelmed with affect. Stay steady, calm, concerned and open. Provide a consistent structured appointment schedule. Help the patient to articulate what your leaving means to the extent possible. It may be useful to discuss for the patient in simple psychoeducational terms what termination may mean based upon your understanding of their relationship history.

Provide protection and containment through increased visits or phone contacts or a START stay if dangerous behaviors escalate. Patients with BPD need steady structured involvement during the transition so it is important to guard against getting provoked into being angry, withholding or punishing and pushing the patient away. Get additional supervision as needed to manage your reactions and maintain the alliance through to the last visit.

**A WORD OF CAUTION:** This transition places our patients at higher risk for suicide or psychotic episode especially with newer unstable, poorly engaged patients. Please take special care to respond to crises and be alert to disorganization and demoralization. Patients with co-morbid anxiety and personality disorders with impulsivity and/or substance abuse are at highest risk as are those who have limited social supports. Please consult. The more responsive and engaged we are with the patient the lower the risk. The goal is to build a prosthetic support structure around them to facilitate a safe transition.
Contact after Termination?
In general we inform our patients that our trainees are not available to contact after the end of the year. Discuss any questions regarding this in supervision.

Transfer or Terminate
For those patients seen in individual therapy we will work towards termination, transfer to community self-help and support services or for those patients still in acute need or high risk (MORS Score 5 or under) transfer to incoming interns and residents. Those patients with continued higher vulnerability will be transferred to group or reduced sessions with incoming interns. Patients who have a MORS score of 6 but require continued medication management should be considered for a transfer to a Family Health Center. Caseloads should be reviewed carefully in supervision to determine the most appropriate discharge plan given the patient’s needs and the resources available.

Medication Management
Our patients rely heavily on their physician-patient relationship even though appointments may be brief and less frequent. The supportive, regulating and containing function of the relationship is very sustaining to them. Consequently, transfer of patients from one physician to the next is just as anxiety provoking as the transfer from intern to intern. All of the principles that apply to transfer and termination for psychotherapy patients apply to the “meds only” relationship.

Groups
In general the same principles apply to patients participating in our groups as for individual therapy and medication management. Discuss with your group members how they would like to handle the last group meeting. It may be helpful to organize a potluck and facilitate a positive social experience. Rituals help but it depends on the nature and length of the group. We also ask that you review the Client Plan and determine future treatment goals beyond group. This can include other community programs, self-help groups and medications alone. Consult with your supervisor as to whether to refer a patient for continued group treatment in July. The same groups will be available during the next training rotation.

Administrative Issues
Review your caseload with your primary supervisor to determine the disposition of each patient. Plan to terminate all patients who appear to have left treatment. Send letters or call those you are concerned about to clarify this issue. A form letter is available online. You and your supervisor will prioritize urgency of next appointment, frequency of visits and identify special needs (wheelchair access, language, gender preference). In general, interns and students will transfer to incoming interns and students. Please coordinate with the intern/resident who is also providing services to your client as to who will complete the Discharge Summary. Please update the Client Plan for group, individual and medication management in Anasazi for continuing clients. Also on the HOMS website please update the MORS score and complete the Client and Clinician Recovery Markers Questionnaire.
Parting Thoughts

Enjoy the good work that you and your patients have done together and all you have learned. Remember that we usually remember how people made us feel not what they said. We carry the heart of the relationship within us as we move through life. Your work with your patients will help sustain them over the years and serve as a foundation for all of your future professional work.

...Nothing matters in the end but the quality of affection that has carved its trace in the mind....

Ezra Pound Canto LXXVI

Poet and patient at St. Elizabeth’s Hospital, Washington, DC 1945-1957

Moonlighting Policy

Moonlighting, i.e. medical practice after the workday (8 am to 5 pm) MUST be reviewed and approved by the Residency Training Director. Factors to be considered are: 1) the place of activity, 2) hours worked, 3) the available supervision, and 4) the malpractice/liability coverage. First year residents are not allowed to moonlight. Moonlighting must not interfere with the educational mission of the program. Thus, moonlighting should never occur during regular work hours, limit the resident’s ability to prepare for seminars or read pertinent psychiatric literature, cause the resident fatigue during the day or night call, conflict with clinical responsibilities, or endanger the resident’s health.

Moonlighting is allowed as long as the resident first informs the training director in writing (the document becomes part of the resident’s file) and does not interfere with the ability of the resident to achieve the goals and objectives of the training program. When a resident’s performance falls short of our program’s expectations (as recorded by formal evaluations, attendance at didactics, examination results or personal observations), the resident and training director meet, and moonlighting privileges may be revoked or limited. Residents will be advised that the combination of their residency plus all moonlighting activities should not exceed 80 hours per week.

The Chief Residents will assist the residents and residency training director in keeping an up to date list of all moonlighting opportunities and be available to consult with the residents about any moonlighting concerns. They also will develop and monitor ‘call-lists’ for all moonlighting that occurs within the residency program.

Daylighting, (the leaving of clinical services early for moonlighting jobs) and the selling of scheduled on-call assignments, is expressly forbidden by the Department and such activities may serve as grounds for discontinuation of a resident in the program.

Suicide/ Adverse Event Protocol
This protocol was created to ensure that residents get proper support in situations where their patient has had a completed suicide, attempted suicide or serious adverse event. As a junior resident, please follow the following checklists. These are divided based on the site you are at. If you are at the hospital, like WW or VA, you would use the hospital checklist. If you are at Gifford clinic or an outpatient clinic, you would use the outpatient checklist. The checklist and protocol can be found on I-share.

**Junior Resident Suicide or Adverse Event Checklist (Hospital)**

- Senior resident and attending involved with patient were notified
- Immediate check-in with either senior resident or attending occurred
- Discussion about how patient family interactions should be handled (junior resident, senior resident, attending)
- Resident assisted with immediate duties and given option to leave (If during business hours treatment team and senior resident will facilitate this. If on call, second call system may be utilized)
- Resident offered days off as appropriate and offered up to 5 days without call
- eQVR filed for UCSD cases, Suicide Behavior Report filed for VA cases
- Team debriefing including involved attending, all involved residents, involved medical students, an nursing if appropriate within 1 week of event
- Individual meeting with designated check-in/support person within one week of event
- Follow up meeting with check-in support person within 8 weeks following event
- Additional treatment arranged for resident if indicated (resident/check-in person decide together)
- Completed checklist submitted to quality assurance representative within 10 weeks

**Guidelines for Checklist**

- Checklist is to be completed after any serious suicide attempt, adverse event or completed suicide.
- Junior resident and senior resident should work together to complete the checklist. On services where there is no senior resident junior resident and attending should work together to complete the checklist.
- Senior resident is responsible for helping junior resident at each step and for turning in completed checklist. On services where there is no senior resident, attending is responsible to helping junior resident and for turning in completed checklist.

**Check-In Support Persons Options**

- Richard Avery, LCSW  619-543-0064
- Nancy Downs, M.D. 858-232-4660
- David Garmon, M.D.858-535-9121
- Julie Kuck, Ph.D. 619-281-1932
UCSD Outpatient Psychiatric Services Suicide or Adverse Event Checklist

- Residents and Psychology/MFT/Social Work Interns and supervisor/faculty attending involved with patient were notified as quickly as possible. Primary clinician and supervisor/attending assume responsibility to inform other team members
- Supervisors/attendings and trainees (ie residents and/or interns) meet/talk for immediate brief check-in
- Determine how patient family interactions will be handled (intern/resident, senior resident, fellow, supervisor/faculty attending, Medical Director, together)
- Trainee(s) assisted with immediate duties and option to leave was assessed (If during business hours treatment team and senior resident/faculty will facilitate this)
- Trainee(s) offered days off as appropriate and offered days without call
- eQVR filed by trainee or supervisor
- Supervisor or faculty attending telephones Program Director (Gifford or COD)within 24 hours who will report to County QI staff
- Supervisor or faculty attending completes County Serious Incident Report within 48 hours and give to Program Director to fax to County QI staff.
- Department chair’s office was notified by supervisor/attending
- Team debriefing occurred including faculty attending, all involved residents/interns, medical students, other trainees and nursing if appropriate within 1 week of event
- Trainee had an individual meeting with designated check-in/support person within one week of event
- Trainee had a follow up meeting with check-in support person 4-8 weeks following event
- Additional treatment arranged for trainee if indicated (resident/trainee check-in person decide together)
- Case reviewed during team meeting or special meeting to include all trainees, staff and supervisors/attendings involved in patient’s care and the County Serious Incident Report Case Summary completed by supervisor/attending and given to Program Director within 30 days of the event
- Case presented at the Departmental Peer review meeting
- Completed checklist submitted to Department of Psychiatry Quality Improvement Representative within 10 wks

Evaluation / Advancement

Evaluation Overview

The UCSD Psychiatry Residency Training Program defines ongoing evaluation of both residents and faculty performance as a mutual obligation. In addition, both residents and faculty must at regular
intervals evaluate the Training Program as a whole as to whether it provides the means to meet the overall goals and objectives of residency training. Residents are evaluated in each of their clinical training services before its conclusion. If significant problems are identified they should receive feedback and recommendations for improvement earlier. In turn, each faculty member, seminar, and clinical service is evaluated anonymously by each resident. All evaluations must be supplemented by direct feedback between resident and faculty member during the process of working together.

Evaluations of performance in clinical services and didactic seminars are based on meeting two standards: 1) satisfying the specific goals and objectives of a clinical service or didactic seminar, and 2) satisfying the goals and objectives of six core clinical competencies: patient care, medical knowledge, interpersonal and communication skills, practice-based learning improvement, professionalism, and systems-based practice. The resident must demonstrate increasing competency in each core area, as it pertains to particular clinical techniques or modalities, and in different settings.

It should be noted that “competency” is a relative term and should be assessed at the developmental level for a particular trainee. For example, one would expect the “competency” of a resident at the end of the first year, in the management of a case, to be different from that of a Board certified psychiatrist 5 years out in practice. As physicians, we must see practice in the context of “life-long learning”, and our evaluations should reflect the minimal standards of competent care for the developmental level of the individual being evaluated.

Supervisors’ Evaluations of Residents

At the end of each rotation (or every 6 months for outpatient supervision), individual supervisors, service chiefs and senior residents are asked to provide comprehensive written evaluations of the resident’s progress. We expect the resident and supervisor will discuss the evaluation before or during the last supervisory session. The resident and supervisor should review and sign the evaluation together, and the evaluation is posted on New Innovations, or, if necessary, returned to the Residency Training Office. In addition, based on the acquisition of phase appropriate knowledge, skills and behavior, as noted in this manual, the service chief or attending in charge for each rotation will certify that the resident has passed each rotation; if deficiencies are noted, the service chief and resident will discuss methods of remediation. Evaluations are reviewed by the Training Director and made a part of the resident’s file. Note: All faculty evaluations are available to residents through New Innovations and residents are always welcome to review summative evaluations and other collated evaluations are kept in each resident’s personal file.

Any failed or conditional evaluations are reviewed at the next Executive Residency Training Committee. To successfully progress to the next year in training, residents are expected to pass each rotation. A failed rotation or 2 ‘conditionally passed’ rotations will automatically trigger discussions/consideration of formal remediation plans and/or a ‘Letter of Warning’ (per UC San Diego House Officer Policy and Procedure Document (HOPPD) which can be obtained from the UC San Diego GME website (http://meded.ucsd.edu/gme).

Examinations
In addition to clinical evaluations provided by supervisors, service chiefs and senior residents, all residents participate in yearly oral and written examinations. Written examinations are the Psychiatry Residency In-Training Exam (PRITE) given each Fall and the Columbian Psychotherapy Examination given in the Spring. Residents are provided feed-back on their performance, how it changes over time and how it compares to other trainees. Residents are expected to demonstrate progressively greater knowledge. Residents scoring below the 20th percentile on the psychiatry global score will be expected to review areas of difficulty and pass a make-up examination. When necessary, remediation is available. For PGY3 and PGY4 residents scoring below the 20th percentile, there is a mandatory board review class (also available voluntarily to residents scoring between the 20th and 40th percentile). An ‘in-house’ PRITE-like examination is given in the spring (after the course). Residents are expected to score > 60% correct.

The oral examinations (Clinical Skill Evaluations or CSE) are given in the spring of each year and are modeled after actual psychiatry specialty board examinations. Residents interview a live patient followed by an oral review of the history, differential diagnosis, case formulations, treatment plan and prognosis. Residents are expected to pass at least one of these examinations yearly (for progression and graduation).

Clinical Skills Verification

Three CSV examinations must be completed on ABPN approved forms by Board certified psychiatrists. We routinely provide these examinations as one component of competency on most PGY2 rotations and on several PGY1 rotations during the latter part of the year. The CSV covers an interview, MSE and case presentation per ABPN guidelines. Residents are required to pass at least 3 of these before entering PGY-3.

Clinical Skills Assessments (CSE) and Clinical Skills Verification (CSV)

Clinical Skills Evaluation (CSE) is an observed patient interview done by a resident which meets the parameters described below under CSV and also includes an assessment of psychobiological formulation, differential diagnosis and comprehensive treatment planning. We are required by the ACGME and Psychiatry RRC to certify that residents pass at least one CSE each year as a pre-requisite for promotion to the next year and for graduation from the program.

Clinical Skills Verification refers to the documentation of competency in clinical interviewing skills required by the ABPN to be eligible to take the ABPN Certifying examination. Therefore, a resident who successfully completes a series of CSAs which results in passing 3 CSVs is credentialled to take the ABPN Boards. Residents must pass at least 3 of these examinations to be eligible for ABPN credentialing. The standard is 'competent psychiatrist' (not adjusted for year of training). The examiner must be board certified and the documentation must be on ABPN approved forms.

Executive Residency Training Committee

Residents are also evaluated by the Executive Residency Training Committee (ERTC-Director, Associate Directors Site Directors, and Fellowship Directors) as a whole in two review meetings each year. During those meetings faculty discuss each resident. Residents who have been identified as having professional
or academic difficulty are discussed at each meeting until these issues are resolved. ERTC meetings also serve to allow key faculty members to review the Training Program.

**Biannual Resident Review Meetings**

The Training Director will collect all faculty evaluations in an ongoing manner and keep a file for each resident with the other evaluative measures noted above. In addition, the file will contain evaluations from students, staff, patients, other residents, self-reflection as well as logs and attendance records. The Director will complete a training summary every six months, based on all the assessments and logs collected at that time. Each resident will meet formally with the Training Director (or a designated Associate Director) at least twice yearly to discuss progress towards the attainment of all the goals and objectives of the Training Program. During those meetings, the resident will also discuss his or her evaluations of faculty and the Training Program.

**Longitudinal Resident File**

The Training Director keeps a longitudinal file that contains all of the resident’s evaluations, PRITE exams, CVSs and CSEs, checklists, patient care logs, and any other material relevant to the assessment of the resident, (e.g. unsolicited letters of commendation, patient or staff evaluations, presentations given at local and national meetings, publications, and awards, among other documents). This will be part of the resident’s permanent record that also includes all application and preliminary interview material, records from adult residency, and any additional documentation about the resident’s performance past and present. It will also include a checklist of procedures and clinical service rotations that are required as part of the residency program, and indication if they were successfully completed. The file will document any evidence of unethical behavior, unprofessional behavior or clinical incompetence. Where there is evidence, it will be comprehensively recorded along with the responses of the resident. If disciplinary or remediation actions were taken, they will be documented with a clear description of the outcome. The record will include a final letter from the Training Director verifying whether the resident has successfully completed the program, and has demonstrated sufficient professional ability to practice competently, ethically, and independently (without direct supervision), based on the program’s defined core competencies.

**Progression**

Housestaff will progress to advanced positions of higher responsibility only on the basis of evidence of satisfactory progressive scholarship and professional educational and clinical growth. Reappointment from one year to the next will be recommended by the Residency Training Director based on performance and reviewed by the ERTC. The Department follows the UCSD Housestaff Policy and Procedure as outlined in the section HOPPD of the titled “UCSD Policy” (http://meded.ucsd.edu/gme). To successfully progress from year to year, residents are expected to:

a. **Pass each rotation** as determined by the clinical service chief on that rotation. If a resident receives an initial grade of “fail”, the service will support specific remediation to re-take part of the rotation or otherwise make up the deficiency. The remediation plan will be reviewed by the
ERTC. Residents may file grievances regarding any evaluation or grade they disagree with. Such grievances will be reviewed by the Residency Training Director and the ERTC. Two ‘condition’ passes in the same year will trigger a similar response and action plan.

b. **Score > 20th percentile on the PRITE.** PGY1s and 2s scoring below that level will be expected to develop a self-study plan. If requested, they may receive additional supervision to help guide their study and review. PGY3 and 4 residents scoring below the 20th percentile on the global psychiatry portion of the PRITE will be given offered an additional supervisor to help guide study, will attend a PRITE-based course, and will take an in-house make up examination after a suitable study period. Residents scoring below the 60th percentile on the make-up examination will be discussed at the ERTC regarding their suitability for advancement. Individualized remediation plans may be implemented. Moonlighting privilege will likely be suspended until an acceptable knowledge base is demonstrated.

c. **Attend 70% of all scheduled didactics.** Any combination of scoring below 60% on the makeup written examination or not passing a CSE oral examination for any year and attending <70% of seminars will likely result in failure to progress to the next year.

d. To progress to the PG-3 year, residents must **pass Step III of the USMLE and have a California State license** to practice medicine before the end of the PG-2 year. In general, residents also are expected to pass ≥ 3 CSV examinations prior to beginning PGY3. To meet this goal, residents are required to take their USMLE Step 3 by the end of the PG1 year (see section on Department Policy (USMLE Requirements) for more details).

e. To successfully graduate the program, residents are expected to:
   
   - Pass oral examinations each year.
   - Demonstrate competency in the 6 core competencies and at least 2 of the psychotherapy competencies.
   - Complete an Independent Study Project.
   - Demonstrate competency to practice psychiatry without supervision.

f. Discipline, Dismissal and Due Process follow the UCSD Housestaff Policy and Procedure as outlined in that section of the manual. In brief, the following guidelines will be followed:
   
   - When a housestaff fails to meet minimal standards of performance, a letter of warning and/or censure will be provided the resident. The letter will document deficiency, the recommended course of action and methods to correct deficiencies. Failure to correct deficiency may lead to suspension or dismissal.
     - Clinical privileges may be suspended for medical record delinquency.
• Suspension for up to sixty days from the residency program may occur when a house officer’s performance fails to meet the standards set by the Program Director and/or patient well-being is jeopardized.

• The house officer may be reinstated to regular activities as soon as he/she demonstrates sufficient improvement to the department chairperson.

• A house officer may be subject to immediate dismissal during the term of appointment only by the Dean, School of Medicine, on the recommendation of the department chair and the Director, UCSD Medical Center, for any of the following reasons:
  a. Failure to rectify deficiencies of which he/she had been notified in one or more letters of warning, censure, or suspension;
  b. Where his /her performance present a serious compromise to acceptable standards of patient care, including medical documentation of that care, or jeopardizes patient welfare;
  c. For unethical conduct;
  d. For illegal conduct

• In matters of discipline and/or denial of privilege or benefit of appointment, the house officer may appeal in accordance with the provisions of UCSD Policy and procedure Manual Section 23-5, “Appeals for Academic Appointees”.

• For more information on due process procedure, please refer to the “UCSD Policies” section of this manual.

**Evaluation Forms (available in Appendix)**

• **360 Degree Evaluations** - To obtain a more comprehensive view of professionalism, patient care, interpersonal skills and communication, practice-based learning and improvement, and systems-based care, we have developed written surveys to be completed by peers, patients and unit staff as well as self-evaluations.

• **Portfolios** - A portfolio is a collection of products prepared by the resident that provides evidence of learning and achievement related to a learning plan. The resident can include video or audio recordings, self-reports of experiences or other documents that demonstrate such competencies as therapeutic effectiveness, ethical integrity, professionalism, self-directed learning and skill development, lectures given and continuing education experiences, and written documents such as
review or research papers or case formulations. Patient logs may be included in portfolios. For this coming year, we are requiring 1 specific portfolio from PGY2s, 3s and 4s.

1. **PGY-1**: A forensic case report based on testimony for CERT or Competency trial testimony.
2. **PGY-2**: A detailed psycho-bio-social formulation of psychotherapy patient. References and all educational endeavors should be included.
3. **PGY-3**: Synopsis and PowerPoint presentation of a case conference for Professors Rounds. In addition to providing information on what was learned and references, the resident should include documentation of teaching effectiveness.
4. **PGY-4**: Independent Study Project in a publishable format.

**Evaluation of Faculty, Services and Seminars**

Residents evaluate faculty, services and seminars in an ongoing manner. Each clinical supervisors and service chiefs are evaluated every rotation. Each seminar and its leader are evaluated every 6 months and/or at the conclusion of the course. The faculty evaluations are collated by the assistant administrator before being given (in collated form) to the Training Director. Residents also have the opportunity to provide anonymous feedback on all aspects of their training on annual surveys (ACGME and Department of Psychiatry) and on the Training Website. Anonymous comments are regularly collected and discussed at quarterly resident meetings.

It is expected that residents give faculty members feedback in both clinical and didactic areas as to how helpful they are in transmitting knowledge, skills and attitudes relevant to psychiatry. Residents give the Training Director a verbal evaluation of each faculty member in the formal biannual individual review meetings with the Training Director, and at an annual retreat. At the end of each year, The Training Director sends each faculty member an annual review of his or her teaching and supervision, based on the anonymous resident evaluations, the individual discussions with each resident, and the written report of the annual resident retreat.

**Program Evaluation**

Both residents and faculty are requested to provide evaluations of the overall Training Program. Residents complete a confidential evaluation form biannually. The form asks residents to assess the clinical, didactic and administrative components of the Training Program. It also asks if the educational goals and objectives of the Training Program have been met. We are in the process of moving these questionnaires to New Innovations to maximize their confidentiality and anonymity. In addition, residents evaluate the program in their annual resident Retreat report, and representatives from each class provide ongoing evaluations at the monthly GEC meetings. Similarly, faculty and recent graduates provide program evaluations is annual surveys and discuss the results in an annual faculty retreat.

The accumulated clinical service, seminar, faculty summary, and Retreat Report evaluations are a part of the Training Committee’s annual review of the entire Program. These and the direct input of the residents to the Training Committee help it determine what modifications in the teaching program are necessary for improvement in the coming year.
New Innovations

The GME Office has incorporated a universal web based residency management system - New Innovations. This software enables all programs to keep more comprehensive records. A few of the highlights of this new system are:

* Duty Hours (Assignments)
* Rotation Schedules (Block schedule)
* Conference Schedules (Didactics, Grand Rounds, etc.)
* Conference Surveys
* Evaluation tracker (rotations, supervision, seminars, etc.)
* Attendance tracker
* Procedure Logs
* Curriculum - Goals and Objectives
* Complete demographics
* Test scores
* Faculty evals on Residents
* Resident evals on Faculty
* Semi Annual Evaluations will be completed using all data provided by New Innovations.

Residents and supervisors are now required to evaluate performance on this new system (although not all faculty have yet converted). Our goal is to eliminate paper evaluations.

Training Committees

The Residency Training Committee (RTC)

A. The RTC shall consist of the following members:
   The Executive Residency Training Committee:
   Residency Training Director
   2 Associate Directors
   Research Track Director
   Child Training Director
   Combined Program Training Director
Geropsychiatry Fellowship Director
Site Directors
Residency Coordinator
2 Faculty members appointed by the Training Director
The Chief Residents and 2 Resident from PGY 2–3 elected by the residents
PGY 1 residents rotating at the VA Medical Center the corresponding month

B. Responsibilities: The Training committee is charged with the following duties:

- Ongoing review of the overall Training Program, based on resident and faculty evaluations
- Ongoing review of:
  - The six general clinical competencies
  - The clinical rotations
  - The didactic seminars
  - Resident working conditions and morale
  - Duty hours
  - Administrative policies and procedures
  - Method of evaluation of resident competency, based on the faculty and resident evaluations, retreat, PRITE results and other proposals of individual faculty, residents and clinical services
  - Clinical services in terms of access to a wide variety of patients, quality and quantity of teaching, service and educational balances
- Facilitation and flow of communication between faculty and residents around training issues
- Program development
- Review semi-annual resident evaluations of program and make recommendations for improvement
- Monitoring of resident safety issues and overall stress levels, person-power issues, fatigue
- Planning for orientation, retreat, selection, graduation and other issues regarding training
- Review of PRITE scores and recommendations for curricular improvements based on results
- Information exchange to and from residents via resident representatives of each class and special programs

C. Committees:
The RTC includes the following subcommittees:
- Executive Residency Training Committee
- Residency Selection Committee
- Curriculum Committee
- Chief Resident Committee
- Residency Morale Committee
- Call Committee

The Executive Resident Training Committee (ERTC)

Members of the ERTC consist of:
• Residency Training Director
• 2 Associate Directors
• Research Track Director
• Child Training Director
• Combined Program Training Director
• Geropsychiatry Fellowship Director
• Site Directors
• Residency Coordinator

Responsibilities: The ERTC meets monthly. It reviews all aspect of the Residency Training Program. In particular it will:

• Discuss and select residents to be nominated for various fellowship and awards
• Review and approve of supervisors (based on resident and RTO feedback).
• Review resident performance morale, stress, fatigue
• Approve leaves of absences or any special modifications of the routine schedule of the Training Program
• Review rotations, curriculum and proposed changes at least annually
• Ongoing review of faculty performance based on confidential resident evaluations, the Resident Retreat Report, and verbal feedback to faculty and member of the Training committee
• Approval and/or modification of remediation plans of faculty members for residents who need improvement in clinical or academic areas
• Make decisions regarding the initiation of disciplinary and/or dismissal procedures for any resident if warranted.
• Approve the progression of residents from year to year
• Approve graduation of all residents (including agreement that resident has demonstrated sufficient professional ability to practice competently, ethically and independently.

The Residency Selection Committee (RSC)

The Residency Selection Committee consists of the following members:

• Department Chair
• Training Director
• Associate Training Directors
• Fellowship Directors (Child, Geriatric Research, Community)
• Director (or Co-Director) of Combined Program in Family Medicine/Psychiatry Program
• 2 additional faculty members selected by the chairman and Training Director
• All Chief Residents
Responsibilities: The RSC Committee will determine and refine the method of selection and structure of interview days, review applications, select applicants for interviews, participate in interviewing and provide input into our selection rank – list (see residency Selection Procedure below).

Curriculum Committee: The Curriculum Committee consists of faculty and volunteer residents from year of training. It meets regularly to ensure a comprehensive, coordinated four-year curriculum and that the didactic program meets the evolving needs of the residency. It provides input on development, evaluation and updating the curriculum course syllabi and core readings.

Chief Resident Committee (CRC): The Chief Residents will meet with the Residency Training Director and the Associate Directors for the PG-4 year monthly. This committee will regularly discuss issues related to transitions (e.g., graduation, orientation), resident well-being, curriculum, evaluations, chief resident duties, call, supervision, etc. As relevant, issues brought up in the GEC may be further discussed and resolved in this committee. Co-ordination of clinical care, coverage, communication, etc, between classes will be discussed regularly.

Resident Morale Committee: A series of resident semi-annual evaluations, discussions with residents and faculty (individually and at Residency Training Committee (RTC), Clinical Service Chief (CSC), and Strategic Planning Committee (SPC) meetings) feed-back from ACGME and UCSD GMEC surveys revealed room for improvement in resident morale. Although morale was difficult to define, important components were identified: training vs. service imbalance; lack of optimal on-site, real-time supervision; fear of intimidation or retaliation and deficient opportunities for residents to provide confidential and anonymous feed-back. The STPC commissioned clinical directors of the 3 major sites (UCSD Hospital, UCSD Outpatient Committee and the VA) to meet with faculty (including the training and associate training directors site directors and the Departments Executive Vice-Chair) and residents to better define the problems at each site and problem-solve solutions. Several recommendations were implemented during the 2011-2 academic year and others are in the process of development. The Morale committee will continue to report directly to the department Chair and SPC.

Call Committee: The Call committee is made up of representatives for each year of training and a faculty advisory. It monitors and evaluates residency call activities, monitors program compliance with the ACGME duty Hours requirements, and offers relevant recommendations to the RTC. It maintains call and call back-up schedules, including “fee-for-service” moonlighting schedules. The call committee meets quarterly at minimum. The Chief Residents serve as the Chairpersons of the Call Subcommittee and reports monthly to the RTC.

Residency Selection Procedure

The Residency Selection Committee (RSC) will meet intermittently through the year, but weekly from late November to mid-February. It will be charged with developing and refining interview procedures, reviewing each of the applicants’ files, reviewing the evaluations completed by each interviewer and coming up with a rank – ordering of applicants for the match.
Each year, we select 10 PGY 1’s for the General Psychiatry Program and 2 PGY1’s for the Combined Family Medicine/Psychiatry Program. We participate in the National Residency Match Program (NRMP) and the Electronic Residency Application System (ERAS). Based on the applicant qualifications (schools attended, Dean’s letter, personal statement, letters of recommendation, grades, special interest and accomplishments) we invite approximately 90 applicants for interviews.

During the interview day, applicants meet several faculty and residents. Each applicant is interviewed by the Training Director and at least three additional members of the Selection Committee, including a mix of faculty and residents. Applicants interested in, and qualified for, the research tract will meet with at least 2 highly research oriented faculty (sometimes this means interviewing an extra day). Every attempt will be made for applicants interested in a future child fellowship to meet with a faculty member from the Child Division. All applicants will have the opportunity to meet informally with a large number of house staff; they meet residents at an evening reception, over lunch and during tours of our 2 major facilities.

After the interviews, the RSC reviews the applicant’s file and the comments provided by interviewers to come up with a rank order list which is submitted to the NRMP. We are particularly interested in high academic achievement, excellence in clinical skills, a deep career interest in psychiatry and potential for clinical scholarship, research, teaching and leadership. Personal traits of maturity, empathy, decisiveness and high standards of professional performance are very important. We are also very interested in highly qualified minority applicants and seek to enroll a balanced group and diverse group of future clinical and research scholars.

After the match results are posted, the RSC will assign mentors to the new house staff, review the process and begin planning for the next year.