

# **PSYCHIATRY RESIDENTS HANDBOOK**

**2010-2011**



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**WAKE FOREST UNIVERSITY SCHOOL OF MEDICINE  
NORTH CAROLINA BAPTIST HOSPITAL**

**Revised September 2010**

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**SECTION ONE:**  
**INTRODUCTORY MATERIALS**

## **THE COMMUNITY**

### **BEGINNINGS OF WINSTON-SALEM**

The Moravians, a Protestant communal sect, settled the town of Salem (meaning “peace”) in 1766. Their disciplined and pacifist lifestyle was fostered by a work ethic and an appreciation for music and the arts. In addition to cotton and wool manufacturing, they relied on trades and crafts to support their community. The Moravians established Salem College, one of the nation’s first colleges for women.

The county of Forsyth and the city of Winston, founded in 1849, were more industrially oriented and developed around the manufacture of textiles, furniture, and tobacco products. In 1913 the two cities of Winston and Salem were joined. This merging of economies, talents, and values reflected a cooperative spirit between the two original settlements that has remained until the present.

### **LOCATION**

In the Piedmont region of north central North Carolina, Winston-Salem is equidistant from Washington, D.C., and Atlanta, Georgia. Winston-Salem joins with Greensboro and High Point to form the Triad region of North Carolina. Residents enjoy proximity to the beautiful Blue Ridge Mountains to the west and relaxing beaches of the Atlantic to the east. The region is served by the Piedmont Triad International Airport, only 20 minutes away.

### **LOCAL ATTRACTIONS**

The Piedmont Triad contains numerous institutions of higher learning including Wake Forest University, Winston-Salem State University, Salem College, Forsyth Technical Community College, High Point College, The University of North Carolina in Greensboro, and the North Carolina School of the Arts. The arts are well represented by the Winston-Salem Symphony and Symphony Chorale, Wachovia Little Symphony, Piedmont Chamber Singers, Piedmont Opera, Southeastern Center for Contemporary Art (SECCA), Museum of Early Southern Decorative Arts (MESDA), Reynolda House Museum of Fine American Art, The Little Theater, The Stevens Center, Films on Fourth, and The Arts Council.

Winston–Salem is the home of African-American history programming celebrating Black History Month during February and The National Black Theatre Festival during August of every other year. It is also the new home of the River Run International Film Festival which takes place annually in April.

Local attractions include the beautiful Reynolda Gardens of Wake Forest University, Tanglewood Park, Old Salem and Historic Bethabara.

The city is transitioning from an industrial to a research and technology center. Recent and planned developments include a \$20 million downtown research park, several retail projects in the financial section of the inner city, and a baseball stadium for the single-A Winston-Salem Dash, an affiliate of the Chicago White Sox.

## **WAKE FOREST UNIVERSITY**

Wake Forest University was founded in 1834 by the Baptist State Convention of North Carolina. The school was opened as Wake Forest Institute, with Samuel Wait as principal. It was located in the Forest of Wake County, on the plantation of Dr. Calvin Jones, near which the village of Wake Forest later developed.

Re-chartered in 1838 as Wake Forest College, it is one of the oldest institutions of higher learning in the state. It was exclusively a men's college of liberal arts until 1894 when the School of Law was established. The School of Medicine, established in 1902, offered a two-year program.

In 1946 the trustees of Wake Forest College and the Baptist State Convention of North Carolina accepted a proposal by the Z. Smith Reynolds Foundation to relocate the college to Winston-Salem, where the medical school had moved five years earlier.

In 1967 Wake Forest College was granted full university status by the Southern Association of Schools and Colleges. Today the University has an undergraduate College of Arts and Sciences, School of Law, the Calloway School of Business and Accountancy, the Babcock Graduate School of Management, the Divinity School, and the Graduate School of Arts and Sciences. The total enrollment is approximately 6,500 students with over 850 full-time faculty. The university receives national recognition for its successful integration of computer and information technologies into all of its educational programs. Two nationally televised presidential debates have been hosted on the campus. Dr. Nathan O. Hatch was inaugurated as Wake Forest University's thirteenth president on October 20, 2005.

## **WAKE FOREST UNIVERSITY SCHOOL OF MEDICINE**

The School of Medicine of Wake Forest College, founded in 1902, was renamed the School of Medical Sciences in 1937 and operated as a two-year medical school until 1941.

It was in 1941 that the School of Medical Sciences was moved from its original college home in Wake Forest, North Carolina (near Raleigh) to Winston-Salem. Wake Forest College remained in the town of Wake Forest until 1956, when moved to Winston-Salem.

The 1941 move resulted in an expansion to four-year medical school status, the opening of the School of Medicine's Department of Clinics [(DOC), renamed Wake Forest University Physicians in 1991] and renaming of the school to Bowman Gray School of Medicine in recognition of the benefactor who made the expansion possible. In October of 1997, the Medical School was renamed the Wake Forest University School of Medicine at the Bowman Gray campus.

The four-year medical school opened with a faculty of 23 and a student body of 73. The Bowman Gray School of Medicine joined forces with North Carolina Baptist Hospital in forming an academic medical center, one of only 127 such centers nationwide today.

Today the school consists of over 100 students per class and has been a national leader in innovative medical education with its problem-based case study curriculum, "Prescription for Excellence: A Physician's Pathway to Lifelong Learning."

## **NORTH CAROLINA BAPTIST HOSPITAL**

The hospital opened in 1923 by the Baptist State Convention of North Carolina as one of its missionary enterprises and originally was an 88-bed facility. Though it did serve some patients from across the state, North Carolina Baptist Hospital generally cared for patients from the immediate area of northwest North Carolina.

In preparation for the opening of Bowman Gray School of Medicine, North Carolina Baptist Hospital expanded to 300 beds. That was followed in 1946 by the opening of an outpatient department designed to handle 50,000 patients a year. In 1954 the hospital expanded to 450 beds.

In 1967 the hospital increased to 701 beds with the opening of the Reynolds Tower. With the addition of the North Tower in 1989, the hospital increased its number of beds to 806. Additionally, the Richard Janeway Clinical Sciences Tower opened in 1990 and serves as the outpatient surgery center and office building for the Wake Forest University Physicians. In 1996 Ardmore Tower opened, housing a state-of-the-art Emergency Department and Level I trauma center and a 1,000-seat cafeteria. A new facility for the Brenner Children's Hospital and additional services opened in 2002. The Comprehensive Cancer Center moved into new quarters in 2004.

Today the Medical Center boasts the most advanced technologies available (including the positron emission tomography [PET] center, a magnetoencephalography [MEG] suite and a gamma knife facility), a strong commitment to quality patient care, education, and medical research, as well as a highly skilled and dedicated medical staff.

### **COY C. CARPENTER LIBRARY**

The Coy C. Carpenter Library of the Medical Center is located on the first floor of the School of Medicine's James A. Gray Building. The library contains extensive collections of all of the medical and surgical specialties and in the basic sciences, as well as collections in nursing and allied health. Wide selections of domestic and foreign periodicals, textbooks, monographs, archival materials and audiovisuals are also available.

In addition to its computerized catalog, the library offers free training in and use of web-based Medline as well as a computerized Drug Information Center, Toxline, Psychological Abstracts, and other national and international databases. Remote access to library databases is also available at no charge to residents and faculty. The library maintains an advanced computer learning resource center with desktop computers. A variety of software is available as are short courses in software usage.

### **STANDARDS**

The School of Medicine is a member of the Association of American Medical Colleges and is accredited by the Liaison Committee on Medical Education (LCME), which represents the Council on Medical Education of the American Medical Association and the Association of American Medical Colleges. The Residency Program in Psychiatry is accredited by the Accreditation Council for Graduate Medical Education (ACGME). The psychiatric residency program conforms to or exceeds the requirements of the ACGME. A copy of "The Essentials of Accredited Residencies in Graduate Medical Education" and the "Program Requirements for Residency Training in Psychiatry" is distributed to all residents. Our program was last reviewed in 2008 and was granted continued full accreditation.

## HISTORY LINE

BGSM	YEAR	WFUBMC
Founding of School of Medicine	1902	
	1923	NCBH opens with 88 beds; Rev. Lumpkin, Super.
Dr. Coy C. Carpenter, Dean	1936	
School moves to Winston-Salem and becomes four-year Bowman Gray School of Medicine; joins NCBH to form the medical center, Bowman Gray's Department of Clinics opens.	1941	
	1942	Hospital expands - 300 beds
	1945	Reed Holmes – President
<i>Department of Neuropsychiatry opens</i>	1946	Outpatient department opened
<i>Department of Neuropsychiatry becomes the Department of Psychiatry of Neurology</i>	1953	
<i>Lloyd J. Thompson, M.D. (1953-1956) Chairman of the Department of Psychiatry and Neurology</i>	1953	
	1954	Hospital Expands-450 beds
<i>Angus C. Randolph, M.D. (1957-1959)</i>	1957	
<i>Interim Chairman of the Department of Psychiatry and Neurology</i>		
<i>Richard C. Proctor, M.D. (1960-1985)</i>	1960	
<i>Chairman of the Department of Psychiatry and Neurology</i>		
Dr. Richard Janeway, Dean	1971	
	1973	Hospital expands - 701 beds (Reynolds Tower)
	1974	Dr. Manson Meads becomes Director of the Medical Center
	1974	John Lynch – President
<i>The Department of Psychiatry and Neurology becomes the Department of Psychiatry and Behavioral Medicine</i>	1979	
<i>Jack M. Rogers, M.D. (1985-1986)</i>	1985	
<i>Acting Chairman of the Department of Psychiatry and Behavioral Medicine</i>		
<i>Burton V. Reifler, M.D., M.P.H. (1987-2001)</i>	1987	
<i>Chairman of the Department of Psychiatry and Behavioral Medicine</i>		
	1990	Clinical Sciences Building opens
	1992	PET Center opens
Dr. James Thompson, Dean	1995	
	1996	Ardmore Tower Opens (Emergency Department and Cafeteria)
	1996	Comp Rehab Plaza Opens
<i>W. Vaughn McCall, M.D. (2001-Present)</i>	2001	
<i>Chairman of the Department of Psychiatry and Behavioral Medicine</i>		
	2004	Comprehensive Cancer Center
	2006	Magnetoencephalography Suite opens

**FULL-TIME FACULTY AND THEIR SPECIALTIES**

<p><b>Elizabeth M. Arnold, Ph.D.</b> Associate Professor Adolescent Health Mood Disorders Risk Behaviors HIV Prevention Suicidal Behavior</p> <p><b>Katherine Atala, M.D.</b> Associate Professor Perinatal and Reproductive Psychiatry Women's Issues in Psychotherapy Psychiatry Disorders in relation to hormonal concerns</p> <p><b>Gretchen Brenes, Ph.D.</b> Associate Professor Geriatrics Behavioral Medicine Anxiety and Stress Psychotherapy Women's Health Issues Grief</p> <p><b>Thomas Brown, M.D., J.D.</b> Assistant Professor Medical Director, Substance Abuse Services</p> <p><b>Mark B. Carroll, M.D.</b> Assistant Professor Director, Child Residency Training Program</p> <p><b>Hal Elliott, M.D.</b> Assistant Professor Director of Resident Education Adult Attention Deficit Disorder Anxiety Disorders College Mental Health</p> <p><b>Larry W. Freeman, D.Min., LCAS</b> Assistant Professor Addiction Issues Ethics Group and Family Therapy</p> <p><b>Ann P. Graves, MSW, ACSW</b> Instructor Cultural Diversity Women's Issues</p>	<p><b>Marcus M. Gulley, M.D.</b> Associate Professor Emeritus General Adult Psychiatry</p> <p><b>Matthew G. Hough, D.O.</b> Assistant Professor Director, Child/Adolescent Outpatient Services General Child Psychiatry</p> <p><b>Robin A. Hurley, M.D.</b> Associate Professor Neuropsychiatry Research</p> <p><b>Sebastian Kaplan, PhD</b> Assistant Professor Child/Adolescent Psychiatry Adult Psychiatry Family Therapy Trauma School-Based Mental Health</p> <p><b>James N. Kimball, M.D.</b> Assistant Professor Associate Director, Resident Education Director, Consultation-Liaison Services Director, Adult Outpatient Services Electroconvulsive Therapy Psychosomatic Medicine Mood Disorders Substance Abuse</p> <p><b>Stephen I. Kramer, M.D.</b> Professor Medical Director, Adult Inpatient Services Director, Neuropsychiatry Service Director, Forensic Psychiatry Consultants General Adult Psychiatry Neuropsychiatry Forensic Psychiatry Psychiatry Education Research</p> <p><b>W. Vaughn McCall, M.D., M.S.</b> Professor and Chairman Head, Section on Geriatric Psychiatry Medical Director, Sleep Disorders Clinic General Adult Psychiatry Geriatric Psychiatry Sleep Medicine Electroconvulsive Therapy Research</p>
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**Guy K. Palmes, M.D.**

Associate Professor  
Section Head, Child/Adolescent Psychiatry  
Medical Director, Child/Adolescent Inpatient  
Child & Adolescent Psychiatry  
Developmental Disorders  
Psychiatry Education

**Donald Peters, M.D.**

Assistant Professor  
Director, Medical Student Education  
General Adult Psychiatry  
Consultation-Liaison Psychiatry  
Trauma and Recovery  
Anxiety Disorders

**Stephen Rapp, Ph.D.**

Professor  
Chief of Psychology  
Cognitive Disorders  
Adult Psychology  
Research

**Burton V. Reifler, M.D., M.P.H.**

Professor  
General Adult Psychiatry  
Geriatric Psychiatry  
Alzheimer's Disease and  
Dementia  
Forensic Psychiatry  
Research

**Eugene Mindel, M.D.**

Assistant Professor  
General Adult Psychiatry

**Peter B. Rosenquist, M.D.**

Associate Professor  
Med. Director, Carolina Behavioral  
Health Alliance  
Director of Clinical Services  
Director of ECT  
General Adult Psychiatry  
Neuropsychiatry  
Developmental Disability  
Brain Stimulation (ECT, VNS, TMS)  
Research

**Charlie Suttentfield, Ph.D.**

Assistant Professor  
Psychological Consultant to Burn Center and  
Cardiac Transplantation Team  
Rehabilitation Psychology  
Chronic Pain Management  
Trauma  
Geriatric Psychology  
Cognitive Behavioral Psychotherapy

**Clinical Associate Faculty  
Department of Psychiatry and Behavioral Medicine  
Revised 06/30/2010**

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## LORETTA Y. SILVIA TEACHING AWARD

**Eligibility:** All clinical faculty members are eligible.

**Criteria:** Faculty member who teaches by example and possesses clinical excellence, empathy, courage and compassion. This award was begun in 2006 in honor and memory of Loretta Y. Silvia, PhD. Dr. Silvia was a beloved and respected faculty member in the Department of Psychiatry and Behavioral Medicine who spent many years teaching and mentoring resident physicians. She was known for her empathy, courage and for the compassion she showed for her patients.

Note: The award cannot be given to the same faculty member for two consecutive years. The faculty member will become eligible again after one year.

**Election:** Recipient chosen yearly via elections by residents and child/adolescent fellows.

**Occurrence:** The award is given towards the end of the academic year at the Senior Banquet.

### Previous Award Recipients:

2006: Loretta Silvia, Ph.D.

2007: Hal Elliott, M.D.

2008: Eugene Mindel, M.D.

2009: Donald Peters, M.D.

2010: Stephen I. Kramer, M.D.

## RESIDENTS AND CHILD/ADOLESCENT FELLOWS 2010-2011

### CHILD AND ADOLESCENT PSYCHIATRY FELLOWS

Asha Davis, M.D. (2 <sup>nd</sup> Year)	University Texas Medical School at Galveston
Kara Emerson, M.D. (2 <sup>nd</sup> Year)	University of Tennessee College of Medicine
Gabriel Garza, M.D. (1 <sup>st</sup> Year)	University of Texas Medical School at Galveston
Melanie Johnson, M.D. (1 <sup>st</sup> Year)	Wake Forest University School of Medicine
Ryan Livingston, M.D. (2 <sup>nd</sup> Year)	University of Cincinnati College of Medicine

### FIFTH-YEAR GENERAL PSYCHIATRY RESIDENTS

Frantz Pierre, M.D.	Wake Forest University School of Medicine
Jennifer Wildpret, D.O. (Chief Resident)	West Virginia School of Osteopathic Medicine

### FOURTH-YEAR GENERAL PSYCHIATRY RESIDENTS

Jennifer Beckman, M.D.	University of South Florida College of Medicine
Mohammed Iqbal, M.D.	Spartan Health Sciences University
Noah Richason, M.D.	University of South Florida College of Medicine
Bryan Smith, M.D.	Wake Forest University School of Medicine
Megan Webster, M.D.	University of Texas Medical School at San Antonio

### THIRD-YEAR GENERAL PSYCHIATRY RESIDENTS

Nicholas Batson, M.D.	American University of the Caribbean
Nathan Carter, M.D.	Howard University College of Medicine
Gregory Caudill, M.D.	Medical University of South Carolina College of Medicine
Deborah Davis, M.D.	Saba University, Netherlands Antilles
Gerhardt Wagner, M.D., Ph.D. (co-Chief)	Creighton University School of Medicine
Lisa Ann Westbrook, M.D.	American University of the Caribbean

### SECOND-YEAR GENERAL PSYCHIATRY RESIDENTS

Mohammed Ahmed, M.D.	Al-Ameen Medical College
Aaron Albert, M.D.	Wake Forest University School of Medicine
Jessica Derreberry, M.D.	Marshall University School of Medicine
Todd Derreberry, M.D.	Marshall University School of Medicine
Tara Farren, M.D.	Wake Forest University School of Medicine
Omar Rana, D.O.	Edward Via Virginia College of Osteopathic Medicine
Steven Sand, M.D.	Case Western Reserve University School of Medicine
Lao Yang, M.D.	University of Minnesota Medical School

### FIRST-YEAR GENERAL PSYCHIATRY RESIDENTS

Heather Clark, M.D.	Wake Forest University School of Medicine
William Carson Felkel II, M.D.	Loyola University of Chicago Stritch School of Medicine
Jennifer Gillis, D.O.	University of New England College of Osteopathic Medicine
Adam McDonough, M.D.	University of Alabama School of Medicine
Mariam Qureshi, M.D.	University of Toledo College of Medicine
Madlena Rush, D.O.	Edward Via Virginia College of Osteopathic Medicine

## OVERVIEW OF THE PSYCHIATRIC RESIDENCY PROGRAM

The house officer education program in psychiatry is accredited as a four-year program by the Accreditation Council for Graduate Medical Education. Applicants are considered for acceptance at the first postgraduate year after medical school graduation or second postgraduate year after satisfactory completion of an accredited clinical training program providing experience in general medical care of adults or children. The residency educational program of the Department of Psychiatry and Behavioral Medicine is designed to prepare the physician for the practice of general psychiatry or further subspecialty training, such as child/adolescent psychiatry, consultation-liaison psychiatry (psychosomatic medicine), substance abuse, geriatric psychiatry, forensic psychiatry, and neuropsychiatry. A Child/Adolescent Psychiatry Fellowship Program began in 1993.

Clinical rotations include the following experiences: inpatient psychiatry at Wake Forest University Baptist Medical Center, Veterans Administration Medical Center, outpatient general medicine and emergency medicine experiences, pediatrics, neurology, outpatient experience in subspecialty psychiatric and multidisciplinary clinics based at the medical center; experience in rural mental health centers; college student mental health at Wake Forest University Student Health Services, outpatient clinics at a Veterans Administration Medical Center and its outpatient center; consultation-liaison; emergency psychiatry; general adult psychiatry and child/adolescent psychiatry, group therapy.

Supervision while on rotations is designed to allow for increasing autonomy for the resident as clinical competence is gained in training. The rotations provide a broad base of clinical experiences reflecting the contemporary practice of psychiatry and preparing the resident for future developments in the field.

Two hours weekly of individual psychotherapy supervision are required for the PG-II, PG-III and PG-IV years of training. During this period, each resident follows his or her own outpatients in long-term and time-limited psychotherapy. For first-year residents, the PG-I Seminar provides weekly instruction in basic psychiatry, emergency psychiatry, psychopharmacology and ECT. For second- and third-year residents, weekly seminar tracks in psychotherapy and biological psychiatry are required. Other lectures include the Psychopharmacology Seminar, the Ethics and Professionalism Seminar, the Morbidity and Mortality Conference and the Advanced Test-Taking Skills Seminar. Journal club and Forensic Psychiatry takes place monthly and twice-monthly Grand Rounds with visiting lecturers are also scheduled. There is a resident business meeting biweekly. On a regular basis, the Chief Residents represent the residents in departmental administrative and inpatient meetings.

A carefully considered teaching program with balanced clinical and formal learning experiences exposes the resident to a broad range of contemporary psychiatric practice. These experiences prepare the resident to move into any of a variety of practice situations within the field of general psychiatry. APA/Psychotherapy conferences are attended on an individual basis; departmental scholarships are offered according to: individual academics performances, PRITE scores, research projects.

## DIRECTOR OF RESIDENT EDUCATION

Hal Elliott, M.D. is the Director of Resident Education in the Department of Psychiatry and Behavioral Medicine. The second son of a family doctor and of a teacher, Dr. Elliott is a native of Clover, South Carolina. He attended public schools in South Carolina and graduated from Davidson College with a Bachelors of Science degree. He received his MD from the Medical University of South Carolina and completed his psychiatry residency at the University of North Carolina in Chapel Hill. As a senior resident, Dr. Elliott was selected by his fellow residents and the faculty at UNC as the Diane Eklund Outstanding Resident in Psychiatry.

After completing residency, he spent a year working in rural mental health in West Virginia and also served on the clinical faculty in the West Virginia School of Medicine. He returned to North Carolina and started a private practice and also continued to work in community psychiatry. Dr. Elliott joined the faculty in the Department of Psychiatry and Behavioral Medicine in 1998. He has served as the Director of Adult Psychiatry Inpatient Services and as the Attending Psychiatrist and resident supervisor in the Wake Forest University Student Health Center. In addition, Dr. Elliott has been a consultant at Davidson College Student Health and at New River Behavioral Healthcare. He began as Director of Resident Education in January of 2007.

His clinical interests include anxiety disorders, adult attention deficit disorder, and college mental health. He has published articles on social anxiety disorder, premenstrual dysphoric disorder, and adult attention deficit disorder. Most recently, he has published an article on accommodations for resident physicians with attention deficit disorder.

Dr. Elliott is board certified and recertified in general psychiatry. He also is board certified in psychosomatic medicine. He is a member of the APA, NCPA, and the AADPRT.

Dr. Elliott and his wife Lisa have four children (Walker, Davis, Jackson and Julia). Because family is important to him, he wants to create a family-friendly and nurturing environment for residents in the program. His goal is to maintain a residency program which produces competent, empathic and compassionate psychiatrists capable of practicing skillfully and independently.

**ADMINISTRATIVE LINE:** The Director of Resident Education is directly responsible to the Educational Policy Committee and Departmental Chair.

**RESPONSIBILITIES:** The Director of Resident Education is responsible for the maintenance of a comprehensive educational program for psychiatric residents of the highest quality. The following areas are his direct responsibility:

1. Selecting residents to maintain a critical nucleus of capable residents to ensure an optimal educational process and meet the needs of the department. This involves recruiting applicants from other institutions, cultivating medical students within our own institution who are interested in psychiatry, and fostering interest in psychiatry in graduating medical students.
2. Developing and maintaining a comprehensive training program of the highest quality, including:
  - a. Maintaining of clinical rotations with excellent supervision and of a variety of clinical experiences to reflect psychiatry as it is practiced today;
  - b. Planning and overseeing educational seminars to ensure coverage of basic knowledge in the field of psychiatry and neurology.
  - c. Developing and coordinating a comprehensive system of resident evaluation with sufficient feedback to facilitate remediation of perceived deficiencies. In the event of failure to achieve minimal standards, to initiate procedures for dismissal;
  - d. Being aware of and enforcing ACGME requirements for psychiatric residency education in the curriculum;
  - e. Directly involving of the residents in curriculum development and evaluation.

3. Chairing the Resident Selection Committee.
4. Being a member of the Educational Policy Committee.
5. Maintaining membership in the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry.

### **EFFECTIVENESS EVALUATION**

The Director of Resident Education will report at least annually to the Educational Policy Committee and to the department chair on the effectiveness of the training program. It is expected that this be documented with standardized measures of resident proficiency, such as the Psychiatric Residents in Training Exam (PRITE), resident evaluations, mock board examinations, and other competency measures.

### **ASSOCIATE DIRECTOR OF RESIDENT TRAINING**

James N. Kimball, M.D. is the Director of Consultation and Emergency Services and Associate Director of Residency Education in the Department of Psychiatry and Behavioral Medicine at Wake Forest University Health Sciences. Dr. Kimball grew up in Bellmaar, New Jersey and graduated in 1994 from Drew University in Madison, New Jersey with a B.A in Biology. In 1998, he graduated with M.D. degree from UMDNJ, Robert Wood Johnson Medical School in New Brunswick, NJ. Dr. Kimball finished his Residency in Psychiatry in 2002 from UNC-Chapel Hill. Dr. Kimball completed a Fellowship Program in Psychosomatic Medicine from VCUHS-Medical College of Virginia in 2003. He is board certified in both adult psychiatry and psychosomatic medicine. He is the director of outpatient services and is responsible for the Faculty Teaching Clinic and for coordinating psychotherapy supervision.

Currently Dr. Kimball is with Wake Forest University Health Sciences as Assistant Professor in the Department of Psychiatry and Behavioral Medicine. Dr. Kimball and his wife, Sally, enjoy dogs, bowling and the outdoors.

## CHIEF RESIDENT(S)

**Description:** Two Chief Residents or a Chief Resident and Associate Chief Resident will be appointed by the Department Chairperson in consultation with the Director of Resident Education approximately four months before the end of the academic year. The current chief residents will spend time during this period orienting the incoming chiefs. The residents will nominate and elect a chief resident from the rising 4<sup>th</sup> or 5<sup>th</sup> year class and an associate chief from the rising 3<sup>rd</sup> year class. Alternatively, they can elect two chief residents from the rising 4<sup>th</sup> or 5<sup>th</sup> year class. These nominees will then be submitted by the Director of Psychiatry Resident Education to the Department Chairperson for final approval.

Child psychiatry residents (fellows) may not serve as the department's Chief Residents.

**Objectives:** The position of Chief Resident is designed to provide the assigned resident an experience of administrative psychiatry. The experience provides an opportunity to exercise leadership and arrange Grand Rounds utilizing speakers of merit from both within and outside the medical center, and to work closely with faculty members within the department.

### Chief Resident Duties:

1. Assigns back-up coverage for the unexpected absence of an assigned resident or to an unmanageable work load of any resident.
2. Orients new residents or rotating residents from other departments or institutions.
3. Prepares the call schedule for residents by the required date- one and half month before next quarter begins.
4. Prepares the clinical rotation assignments, including mental health centers at the start of an academic year and when revisions are needed.
5. Works with Department Chairperson or other designated faculty to schedule speakers for Ground Rounds held on the 1st and 3rd Friday of each month (September through June).
6. Orients medical students on clinical rotations.
7. Participates as member of the Educational Policy Committee and attends Senior Staff meetings.
8. Participates as member of the Resident Selection Committee and participates in interviewing and selecting residency applicants.
9. Is available by beeper or phone at all times during regular duty hours unless an acting chief resident is assigned during chief resident's absence.
10. Participates as a member of the institutional Chief Residents Council.
11. Works closely with associate chief or co-chief in dividing responsibilities.

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## CHIEF RESIDENT ELECTION PROTOCOL

**To be considered for Chief:** A resident who wants to be considered for Chief should submit a brief statement as to why they are interested in the position and/or why they should be considered. The statement should include any administrative experience the resident may have had.

**Protocol & Guidelines:** The chief resident ultimately is selected by department Chairman, Dr. McCall, who receives recommendation(s) from the Program Director, Dr. Elliott. The program director will ask residents to make a selection on the distributed secret ballot and submit their selection either to the Residency Program Assistant, Sheila Leach. When the election is over, Dr. Elliott will submit the selection directly to Dr. McCall. In order to have the selection involve BOTH faculty and residents, the following guidelines/rules will be utilized:

- only residents who ask to be considered will be candidates for chief
- residents will select/elect two chiefs from the rising PG4/PG5 class; or a chief from the rising PG4/PG5 class and an associate chief from the rising PG3 class by secret ballot

- secret ballots should be turned into the Residency Program Assistant and collected by the current chiefs who will submit that selection to Dr. Elliott ( the results will remain confidential)
- the program director will then submit the results to the EPC who will make a decision and submit their recommendation to the chair
- after the process is complete and Dr. McCall makes the final decision, Dr. Elliott will inform the residents via email

We hope this clarifies the process and that it ensures that both residents and involved faculty have input into what is a very important part of the residency program.

**SECTION TWO:**  
**SCHEDULING AND ROTATIONS**

## **CLINICAL ROTATIONS**

### **OBJECTIVES**

The clinical rotations are designed to provide supervised contact with a wide variety of psychiatric patients of varying diagnoses, ages, gender, and racial and ethnic backgrounds. Patient exposure is monitored to ensure that a good spectrum of clinical material is encountered during training. Treatment settings are selected to provide a cross-section of psychiatry as currently practiced. Residents should be able to observe and practice a number of treatment techniques, including brief and long-term psychotherapy, supportive therapy, crisis intervention, family therapy, group therapy-DBT, CBT, pharmacotherapy, and ECT. Supervision at different levels of training allows greater responsibility in patient management with increased level of training and sophistication. In addition, an experience of general medicine (including emergency room) during the first year of training is designed to familiarize the resident with the diagnosis and treatment of common medical problems in ambulatory or inpatient settings. The inpatient units of North Carolina Baptist Hospital (WFUBMC), a tertiary care center, have a number of patients with complex medical as well as psychiatric problems. During the first year of training, a two-month rotation in neurology provides experience with both common and unusual neurological problems. Increased proficiency in performance of an extensive neurological examination is expected to be developed during this rotation.

Because of the more intensive emphasis on neurology and medical illness and co-morbidity in the first two years, we strongly recommend that our residents pass step three of the national board exam by the end of the 2<sup>nd</sup> year of the residency training.

### **EFFECTIVENESS EVALUATION**

The general effectiveness of the clinical rotations is evaluated along with the residency training program in general. Individual rotations are overseen by the Director of Residency Training using both feedback from resident evaluations of the rotation through E-Value and direct observation. When a rotation is found to be below expectation, every effort will be made to work with the supervisor of the rotation to improve it. If this cannot be done, alternate equivalent experiences will be sought, and the deficient rotation site will be dropped.

There is some necessary variation in the clinical assignments during the second through fourth years due to scheduling. The structure below is approximate but accurate as to lengths of assignments. The first year is the only relatively fixed scheduled time. The other rotations are completed in second through fourth years as resident desires and scheduling requirements dictate. Formal electives and selectives are available to upper-level residents. Most clinical rotations include required reading materials from the department's CERP (Core Essential Readings in Psychiatry), an electronic bibliographic database.

<b>YEAR</b>	<b>ROTATION</b>	<b>DURATION</b>
<b>First Year</b>		
	Neurology	2 months
	General Medicine (Internal Medicine, Pediatrics and Emergency Medicine )	4 months
	WFUBMC Adult Inpatient Services	6 months
<b>SECOND YEAR</b>		
	Consultation-Liaison & Emergency Psychiatry Service	4.5 months
	Child Outpatient Psychiatry (1/2 time)	½ time over 6 months= 3 month full-time equivalent
	Selective	3 months
	ECT (1/2 time)	½ time over 3 months= 1.5 month full time equivalent
<b>THIRD YEAR</b>		
	Adult Outpatient Psychiatry	12 months
	*Community Health Settings	1 day/week for 12 months
<b>FOURTH YEAR</b>		
	WFUBMC Inpatient Service (Child & Adolescent)	1 month
	Upper-Level Inpatient Psychiatry/ Geriatric Outreach (GO) Program	3 months
	VA Selective	3 months
	Forensic Selective	1 month
	Electives	5 months

\*Community Health Settings are comprised of mental health centers in a variety of settings. This is not a block assignment and is considered a longitudinal assignment. This provides a long-term exposure to outpatient management of chronically ill patients. Residents are typically assigned to at least two different sites during their residency for a total minimum experience of 12 months during the PGY-3 year or when the resident rotates through the Adult Psychiatric Outpatient Clinic Rotation.

## NCBH ADULT INPATIENT PSYCHIATRY ROTATION

**Director:** Dr. Stephen Kramer

**Team Leaders:** Dr. Stephen Kramer, Dr. Thomas Brown, Dr. James Kimball,  
Dr. Eugene Mindel, Dr. Peter Rosenquist, Dr. Hal Elliott

### Teaching Objectives:

1. To gain experience in inpatient psychiatric diagnosis and treatment.
2. To learn different treatment modalities.
3. To learn appropriate use of psychotropic medicines.
4. To gain experience and practice in the multidisciplinary team approach to comprehensive patient care.
5. To learn the indications, contraindications, and performance of ECT.
6. To learn to make proper referrals for consultation.
7. To gain experience in teaching medical student and the health care staff.
8. To learn to deal with difficult patients, including those with multiple medical problems and complex co-morbidities.
9. Twenty (20) per cent of the PG-1 rotation is designated as *geriatric psychiatry* training experience. Ten (10) per cent of the PG-1 rotation is designated *addiction psychiatry* experience.
10. To gain experience in work with families and inpatients.
11. To learn to utilize psychological testing in the process of diagnosis and treatment planning.
12. To learn technique and formulation of psychiatric history and physical examination.
13. To gain experience in systems-based practice, including service delivery oversight.

**Responsibilities:** The residents perform preliminary evaluation of the newly admitted patient with a complete history and physical examination and subsequent suggestion of appropriate lab work and treatment plan. The residents make daily rounds on weekdays with the attending at 8:00 a.m. and attend team meetings twice weekly. The inpatient team has up to 12 patients and is comprised of the attending psychiatrist, 1-2 PG1 residents, 2-4 medical students and/or an Acting Intern (AI), a nurse, a social worker, a recreational therapist and a faculty level PhD psychologist. Often, there will also be a senior level resident assigned to the inpatient team. The residents write orders and daily progress notes. Residents are encouraged to attend group therapy daily and family meetings when time permits. These responsibilities generally take up the whole of each weekday morning from 8-12 except Friday. Fridays have protected time for seminars and Grand Rounds.

In the afternoon, the residents make appropriate follow-up plans, write prescriptions/orders and give instructions to the patient and family regarding medications and side effects and the follow-up plan. The residents coordinate and schedule family evaluations. The residents have the additional responsibility for daily instruction of medical students in performance of history and physical exams and in general psychiatry. The patient caseload is generally 6 to 12 patients per resident. PG-1 and PG-2 (transfer) residents must pass two (2) core competency evaluations and present six (6) satisfactory discharge summaries to complete the rotation, and be promoted to the second year of residency.

## GENERAL MEDICINE ROTATION

**Directors:** Internal Medicine - Dr. Frank Labagnara  
Pediatrics - Dr. Lenore Parks  
Emergency Medicine - Dr. Howard Blumstein

**Location:** Internal Medicine - VAMC Salisbury  
Pediatrics - Downtown Health Center  
Emergency Medicine - Wake Forest University Baptist Medical Center

### Teaching Objectives:

1. Exposure to a broad range of general medicine problems, especially those likely to be encountered in a psychiatric population in hospital and in office.
2. To apply knowledge of diagnostic criteria and perform laboratory work-ups for common and uncommon medical disorders.
3. To learn and practice of principles of medical management of common medical disorders.
4. To gain experience in use of medical and surgical consultation in the ongoing out patient management of medical disorders.

### Responsibilities:

1. The resident is assigned to the outpatient pediatric clinic at Reynolds Health Center, the primary care program at the VAMC, and the WFUBMC Emergency Room, or comparable services.
2. The resident is responsible for seeing the patient initially performing a history and physical examination, and reviewing the chart.
3. The resident presents his findings and recommendations to the attending, and they see the patient together to confirm the findings. Cases are analyzed and discussed at the time of presentation or after the patient leaves.
4. The resident attends the PG-1 conferences (when not assigned to the VA) and Grand Rounds in the Department of Psychiatry during this rotation, and has opportunities to present didactic and clinical case conferences on each assigned service.

**GOALS AND OBJECTIVES FOR PSYCHIATRY RESIDENTS  
DOWNTOWN HEALTH PLAZA GENERAL PEDIATRIC CLINIC ROTATION**

**I. Patient Care:**

At the end of their month of training, residents are expected to exhibit competency in the following areas:

**A. Accumulation of data**

1. Obtain and record a complete pediatric history, appropriate to clinical circumstances.
2. Make efficient use of both patient and family in gathering information.

**B. Performance of physical examination**

1. Recognize clinical situations which require a focused examination and those which require a complete examination.
2. Describe ways to modify the approach to the examination when faced with an uncooperative child.

**C. Diagnosis and management of patients**

1. Establish a differential diagnosis and assessment plan with appropriate prioritization.
2. Arrive at a decision or conclusion when reasonable data are available.
3. Complete prescriptions, consider potential document drug interactions, and provide patient education about medications.
4. Provide appropriate patient education regarding anticipatory guidance, immunizations, development, diagnostic and treatment modalities, and expected courses or outcomes.

**D. Utilization of patient care resources**

1. Identify the indications for referral.
2. Develop and understanding of community services when providing care to families in need.

**II. Medical Knowledge:**

At the end of their month of training, residents are expected to demonstrate appropriate pediatric knowledge in the following areas:

**A. Health maintenance**

1. Describe normal patterns and variants of growth and development in infancy, childhood, and adolescence.
2. Discuss knowledge of recommended periodicity schedules for routine health supervision visits and for the content of these visits.
3. Utilize of screening tools, schedules, and guidelines to assure growth and developmental progress.
4. Discuss appropriate nutritional intake for children at various stages of development.

**B. Acute and Chronic Conditions**

1. Recognize normal and abnormal physiology causing the symptom(s).
2. Develop a differential diagnosis and plan with appropriate prioritization.
3. Understand of the pathophysiologic processes of a disease and its treatment.
4. Use of laboratory, x-ray, and ancillary services for diagnostic evaluation.
5. Interpret results of common tests.

**C. Use of Educational Resources**

1. Use literature, including AAP guidelines and practice parameters, to expand knowledge and to develop sound, evidence-based patient care plans.

**III. Practice-Based Learning and Improvement**

At the end of their month of training, residents are expected to be developing competence in the following areas:

**A. Utilization of Educational Resources**

1. Initiate and facilitate group discussion and teaching. **Each resident is responsible for presenting 1-2 morning talks. See the schedule at the DHP for your assigned date.**
2. **Each resident is expected to attend and participate in all of the morning lectures. 8-8:30AM**

**IV. Interpersonal and Communication Skills**

Throughout the month, residents are expected to be developing their skills in the following areas:

**A. Communication with Patients and Families**

1. Learn how to appropriately use interpreters.
2. Recognize cultural differences and how they affect communication in health care.

**B. Communication with Members of the Health Care Team**

1. Maintain medical records properly and in a timely fashion. All **Centricity records should be completed by the end of each day if possible, and absolutely no later than one week following the patient visit. All records need to be completed no later than 1 week after finishing the rotation.**

## **V. Professionalism**

Throughout their month, residents are expected to develop and exhibit the following skills of medical professionalism:

1. Evaluate and enhance performance based on self-assessment and feedback from others.
2. Recognize one's own limits and accept accountability for actions and errors.
3. Demonstrate respect for a patient's privacy.

## **VI. System-Based Practice**

By the end of their month, residents are expected to develop competence in the following areas:

### **A. Advocacy for Patients and for Children's Health Issues**

1. Access and utilize local, regional, national, and international information related to health care issues.
2. Develop awareness of policies and legal issues at each level of governance that may influence population health and patient care.

### **B. Practice Management**

1. Collaborate with other providers and staff to assess and improve clinic flow and quality of services.
2. Develop awareness of financial and organizational structures in the practice of pediatric medicine.
3. Consider cost-effectiveness and utilization of limited resources in the development of care plans.

## NEUROLOGY ROTATION

**Director:** Dr. Jane Boggs

### **Teaching Objectives:**

1. To learn to perform a competent and complete neurological history and examination.
2. To develop competence in diagnosis and treatment of common neurological disorders.
3. To perform laboratory and diagnostic procedures for the diagnosis and monitoring of common neurological disorders.
4. To summarize and present neurological findings in a lucid and coherent manner to support a differential diagnosis.

### **Duties:**

1. The resident works in the Neurology Outpatient Department primarily. This involves taking a complete history, reviewing records and referral information, performance of a complete physical and neurological examination and preparation of a differential diagnosis and a treatment and/or diagnostic plan.
2. The resident presents his findings to the assigned attending neurologist (this includes the entire attending Neurology faculty). The attending then comments, examines the patient, and supervises in the implementation of the plan.
3. The resident attends teaching rounds and conferences in the Department of Neurology and attends PG-1 level seminars and Grand Rounds in the Department of Psychiatry.

## ECT AND BRAIN STIMULATION ROTATION

**Director:** Peter Rosenquist, M.D.

**Faculty:** Vaughn McCall, M.D., M.S.  
James Kimball, M.D.

### Teaching Objectives

1. To be able to perform a complete evaluation of the patient with a treatment-resistant affective disorder
2. To be able to evaluate a patient for ECT while weighing the pros and cons and risks and benefits of treatment with ECT
3. To be able to conduct ECT including patient preparation, device set-up, treatment delivery, and aftercare
4. To become familiar with newer treatment modalities of brain stimulation such as rTMS, VNS, and DBS as they become integrated into the Department's research and clinical practice

### Resident Responsibilities

1. Residents are assigned to this rotation for a three-month block, 1-2 days per week, while assigned to the Child Outpatient Psychiatry half-time rotation.
2. Residents assist with ECT consultations, ECT procedures, and aftercare management. This includes treatment coordination, interagency liaison, and providing clinical data for insurance verification and authorization as necessary.
3. Residents will submit 5 completed consultation reports, including assessment and plan covering the following key somatic therapies:
  - 1) Pharmacologic augmentation strategies
  - 2) ECT index course
  - 3) ECT continuation and maintenance therapies
  - 4) Vagal nerve stimulation (when available)
  - 5) Transcranial magnetic stimulation (research cases or when available)
4. Each case report will be used as a stimulus for assessment consisting of either a 15 minute oral examination or a one page (single spaced, typed) case discussion. At least three relevant references, one being a recent journal article, must be included in either assessment form.

## ADULT OUTPATIENT CLINICAL ROTATION

**Director:** Dr. James Kimball: General Adult Outpatient Psychiatry Clinic  
Drs. Burton Reifler, Eugene Mindel: Geriatric Psychiatry Clinic  
Drs. Peter Rosenquist and Stephen Kramer: Neurobehavioral Clinic  
Dr. Gretchen Brenes: Group Therapy Elective

### Teaching Objectives

1. To improve and practice clinical interviewing, diagnostic, and formulation skills in the context of outpatient clinical settings
2. To observe and participate in a variety of outpatient treatment modalities, including individual psychotherapy, brief psychotherapy, pharmacotherapy and supportive therapy, outpatient group therapy, geropsychiatry, and neuropsychiatry
3. To provide a framework for supervised long-term psychotherapy cases
4. To supervise medical students in their initial evaluation of patients in the adult outpatient clinic

### Resident Responsibilities

1. Residents will perform initial clinical evaluations of diagnostic cases. The attending will observe the residents' interview techniques, either directly or by one-way window. The cases will be presented and discussed with the attending and assigned to a resident for follow-up care.
2. Residents will teach medical students and supervise and critique their initial diagnostic evaluation.
3. Residents will participate in subspecialty clinics, which will include a triage clinic, psychopharmacology clinic, geropsychiatry, neurobehavioral, and group therapy electives.
4. Residents will continue working at a more intensive level with long-term psychotherapy patients.
5. Residents will be regularly supervised by faculty members in the specialized areas of group therapy, brief, cognitive-behavioral, psychodynamic, and supportive psychotherapy.
6. Each resident will submit a videotaped new patient evaluation to evaluate patient care, interpersonal and communication skills, and professionalism core competencies. The videotape may be used in group supervision and feedback sessions.
7. Residents will submit 5 complete case reports including assessment and treatment plan for patients with the following issues:
  - 1) Mood disorder
  - 2) Anxiety disorder
  - 3) Psychotic disorder
  - 4) Substance use disorder
  - 5) Other diagnosis (e.g. adult ADHD, dementia, personality disorder)
8. Residents will provide complete, accurate, and timely documentation of patient contacts and care provided. The OPD attending will review all charts for completeness, accuracy, and quality of patient care.
9. Residents will complete chart-stimulated recall exercises based on numbers 7 and 8 above which may include oral or written examinations provided by the OPD attending.

## PSYCHIATRY FACULTY TEACHING (FT) CLINICS GENERAL INFORMATION FOR RESIDENTS

1. Each week, you (the residents) will be provided with two half-days during which time you will not be scheduled for off-site clinic duties or FT clinic duties. The two half-days could both be on the same day of the week, depending upon the scheduling. During this time, you are to:
  - see your private psychotherapy patients
  - meet with your psychotherapy supervisors
  - attend to clinic-related work, such as returning patient phone calls, charting or preparing for upcoming clinic patients
  - attend to other responsibilities, such as personal physician/dentist appointments or having the car serviced (non-work issues)

During these times you are to be on your pager, since the department's secretaries may need to get in contact with you for various reasons. If you are planning to attend to an activity (like a dentist appointment) where it is not feasible to be on your pager, you need to let the FT clinic secretaries know, so that they are not needlessly paging you (they will page the clinic resident on call, instead).

2. Every business day (not weekends or holidays) from 8am-5pm, a clinic resident will be assigned to cover clinic call. This call schedule is set up prior to the beginning of each month, and copies will be placed in your mailboxes and with the secretaries. The responsibilities of the resident on clinic call are as follows:
  - review any prescription refill requests for residents who are off-site that day
  - handle any issues involving clinic patients (whose resident providers are off-site or absent from work that day) who call the department with urgent questions or who are "in crisis" (if this happens, one of the secretaries will page the resident on clinic call).

It is your responsibility to review the monthly clinic call schedule when it comes out and to arrange for a colleague to cover you if you are scheduled for vacation on a day you are assigned for clinic call. Be sure to let the FT clinic secretaries know of any changes to this schedule.

3. It is important that you review the patient charts prior to the start of the clinic session, especially if the patient is new to you. Also, take the time to review any recent labwork for the patients prior to the start of the FT clinic session.
4. Every FT clinic patient *must* be staffed by an attending psychiatrist. Be sure to budget the time needed to review the case with an attending and have the attending physically staff the patient, so that you can remain (reasonably) on schedule in clinic.
5. Documentation must be made for every patient seen. It is important that you make sure that some type of Centricity documentation is provided for each patient interaction.

6. Every time a medication prescription is written or called into a pharmacy, be sure to document this under the medication section in Centricity.
7. If the front desk or telephone triage pages you during clinic time (the call-back number will either be 66312 or 64551), call back immediately because they probably have a question regarding the check-out of the patient you just finished seeing or an urgent patient call, and it is not appropriate to wait 30 minutes before you return the secretary's page.
8. If you are scheduled to see a patient at a certain time, and it is past that time and no one has paged you to let you know that your patient has arrived, go to the front desk and double-check to make sure your patient has not arrived. The front desk secretaries often get very busy and occasionally they forget to page the resident for a patient.
10. If patients you have seen in FT clinic call and leave you an office voicemail message, return their calls at your earliest convenience, but do not wait days before doing so. Also, be sure to document your return call (with a telephone note) in the chart afterwards.
11. Whenever possible, be proactive in clinic. For instance, at the end of each week, check in Centricity and with the FT clinic secretaries to preview your clinic schedule for the upcoming week. Sometimes, patients are mistakenly double-booked for you or scheduled during times when you are not supposed to be in FT clinic. By doing this, the secretaries will be able to call ahead and reschedule these patients, instead of having to deal with it on the day of the patient's appointment (or worse, when the patient has already shown up for clinic).
12. It is your responsibility to inform the clinic secretaries of your call/post-call schedule when it is released, so that you will not have any patients scheduled for the afternoon of your post-call days. You are expected to be in clinic during the morning clinic session on your post-call days, since this falls within the resident work hour limits. You are expected to see return patients only on your post-call days.
13. Generally you should not schedule your patients for follow up with a different resident. There could be exceptions, e.g., if you will be on vacation and someone else has agreed to cover your patients and you have a patient who will need to be seen in your absence. Also, if patients request a different clinician the department may or may not grant that request, depending on what would be best for the patient. Generally, the FT clinic does not change residents unless there is a compelling clinical reason.
14. Your voicemail should be explicit in terms of when you will be at the office, when you are away from the office, and when you are on vacation. For example, "This is Dr. X from the Dept. of Psychiatry at Wake Forest University Baptist Medical Center. I am currently not able to take your call. I will attempt to return all calls within one business day. If this is an emergency, please call 911 or call the psychiatrist on call. If you are

calling for a refill, please leave your pharmacy number. Please note I am not in the office on Tuesdays.”

15. All patients who are to be terminated from the FT clinic should be discussed with Dr. Kimball and Risk Management first. In addition, clinic patients who pass away for any reason during your time in the clinic should be discussed with Risk Management.
16. If you are absent from FT clinic due to illness, it is necessary that you call or email Sheila Leach [saleach@wfubmc.edu](mailto:saleach@wfubmc.edu) (the residency coordinator) and also telephone triage to inform them of your absence. They will then inform others in the FT clinic of your absence.

### **Learning Objectives of this Experience** (Provided by Dr. James Kimball, Director of the FT Clinic)

By the end of this rotation you should feel comfortable with the following issues pertaining to outpatient practice:

#### **I. Issues of confidentiality:**

- 1) Phone calls from relatives
- 2) Communication with physicians/therapists  
Is it necessary to get authorization (written or verbal) from the patient?  
What and how often do you get back to a referring physician: phone call? Written note? Getting in touch with a patient's other physicians: how much do you share/reveal?
- 3) How many notes and of what type do you keep for what purpose?
- 4) Do you ever audiotape sessions? Videotape sessions?
- 5) When and how do you tell a patient that you would like to see or phone a family member?
- 6) What can/should you say to a family member who is seeing you individually, with your patient's permission? What do you reveal/not reveal?
- 7) When do you get a live consultation/second opinion for a long-term outpatient?
- 8) How do you handle a patient's request for either a second opinion or to be referred to another therapist?

#### **II. Financial Issues**

- 1) When and how is it appropriate to charge for missed sessions?
- 2) Is it ever appropriate to lend a patient money?
- 3) How do you set or modify fees?
- 4) How do you deal with the patient who doesn't pay?
- 5) How do you deal with a patient who wants to bend the rules for insurance purposes?
- 6) What about seeing a family member? Whom do you charge?

#### **III. Late/missed sessions**

- 1) When do you phone if a patient misses a session?

2) How do you deal with repeated lateness: extend the session? "demand" an explanation? What is the therapeutic value in exploring this issue and if so, how is this done?

#### **IV. Boundary issues/self-disclosure**

- 1) When do you initiate a phone call to a patient at home or work? And how do you identify yourself?
- 2) Physical touching: handshakes, hugs, etc. When are these appropriate?
- 3) Gifts, cards, invitations to special events: how do you handle these?
- 4) Pictures on your desk?
- 5) Seating arrangements?
- 6) Lighting in your office?
- 7) When you get sick or have a personal problem, do you ever share information about these events?
- 8) How much do you reveal about yourself (e.g., marital or parental status, age, specific vacation plans, etc.) and in what circumstances?
- 9) When do you ever extend sessions beyond your usual time (e.g., if a session is particularly "fruitful", if you were late because of another emergency, etc.)?

#### **V. Counseling vs psychotherapy**

- 1) Is there a difference? If so, what?
- 2) Giving "advice": when, if ever, is it appropriate and how is it done?

#### **VI. Therapeutic Style**

- 1) Use of affect by the clinician: do you ever get angry, enthusiastic, express affection?
- 2) What do you say to a patient at the start of therapy? Do you explain the nature of psychotherapy, about the role of the therapist, the patient? Do you "educate" the patient about the process of psychotherapy?
- 3) How do you select the appropriate mode of therapy for a given patient (e.g., brief or long-term psychodynamic, interpersonal, cognitive-behavioral, couple, family, group)? How do you formulate a therapeutic contract?
- 4) How does a clinician dress?
- 5) How do you explain specific psychodynamic therapeutic techniques (if you use them) to a silent patient: silences, refusal to direct questions, and other behaviors that on the surface look strange to the uninitiated?
- 6) Is there ever any justification for expecting patients to figure out rules of psychotherapy on their own, or are they entitled to patient education and informed consent as in all other medical treatment?
- 7) How do you explain to a patient that you would like to do a mental status exam and the reasons for it?
- 8) Silence in psychodynamic psychotherapy: when, how long, who ends it?

#### **VII. Medication Issues**

- 1) How do you incorporate pharmacotherapy into psychotherapy?

- 2) What strategies are used when the psychiatrist acts as a medical consultant for patients in psychotherapy with non-M.D. therapists?
- 3) What are the psychodynamic aspects of medication management?
- 4) How do you deal with issues related to medication consent in outpatient psychiatry?
- 5) What issues arise and what strategies are used with outpatients who are having medication side effects?
- 6) How do you deal with patients who are noncompliant with medications?

**VIII. Suicide/assault/legal issues**

- 1) How do you deal with suicidal threats in therapy: veiled and unveiled?
- 2) How do you deal with patients who are angry at you?
- 3) How do you deal with patients who make a veiled (or open) threat toward you or someone else?
- 4) What do you do when a patient reveals child abuse?
- 5) What do you do when a patient reveals illegal activities such as drug dealing, theft, fraud?
- 6) What do you do when you learn that a patient is using or abusing substances or alcohol?

**IX. Countertransference/transference issues**

- 1) What is your usage of the terms "transference" and "countertransference"?
- 2) How do you handle your own hostility to patients?
- 3) How are you affected by and how do you respond to patients considered boring, kvetchy, selfish, immature, abrasive, oppositional, condescending, controlling?
- 4) Borderline rage in the therapy hour: how much destruction or abuse do you tolerate? How do you respond?
- 5) How do you handle your own attraction to patients, and patients' attraction to you?
- 6) How do you handle countertransference to patients with characterological/personality problems?
- 7) How do you handle the exhibitionistic patient?
- 8) What do you say (do) when a patient reveals sexual thoughts about you?

**X. Dreams**

- 1) Do you make use of dreams in psychotherapy? If so, what?

**XI. Termination**

- 1) Planned
- 2) Abrupt
- 3) Patient-initiated
- 4) Therapist-initiated
- 5) When do you try to talk an ambivalent patient into staying in therapy? When don't you?

## CONSULTATION-LIAISON ROTATION

### Directors:

Dr. James Kimball - Adult Psychiatry

Dr. Matt Hough - Child and Adolescent Psychiatry

### Teaching Objectives

1. To understand the nature of the consultative process and distinguish the responsibilities of a consultant from those of a primary physician
2. To understand medico-legal problems that present to the consultation-liaison services (e.g. commitment, capacity) and provide appropriate consultation for these problems
3. To distinguish the various types of consultations (patient centered, physician centered, program centered, and nurse centered), and observe and practice each type
4. To formulate and articulate psychosomatic problems in a biopsychosocial context meaningful to the non-psychiatric physician
5. To recognize the signs and symptoms and diagnose psychiatric conditions most commonly encountered in medical settings
6. To observe and practice crisis intervention, brief psychotherapy, brief family intervention, patient education, and appropriate referral in medically hospitalized patients
10. To perform an adequate psychiatric consultation and present it in an effective manner to the consultation-liaison team

### Resident Responsibilities

1. Covering all psychiatric consultations requested during the working day Monday-Thursday 8:00 a.m. - 5:00 p.m. and on Fridays from noon until 4:00 p.m.  
On Fridays from 8am-noon a PGY-4 resident and faculty will cover floor consults on an as needed basis and non-urgent floor consults may be deferred for the assigned Consult team.
2. Present the case to the consult attending or the requested faculty member. The patient is then seen jointly by the resident and the attending physician to develop diagnostic and treatment recommendations. Areas of review are interpersonal and communication skills, professionalism, and systems-based practice.
3. Initiating and maintaining appropriate follow-up with inpatient consults.

4. Supervising medical students rotating on the consultation-liaison service.
5. Submit 5 typed Consultation Reports, complete with your own assessment and plan, illustrating each of the following key consultation issues:
  - 1) Delirium
  - 2) Medical decision-making capacity
  - 3) Depression in a medically ill patient
  - 4) Somatoform disorder
  - 5) Suicidality
6. For each of the reports in #5 above, complete either a 15 minute oral examination by the C- L attending or submit a one-page, single-spaced typed case discussion. In either case, submit at least 3 relevant references with at least 1 being a recent journal article in the area.
7. Consultations seen on the Emergency Psychiatry Service may be used for items 5 and 6 above.

## **EMERGENCY PSYCHIATRY ROTATION**

**Director:** Dr. James Kimball

### **Teaching Objectives**

1. To appropriately assess patients presenting with psychiatric emergencies, including history gathering (from patient or additional sources), mental status assessment, and laboratory assessment, and triage patients to the appropriate level of care
2. To identify situations which present an imminent danger to the patient or others and make appropriate interventions; special consideration should be given to the assessment of potentially suicidal patients and violent or threatening patients
3. To understand indications for, and principles of, emergency psychopharmacologic intervention including the use of antipsychotics and benzodiazepines
4. To understand and utilize the involuntary civil commitment process
5. To consider possible general medical conditions which may present as psychiatric emergencies, and utilize medical consultants appropriately
6. To recognize non-urgent psychiatric conditions and make appropriate referrals to other available services
7. To recognize indications for and perform brief crisis intervention therapy

### **Resident Responsibilities**

1. Residents assigned to the Consultation-Liaison Psychiatry Service are responsible for seeing urgent psychiatric consults in the emergency room (as assigned on a rotating basis) during the following daytime hours: 8:00 a.m. - 5:00 p.m., Monday – Thursday and noon - 4:00 p.m. on Fridays. On Fridays from 8am-12pm a PGY-4 resident and faculty member will cover the emergency department. Urgent consults should routinely be seen in 30 minutes or less from the time of the initial request.
2. On-call residents are responsible for seeing all after-hours and weekend urgent consults. Urgent consults should routinely be seen in 30 minutes or less from the time of the initial request.
3. All emergency consults must be discussed with the attending psychiatrist immediately after the patient is seen and prior to final disposition of the patient.
4. Residents should adequately document all emergency psychiatry contacts immediately after completing the consultation.

5. Residents should involve rotating psychiatric medical students either assigned to the Consultation-Liaison Service or on-call as much as possible in the consultative process and teach the students as time allows.
6. Re-evaluate patients who have been in the ED psychiatric holding area (awaiting final disposition) for longer than 24 hours. These re-assessments must occur at least once every 24-hour period while psychiatric patients are in the ED.

### **What to know about consults as an intern:**

When you are summoned to the ED or the floor for a consult, your role is just that – as a consultant – you are not the primary MD for that patient, and as such, you should not write orders or disposition a patient without the approval of the patient’s primary doctor.

When asked to do a consult, you should say something to the effect of: "We are glad to see them. I just need the following information before I can do the consult:" and should keep in mind the following 6 basic questions:

- 1) What is the reason for the consult? (this should ideally take the form of a question i.e. does this person have capacity?, can you help me manage this person’s depression?, etc) The reason “My attending told me to call it in” is not a valid reason for a consult.
- 2) How will this consult affect the medical management of this person while they are in the hospital? (i.e. someone who has been on an antidepressant and followed by a psychiatrist for years and mood has been stable probably doesn’t need a psych consult).
- 3) Has the patient been notified that a psych consult is pending? The referring team should always do this, unless the patient is in such a state that notification would be irrelevant (i.e. who is delirious).
- 4) How urgent is this consult? As a rule all floor consults should be done within 24 hours of the call, unless mutually agreed upon. Regardless, please communicate with the referring physician.
- 5) Is the person awake and coherent enough to participate in a psychiatric interview? Unless the consult is to help with agitation or delirium, it is reasonable to postpone the consult until the person can participate in the interview. We are not mind readers!! In addition, being on call it is important to utilize your resources wisely.
- 6) Has the patient been physically examined yet? Have appropriate labs been drawn? What pertinent findings should I be aware of before seeing the patient?

You should always ask at a minimum questions 1 and 3.

### **Evaluation of Psychiatric Patients in the Emergency Department**

An emergency psychiatric evaluation generally occurs in response to thoughts, feelings, or urges to act that are intolerable to the patient, or to behavior that prompts urgent action by others, such as violent or self-injurious behavior, threats of harm to self or others, failure to care for oneself, bizarre or confused behavior, or intense expressions of distress. It is expected that under ordinary

circumstances e.g. when there are no other patients in the E.D. needing initial psychiatric assessment, patients needing a psychiatric consult in the E.D. should be seen for the initial assessment in 30 minutes. Generally when there are 3 or more patients in the E.D. requiring initial psychiatric assessment, the Back-up Psychiatry resident should be called in.

**The aims and specific approaches to the emergency include the following:**

1. Discuss with the referring physician the specific question or issue to be answered.
2. Confirm with the physician requesting the consult that the patient is aware that a psychiatric consultation will be performed.
3. Carefully consider matters of safety of the patient and others in your assessment.
4. Establish a provisional diagnosis (or diagnoses) of the mental disorder(s) most likely to be responsible for the current emergency, including identification of any general medical condition(s) and/or substance use that might be causing or contributing to the patient's mental condition.
5. Identify family or other involved persons who can give information that will help determine the accuracy of reported history, particularly if the patient is cognitively impaired, agitated, uncooperative, or psychotic and has difficulty communicating a history of events. If the patient is to be discharged back to family members or other caretaking persons, their ability to care for the patient and their understanding of the patient's needs should be addressed.
6. Identify any current treatment providers who can give information relevant to the evaluation and obtain this information whenever possible.
7. Identify social, environmental, and cultural factors relevant to immediate treatment decisions. Remember that a patient's level of "dangerousness" can be effected by "care and supervision otherwise available".
8. Determine whether the patient is able and willing to form an alliance that will support further assessment and treatment, what precautions are needed if there is a substantial risk of harm to self or others, and whether involuntary treatment is necessary.
9. Develop a specific plan for follow-up, including immediate treatment and disposition; determine whether the patient requires treatment in a hospital or other supervised setting and what follow-up will be required if the patient is not placed in a supervised setting.

**In addition, the following are also indicated for patients who present intoxicated to the emergency department:**

1. Discuss with the referring physician whether or not the patient is capable of providing a coherent history.
2. Discuss with the physician whether or not the patient can provide a reliable and consistent mental status exam, and whether or not the patient's symptoms are more closely related to an urgent medical condition (encephalopathy, BAC > 300, diabetic ketoacidosis, etc). The presence or level of a specific intoxicant should not necessarily preclude a psychiatric consultation.
3. Proceed with the Psychiatric assessment of the patient when deemed appropriate and tailor the assessment to the reason for the consultation.

4. Reassessment of the patient may be necessary as the intoxicant begins to clear. Not infrequently a patient's status with regard to "Dangerousness" may change with clearing of their mental status.

**Emergent psychiatric consultation is not required for the following conditions:**

- 1) Routine consults for depression / anxiety. These can be referred to an outpatient clinic or provider
- 2) Detoxification without suicidality (can be referred to ARCA or Centerpoint)
- 3) Patients who will be admitted to the medical floors, unless there are urgent management decisions involved. Generally psychiatric consultations for patients being admitted to the general hospital should be done by the C/L Service during normal hours.
- 4) Patients who are simply seeking to 'expedite' an outpatient referral should be referred to an outpatient clinic or provider.

There is a psychiatric social worker in the ED who can assist with disposition and can be reached at 713-5747.

**Effectiveness Evaluation:** Effectiveness of the policy will be periodically evaluated by psychiatry and emergency department faculty, as well as periodic review by the Educational Policy Committee.

**References:**

1. Reischel UA, Shih RD. Evaluation and Management of Psychotic Patients in the Emergency Department. *Hospital Physician* 1999 Oct: 29-38.
2. Pizon AF, Becker CE, Bikin D. The clinical significance of variations in ethanol toxicokinetics. *J Med Toxicol.* 2007 Jun;3(2):63-72
3. American Psychiatric Association. Practice Guideline for the Evaluation of Adults, Second Edition.

## COMMUNITY HEALTH SETTINGS IN PSYCHIATRY

### **Directors:**

Dr. Travis Anderson: Area Services and Programs – Statesville

Dr. Liz Arnold: Homeless Opportunities and Treatment Project (see description on following page)

Dr. Thomas Brown: New River Telemedicine - Mt. Airy

Dr. Hal Elliott: Wake Forest University Student Health Center – Winston-Salem

Dr. Rommel Ramos: VA Outpatient Clinic - Winston-Salem

### **Teaching Objectives**

The teaching programs at each community health setting are unique. The following is a generic description of the expected experience.

1. To develop an understanding of the psychiatry problems encountered in a community health setting population
2. To participate in a multidisciplinary treatment team consisting of physicians, social workers, psychologists, and mental health workers
3. To manage chronically ill patients in community or structured placement situations through appropriate pharmacotherapy, judicious outpatient follow-up, and supportive therapy when deemed necessary
4. To cooperate with and direct non-physician therapist in patient management
5. To perform education as to medication therapeutic value, side effects, dosage and problems with patients and their families

### **Resident Responsibilities**

1. Hours at community health settings are one day per week, typically from 9:00 a.m. to 5:00 p.m. excluding travel time.
2. Individual cases generally are assigned to the resident for new patient evaluation and longitudinal follow-up, which involves pharmacotherapy and supportive psychotherapy.
3. New diagnostic evaluations and follow-up cases will be evaluated and presented by the resident and then with the attending psychiatrist.
4. 1/2 hour is allowed for follow-up visits and one hour is allowed for initial diagnostic interviews. There are no exceptions to this time requirement.
5. The attending physician will provide regular supervision for all patients and is available on call for emergency consultation.
6. The resident is responsible for dictation or written notes of a complete diagnostic evaluation, notes and treatment plans as per mental health center policy.

## **Homeless Opportunities and Treatment Project Clinical Rotation**

**Director:** Dr. Liz Arnold, Project Director

### **Teaching Objectives**

1. To improve and practice clinical interviewing, diagnostic, and formulation skills in the context of a community-based outpatient clinical setting with individuals who are homeless
2. To observe and participate in a variety of outpatient treatment modalities, including medication management and individual psychotherapy

### **Resident Responsibilities**

1. Residents will perform initial clinical evaluations of diagnostic cases. The cases will be presented and discussed with the project director or the attending psychiatrist. Evaluations will include information on relevant psychosocial stressors unique to the homeless population.
2. Residents will follow patients for medication management and/or psychotherapy. They will arrange for clinically appropriate referrals for those needing additional services.
3. Residents will provide complete, accurate, and timely documentation of patient contacts and care provided. The project director and/or attending psychiatrist will review all charts for completeness, accuracy, and quality of patient care.
4. Residents will participate in team meetings for the clinic as scheduled during the rotation. Residents will be responsible for presenting their cases to the team and incorporating any feedback into the treatment plan.

## **CHILD & ADOLESCENT PSYCHIATRY ROTATION**

**Director:** Dr. Guy Palmes

**Supervisors:**

Dr. Guy Palmes

Dr. Matt Hough

Dr. Mark Carroll

**Teaching Objectives**

1. To diagnostically evaluate and treat children and adolescents, under supervision of faculty child psychiatrists
2. To observe psychological testing, speech and language evaluations and social work case history taking
3. To participate in a multidisciplinary diagnostic and treatment team and synthesize information from various disciplines
4. To observe preschool children in a classroom situation with and without psychiatric morbidity
5. To attend child guidance seminars

**Resident Responsibilities:**

1. Residents are assigned half time to Child Outpatient Clinic for six months and the Child and Adolescent Inpatient Service for one month.
2. Perform diagnostic evaluation and treatment assigned during the rotation under the supervision of the attending psychiatrists. Written initial evaluations with assessment and treatment plan will be reviewed each week, covering patients with each of the following issues: 1) ADHD 2) Mood Disorders 3) Anxiety Disorders 4) PDD 5) Substance Use Disorders, for the Medical Knowledge core competency. Each disorder discussion should include 2 relevant references to demonstrate the Practice-based Learning and Improvement core competency.
3. Proper documentation of new patient evaluations, discharge summaries and progress notes.
4. Attending assigned seminars and clinics.
5. Performing supervised consultations for children in the pediatric units, and demonstrating appropriate interagency and family facilitation in all clinical venues for the Systems-Based Practice core competency
6. Successfully complete 2 new child evaluation interviews observed by faculty to assess Patient Care and Professionalism core competencies.

## **ADVANCED INPATIENT EXPERIENCE**

**Director:** Dr. Donald Eknoyan: VA Medical Center  
Dr. Stephen Kramer: NCBH Inpatient Unit

### **Teaching Objectives**

1. To gain experience in evaluating and treating chronically ill patients in a public hospital
2. To participate in and lead a multidisciplinary treatment team
3. To participate in forensic evaluation of dangerousness in commitment proceedings and potential testimony in commitment proceedings
4. To gain experience in group leadership in therapy of inpatients, often chronically ill
5. To perform initial evaluation, history, physical exam and laboratory evaluation, and prepare treatment plans for newly admitted patients

### **Resident Responsibilities**

1. The Advanced Inpatient rotation requires that the resident spend at least three nights per week at the hospital. A comfortable apartment is provided for the resident to use during the rotation.
2. The resident is required to be available in the hospital from 8:30 a.m. -5:00 p.m. Monday through Thursday.
3. The resident is required to dictate discharge summaries, maintain current and legible progress notes, and administer treatment of all assigned patients.
4. The resident is to assume active team leadership of a multidisciplinary treatment team.
5. The resident takes call one weekday night every two weeks during the assigned rotation. Backup assistance is available from an assigned attending for emergencies.

## **STICHT CENTER ADULT INPATIENT PSYCHIATRY ROTATION UPPER LEVEL RESIDENTS**

**Director:** Dr. Stephen Kramer

### **Patient Care**

- 1) Primary responsibility for 3-5 more complex patients from one team, including crisis-oriented and brief psychotherapy techniques
- 2) Lead 2 Treatment Team Meetings weekly
- 3) Co-lead Group Therapy sessions when not leading Team Meeting
- 4) On call responsibilities: Recommended 1 weekday every other week
- 5) Maintain reduced psychotherapy (outpatient) caseload and supervision

### **Administration**

- 1) Assist attending faculty in monitoring patient admissions, acuity level, and team distribution, and learning objectives for trainees
- 2) Participate in monthly Inpatient Staff Conference

### **Teaching**

- 1) Supervise PG-1 residents on unit regarding general procedural and clinical issues
- 2) Provide weekly PG-1 case conference to assist PG-1 residents in preparation for their core competency examinations
- 3) Provide interview opportunities and feedback to medical students assigned to the unit
- 4) Participate in daily check-out rounds, including relevant literature reviews and principles of evidence-based patient management

### **Didactic Program**

- 1) Participate in Senior Seminar, Grand Rounds, and other educational requirements of the department

## **ELECTIVE ROTATIONS**

**Director:** Dr. Harold Elliott

**Supervisor:** Resident Choice

The elective rotation is designed by the resident in cooperation with the Director of Residency Training. It should be compatible with the education goals of both the individual resident and the Department.

One month before starting the three-month elective experience, the resident must submit a written proposal that includes a title for the elective, a supervisor, educational objectives, resident responsibilities, and a reading list. The elements of the elective must be acceptable to the supervisor. The elective takes place during the PG-4 year, though on rare occasions it may occur during the PG-3 year.

### **Elective Examples**

- 1- Sleep Medicine
- 2- ECT
- 3- Utilization of Psychiatric Rating Scales
- 4- PTSD
- 5- Forensic Psychiatry
- 6- Emergency Psychiatry
- 7- Inpatient Psychiatry
- 8- Medical Student Teaching
- 9- Geriatric Psychiatry
- 10- Neuropsychiatry: Neuroimaging, Neuropsychological Testing, TBI, Seizure Disorders
- 11- Addiction Psychiatry
- 12- Genetics
- 13- Private Practice Management
- 14- Pain Medicine
- 15- Administrative Psychiatry

## **Selectives for VAMC – Salisbury**

**Director:** Dr. Donald Eknoyan

Welcome to the VAMC-Salisbury and its accompanying satellite clinics (Winston-Salem and Charlotte). The Salisbury VAMC has been a large tertiary referral center for psychiatric care for veterans throughout the state of NC for decades. We are excited about adding Wake Forest psychiatry resident rotations to the hospital, and look forward very much to your arrival.

Below you will find a list of possible rotations from which you may choose to participate for your time in the VAMC. In most cases, you will have a 3-month rotation with us. If you choose to participate in the group process format, we ask that you commit to at least a 3-month rotation block (a 2-month rotation may be possible under some circumstances). It is difficult for patients to have a new therapist that leaves in shorter periods of time. Elective experiences can be combined in a variety of ways to meet your educational and professional development requirements.

### **Core Electives**

#### 1) PTSD

Salisbury: outpatient PTSD clinics providing group therapy and medication management, as well as one of the nation's leading inpatient programs (20 beds).

This unit provides a 45-day intensive program to treat combat-induced PTSD. The program provides medication management, state-of-the-art psychotherapies that include intense process groups, psychodrama, art, and specific therapies. The resident would follow a group of patients from the beginning of their admission until discharge. The resident would participate as a co-leader of groups, evaluate patients in 1:1 therapy, and participate in treatment team conferences. You may select either 60 or 90-day rotations for this experience. If you choose a 60-day rotation, you would finish the rotation with outpatient PTSD clinics after the 45-day program is completed or do screenings for future admissions.

#### 2) Group Psychotherapy

Salisbury: outpatient group therapy for mood disorders, anger management and stress management

#### 3) Addiction Psychiatry

Salisbury: substance abuse residential program. This 35 bed unit functions as a 30-35 day residential program for patients with substance dependence. You will function as co-therapist for the group therapies, serve as a case manager, follow patients from start-to-finish in the program, and address any medication-related issues.

#### 4) Research

Salisbury: brain imaging research. You could do any elective that focuses on the writing of a brain injury case report or brain imaging paper. You will learn how to write an academic paper, submit it to a journal, and follow the process until publication. You will also gain a deeper knowledge of imaging tools in psychiatry and visit the Wake Forest radiology department's vast neuroimaging resources.

In addition to the core electives, you may select from the following clinical opportunities at the Salisbury facility:

##### Outpatient Rotations:

- General mental health medication clinics
- ACT team (assertive community treatment)
- Homeless program
- Brain Injury Clinic (possibly available by late summer or early fall of 2004)
- Primary care psychiatry clinic
- Psychiatric emergency service

##### Inpatient psychiatry:

- Psychiatric Intensive Care Unit
- General inpatient psychiatry (acute)
- Chronic inpatient psychiatry

##### Brief Description of additional rotations and programs:

The Mental Health Clinic provides medication and group therapy for patients with mood, psychotic, or cognitive disorders. Patient may have dual diagnosis or PTSD in some cases. You could design the rotation for the proportion of med check visits vs. group therapy to fill the work week.

Mental Health Intensive Case Management (MHICM) (a.k.a. "ACT" team): The program provides case management, medication management, and social interventions for chronically mentally ill psychiatric patients in their homes. The MHICM team members travel to the patient's homes together as a team and provide services that include evaluation, medications, decanoate injections, etc. You will travel with other team members to evaluate chronically ill patients in their homes.

Homeless Program: This program provides initial visits and screenings for homeless veterans in the community. The team members go to shelters to screen patients. An additional part of the program includes placement into housing services with support to assist in the rehabilitation of the homeless veteran. You will be a full member of the team traveling to the shelters and placements for screening and evaluations.

Brain Injury Clinic: At the time of this printing, this clinic only meets ½-day per week and would need to be combined with another rotation to meet a full work-week schedule. This clinic evaluates and treats patients with psychiatric symptoms following brain injury. The clinic can be tied to the brain imaging research rotation.

Psychiatric Primary Care Clinic: This clinic (staffed by 2 psychologists and 1 psychiatrist) evaluates and treats patients with milder psychiatric illnesses. The goal for this program is to serve as a consultative service to the primary care practitioner in order to maintain treatment in the primary care setting. Clinicians diagnose, treat, and make recommendations for future interventions – both to the patients and to the providers. You will serve as a full treatment team member.

Psychiatric Emergency Service: The emergency room at the Salisbury VAMC provides psychiatric services on a full-time basis. You will evaluate patients in the E.R. setting during regular business hours. This rotation could be combined with another – to complete a full-time work-week.

Psychiatric Intensive Care Unit (PICU): The PICU is an 8-bed intensive care unit for the most acutely ill patients. The unit has a higher level of nursing care than acute psychiatric units and provides rapid stabilization in a safe environment. You will function as a “junior attending” on the unit with supervision.

General Inpatient Acute Psychiatry Units: The Salisbury VAMC has 2 acute inpatient units with a 9-day length of stay. You will function as a “junior attending” with supervision on the inpatient unit of your choice.

Chronic Psychiatry Unit: This 20-bed inpatient unit treats those patients who have had multiple inpatient admissions to the hospital and failed outpatient placement multiple times. Common diagnoses include severe schizophrenia, severe bipolar disorder, chronic delusional disorder, or “organic” conditions that have led to the failures noted above. The goal for this unit is rehabilitation to successful living in a care home or placement outside of the hospital. You will function as a “junior attending” and lead a multidisciplinary team (under supervision).

Salisbury VAMC Campus: located on Brenner Ave. – off Innes Street. The VAMC has resident sleeping quarters/dorms. You are welcome to reserve these rooms, if you want to stay overnight in Salisbury. The contact person is Anita Demitry at 704-638-9000 – ext. 3338. You will have to contact Ms. Demitry as early as possible, if you want to reserve quarters, as they fill to capacity quickly.

## CLINICAL SUPERVISION

Supervision is provided in four basic formats:

- Faculty advisors
- Supervision of psychotherapy
- Supervision of pharmacotherapy
- Direct supervision during clinical rotations

### **Faculty Advisors**

Each resident will be assigned a faculty advisor from the beginning of the residency. This is to be considered a permanent assignment for the duration of residency training, subject to change by mutual agreement and at the discretion of the director of residency training. The role of the faculty advisor is expected to be primarily advisory, supportive, and non-evaluative. The advisor is expected to act primarily as an advocate for the resident as he sees fit with respect to interfacing with the residency program and personnel. Should the advisor feel that any material brought up in the context of the relation would seriously affect the performance of the resident, such as drug abuse, this material should be discussed (hopefully jointly) with the director of residency training. The relationship is not confidential in the same sense as the therapeutic relationship. Frequency of contact is at the mutual discretion of the advisor and resident but expected to be more frequent during the initial months of residency and diminish as confidence grows. Certainly, extra time may be required during stressful periods for the resident.

The faculty advisor system is designed to provide support for the resident, particularly early in residency and during periods of stress, advise the resident in terms of his present learning role as resident and future roles within psychiatry, mediate and, if necessary, advocate in conflicts with teaching hierarchy, and facilitate the learning process with advice as to extra learning materials.

### **Supervision of Psychotherapy**

Residents are assigned two supervisors of psychotherapy beginning with the second year of training. Residents must demonstrate core competency in a variety of psychotherapies, including dynamic, supportive, brief, cognitive-behavioral, and combined psychotherapy-psychopharmacology. Supervision with individual supervisors is expected to be 1 hour weekly with a minimum term of three months. Some cancellation is inevitable on the part of both the supervisor and resident but excessive cancellation of supervision on the part of the resident will be subject to disciplinary action. Occasional use of audio and video tapes or one-way window interviews during supervision is encouraged. Supervision should center on techniques of psychotherapy and suggestions for supplementary readings on the presented cases. Two hours of weekly supervision will continue through the fourth year of training. Supervision and movement towards demonstrating core competency will be documented through regular evaluations submitted by the supervisor. Residents must complete a minimum of 300 hours of psychotherapy under supervision to graduate.

As of July 1, 2010, E\*Value was implemented to track psychotherapy supervision hours. Residents will log the date of supervision, the supervisor's name and the patient's medical record number. Logs will be ran from E\*Value after the end of the semester and discussed with the resident as needed.

## **Direct Supervision During Clinical Rotations**

Each clinical rotation will provide direct supervision within the specialty area that it serves. All clinic cases will be supervised by an attending physician who will discuss medication management with the resident and any other pertinent teaching options. The attending will also meet with the patient. Supervision of the resident also includes observation of resident performance, feedback as to performance and observation and participation in different techniques of patient management.

## **MUTUAL EVALUATION OF RESIDENT PERFORMANCE AND TEACHING QUALITY**

### **Evaluation**

Feedback on resident performance should be both on a daily basis and at the end of each clinical rotation. Supervisors will write formal evaluations on E-Value at the end of each rotation to include constructive criticism feedback. Residents are expected to review all evaluations on E-Value. In addition to supervisor/faculty evaluations, 360 evaluations will be compiled. The 360 evaluations will occur twice yearly and residents will receive feedback from medical students, nursing supervisors, social workers, and psychologists. This will mainly occur while the resident is completing their requirements on the inpatient unit.

Residents are given the opportunity to evaluate, in writing through E-Value, all rotations, services, educational experiences and faculty. Written comments are summarized in an anonymous fashion prior to feedback to specific faculty to maintain individual resident confidentiality. Feedback is also solicited during resident semiannual reviews. In addition, the residents will complete an overall evaluation of the program annually.

### **Director of Resident Education Semiannual Review**

At the end of each semester, the resident's overall performance based off of written and oral evaluations will be compiled and discussed during a personal meeting with the Residency Program Director. Suggestions for improved performance, areas for more intensive study, and remedial work are integral to this discussion. It is expected that positive feedback for achievement is a part of this process.

### **Educational Policy Committee (EPC)**

At the end of each academic year, each resident's performance will be reviewed by the Educational Policy Committee. The results of the committee evaluation along with a written summary will be provided to the Training Director. Any recommendations, such as dismissal or requirement for remedial or additional training are prepared as reports forwarded for action by the Department Chairman, who is responsible for formal action. It is expected that positive feedback for achievement is a part of this process.

### **Psychiatry Resident In-Training Examination (PRITE)**

All residents will take the annual PRITE, which takes place on the first two Fridays in October. Each resident receives direct feedback on his or her performance. Cumulative data is given to the training director.

### **Mock-Boards (Clinical Competency Examination)**

Mock-board examinations, during which a resident evaluates and presents a patient while observed by two faculty members, will be given during the third and fourth years of the residency program. Faculty will question the resident about the diagnosis, etiology, and treatment of the patient. This should parallel the oral Board experience and enable the resident to reduce the anxiety produced by novelty in taking oral exams.

## **Core Competency Evaluation**

Two core competency evaluations are designed to evaluate first year residents' progress during their inpatient rotation. Faculty will question the resident about the diagnosis, etiology, and treatment of an observed patient interview. The attending will complete an evaluation form and submit it to the Residency Training Director. In addition, each first-year resident submits 6 completed and signed discharge summaries for review.

**SECTION THREE:**  
**SEMINARS AND CONFERENCES**

## **GENERAL TEACHING OBJECTIVES OF PSYCHIATRY DEPARTMENT SEMINARS & CONFERENCES**

### **A. Knowledge Objectives**

1. Thorough knowledge of medical disorders having psychiatric presentations and psychiatric disorders presenting as medical problems.
2. Knowledge of clinical and laboratory diagnostic techniques for diagnosis of common medical and surgical problems.
3. Thorough knowledge of the currently applicable (DSM-IV-TR) diagnostic system, clinical criteria, and the system of multi-axial diagnosis. Knowledge of the presumed etiology, prevalence, differential diagnosis and treatment of these conditions.
4. Awareness of the major theoretical systems in psychiatry, their theories of disease causation and treatment techniques.
5. Knowledge of the interaction of biological, psychological, sociocultural, and familial factors on development from infancy to late adulthood, with particular reference to disease production.
6. Knowledge of the diagnosis and treatment of common neurologic disorders.
7. Critical appreciation and knowledge of commonly used psychological assessment techniques, their utility and limitations.
8. Familiarity with the existing systems of financing and regulating psychiatric practice, public policy that influences psychiatric care and current problems in these areas.
9. Familiarity with the ethics underlying psychiatric practice, their rationale, and their application to common clinical situations.
10. Appreciation of the history of psychiatry in the broader context of the evolution of modern medicine.
11. Familiarity with common legal procedures related to psychiatry, such as commitment, competency, liability, and determination of criminal responsibility.
12. Familiarity with self-limitation necessitating the process of referral for psychiatric or medical intervention.
13. Knowledge of research methods and experimental design in psychiatry and the behavioral sciences sufficient to critically read new literature, including critical knowledge of the commonly read psychiatric journals and an appreciation of their relative accuracy.

## **B. Skills**

1. Ability to evaluate and diagnose psychiatric and neurological disorders through the clinical interview, history taking, mental status examination, and the physical and neurological exam, including the knowledgeable application of DSM-IV- TR diagnostic criteria. This proficiency should exist for all age groups of patients, including children.
2. Ability to deal effectively with difficult patients who may be frightened, angry, seductive, or provocative.
3. Ability to synthesize biological, psychological, and social factors derived from the clinical examination and other data into an acceptable formulation, differential diagnosis and treatment plan.
4. Demonstrate clinical competence in providing major therapies, including short- and long term individual psychotherapy, psychodynamic and cognitive-behavioral psychotherapies, family therapy, group therapy, crisis intervention, pharmacotherapy, ECT, and drug and alcohol detoxification.
5. Capacity to provide ongoing care for a variety of patients of all age groups through a variety of treatment modalities, including the chronically mentally ill.
6. Ability to perform adequate psychiatric consultation in the medical-surgical setting and effective communication of findings to medical peers.
7. Demonstration of competence in psychiatric administration, especially the experience of managing an interdisciplinary treatment team.
8. The ability to apply in a selective manner commonly available psychological testing, including clinical assessment scales in the diagnosis and treatment of psychiatric and neurological disorders.
9. Ability to critically read the professional and scientific literature.
10. Ability to teach basic psychiatry to students in the health professions.

## **C. Attitudes**

1. Intensive development of a sense of responsibility for the optimal care of patients.
2. Develop an awareness of self-limitation and the ability to get help for difficult cases by appropriate referral.
3. Development of a desire for continued self-instruction in the fields of medicine, neurology, and psychiatry.
4. Develop an awareness of how the physicians' attitudes may influence patient response in the treatment situation.

## SEMINARS

Interns are required to attend a weekly PG-I Seminar that covers a variety of topics on general psychiatry. In addition, participation is expected for the Psychopharmacology Seminar. Interns rotating on the inpatient service will also attend a weekly ECT Conference. Other learning/teaching functions include Grand Rounds, Journal Club, Morbidity and Mortality Conference, Advanced Test-Taking Skills Seminar, Ethics and Professionalism Seminar, forensic seminar and rotation-specific conferences. The first-year seminars are designed to provide a basic background of general psychiatry for the starting resident, expose the residents to senior faculty in areas of their expertise, and build a foundation for later didactic material.

Second- and third-year seminars are intermediate in difficulty with attention to supplementary reference reading. There are two areas of learning running continuously over the course of two years: 1) the Psychotherapy Case Conference and the Psychotherapy Didactic include an introduction to psychoanalytic theory and individual psychotherapy, cognitive-behavioral therapies, group psychotherapy, marital and family therapy and a practicum in writing case formulations, and 2) the Biological Psychiatry Seminar includes modules in genetic and biological factors in psychiatric disorders, research methods and design, substance abuse, neuropsychiatry, and cognitive neuroscience. These seminars run concurrently on a weekly basis and are required of all second- and third-year residents.

Residents participating in the geriatric outpatient clinic rotation attend an additional monthly seminar covering the differential diagnosis of dementia, geriatric psychopharmacology, depression, aging and psychometrics.

A course on Ethics and Professionalism will alternate with the Advanced Test-Taking Skills Seminar and the Morbidity and Mortality Conference. The Psychopharmacology Seminar is based on the model curriculum of the American Society of Clinical Psychopharmacology and will run throughout the year.

**Attendance:** Attendance at these seminars is taken regularly via hard copy sign in or barcode scanner. 100 percent attendance is expected and at least 70% attendance record is required for each seminar assigned to year in training. It is the responsibility of the resident to ensure attendance is appropriately logged in order to ensure proper credit is given. PG-4 residents cover the emergency room in the mornings so that residents have protected time for seminars. PG-1 residents are to be excused from inpatient rounds so that they can attend their required seminars.

The Psychotherapy Case Conference and Psychotherapy Didactic will be facilitated and supervised by senior faculty members. Cases will be discussed from a variety of theoretical frameworks in order to give the resident a different perspective on approaching therapeutic problems.

## **PSYCHIATRY SEMINARS AND RESIDENT ACTIVITIES**

Psychotherapy Case Conference (PG 2-3)

Psychotherapy Didactic (PG 2)

Psychotherapy Patient Supervision (PG-3)

Biological Seminar (PG 2-3)

PG-1 Seminar (PG-1)

Psychopharmacology Seminar (PG 1-2)

Forensic Psychiatry Seminar (All residents)

Psychiatry Grand Rounds (All residents)

Psychiatry Journal Club (All residents)

Ethics and Professionalism Seminar (All residents)

Advanced Test-Taking Skills Seminar (All residents)

Morbidity and Mortality Conference (All residents)

Resident Meeting (All residents)

Miscellaneous/Guest Lectures (All residents)

**FIRST YEAR RESIDENT SEMINAR IN  
GENERAL PSYCHIATRY (PG-1 SEMINAR)**

**Topics Covered:**

The Psychiatric Interview  
Suicidality  
Telephone Hot Line Crisis Intervention  
Mental Status Examination  
Library Orientation  
Assessment of Cognitive Dysfunction  
Family Assessments  
Involuntary Civil Commitment  
Child/Adolescent Emergency Psychiatry  
Sleep and Fatigue Management  
Crisis Intervention  
Informed Consent/Forced Medications  
Psychiatric Assessment of Child Patients  
Psychiatric Assessment of Adult Patients  
Texts and Journals  
Substance Abuse Treatment  
Evidence-based Medicine  
The Aggressive and Violent Patient  
Your Role as a Teacher  
Religion and Psychiatry  
Geropsychiatry  
Sexual Disorders  
The Family Evaluation  
Dissociative Disorders  
Neuropsychological Testing  
Impulse Control Disorders  
Personality Disorders I & II  
Anxiety Disorders –Pharmacological Treatments  
Anxiety Disorders –Nonpharmacological Treatments  
Eating Disorders  
Introduction to Cognitive Behavior Psychotherapy  
Cultural Competence in Psychiatry  
Introduction to Community Psychiatry  
Factitious Disorders/Malingering  
Mourning and Bereavement  
Amytal Interview  
Introduction to Interpersonal Psychotherapy  
Sleep Disorders  
Ethics and Clinical Practice  
Case Conference (each intern will present a case for discussion)

**SECOND-THIRD YEAR RESIDENT SEMINAR IN  
BIOLOGICAL PSYCHIATRY**

**Topics Covered:**

**Research Methods and Design**

Neuropsychological Testing Methods  
Methodology in Psychiatric Research  
Clinical Rating Scales I-II  
Accessing the Literature  
Experimental Design  
Epidemiology  
Evaluating the Literature  
New Drug Development  
Research Ethics and Protection of Human Subjects  
Statistical Overview I-II-III  
Placebos  
Evidence Based Medicine in Psychiatry I-II

**APA Practice Guidelines**

Panic Disorder  
Bipolar Disorder  
Dementia  
Schizophrenia  
Major Depressive Disorder  
Eating Disorders

**Selected Topics in Clinical Neurophysiology**

EEG  
Primary Sleep Disorders/ Sleep Physiology  
Epilepsy  
Chronobiology  
Kindling, Sensitization, and Transduction

**Forensic Psychiatry**

Introduction to Forensic Psychiatry  
Medical Malpractice  
Medication During Pregnancy  
Forensic Neuropsychiatry  
ICC and the Right to Treatment/Refuse Treatment

**Neurogenetics**

Psychiatry Disorders  
Principles of Molecular Genetics  
Molecular Receptor Pharmacology  
Neurotransmitters and Gene Activation  
Neurochemical Individuality

## **Clinical Neuropsychiatry: Traumatic Brain Injury**

Definitions and Phenomenology  
Neuroimaging  
Post-concussive Disorder  
Pharmacotherapy  
Cognitive Testing and Rehabilitation

### **Selected Topics in Neurobiology**

Psychobiological Foundations of Clinical Psychiatry  
General Systems Theory  
Ecological Biological and Darwinian Medicine  
Topobiology and Neural Darwinism  
Prospects for Psychiatry and Neurology  
Introduction to Psychosomatic Medicine  
Introduction to Cognitive Neuroscience  
Brain Development  
Attention  
Disorders of Attention  
Autistic Savantism  
Hemispheric Specialization  
Hemispheric Disconnection  
Emotion  
Selected Disorders of Emotion  
Language  
Developmental Language Disorders  
Memory  
Amnesic Disorders  
Consciousness  
Neural Networks

### **Neuroimaging**

Neuroanatomy Review  
Introduction to Clinical Imaging  
Imaging of Poisons and Toxins  
Review of Circuits and 3-D Model  
Functional Imaging

### **Pain Disorders and their Management**

Pain: A Revised Perspective  
Neuroanatomic Substrates of Pain  
Neurophysiologic Substrates of Pain  
Selected Pain Syndromes  
Pain Management: Analgesics  
Opiate Treatment Pitfalls  
Interventional Procedures for Chronic Pain  
The Pain Patient Profile  
Adjunctive Therapies

**SECOND-THIRD YEAR RESIDENCY SEMINARS IN  
PSYCHOTHERAPY: PSYCHOTHERAPY CASE CONFERENCE, PSYCHOTHERAPY  
PATIENT SUPERVISION AND PSYCHOTHERAPY DIDACTIC**

**Topics Covered:**

**GENERAL TOPICS**

Introduction to Psychotherapy I-II  
Learning Psychotherapy  
Verbal Response Modes and Interaction I-III  
Freud's Technical Papers  
Working Alliance  
Threats to the Working Alliance  
Inducing Patterns I-III  
Change I-II  
Resistance  
Transference and Countertransference I-III

**MARITAL AND FAMILY THERAPY**

Conceptual Framework: Family Systems Theory  
Brief Strategic Family Therapy  
Structural Family Therapy I-III  
Emotion-focused Therapy for Couples I-IV  
Genograms

**GROUP THERAPY**

The History of Group Therapy  
Large Group Dynamics  
Small Group Dynamics I-II  
Leaders and Co-leaders  
Patient Selection  
Therapy Groups: Process  
Time-limited Group Therapies  
Charismatic Groups and Cults  
Administrative groups

**BRIEF THERAPIES**

Introduction I-III  
Demonstration Case  
Adult Development: Gender, Culture, and Life Phases

**SPECIFIC THERAPIES**

Dynamic Psychotherapy-Supportive Therapies  
Dynamic Therapy Cases and Formulations  
Behavioral Therapies  
Cognitive Behavioral Therapy  
Rational Emotive Therapy  
Dialectical Behavior Therapy  
Cognitive Behavioral Therapy Cases and Formulations  
Culture in the Formulation  
Cultural Competence in Psychotherapy

Combined Psychotherapy and Psychopharmacology  
Combined Therapies Cases and Formulations  
Multimodal and Transtheoretical Therapy  
Asian and Eastern Therapies  
Current Issues in Psychotherapy Practice

## **Advanced Test-Taking Skills Seminar**

The board review seminar series will meet every two weeks. Residents will present a selected topic, and lead a discussion. The residents attending will review board style questions in order to prepare for PRITE exam and written board exam.

## **Ethics and Professionalism Seminar**

The ethics and professionalism seminar series will meet each month. The seminar series will review selected topics using the Ethics Primer of the American Psychiatric Association and the Professionalism and Ethics for Mental Health Professionalism Question and Answer Self-Study Guide.

## **Morbidity and Mortality Conference**

The morbidity and mortality conference will meet each month. In each conference, a resident will work with a fellow resident to present a complicated or interesting case to his or her fellow residents and faculty members. They will lead a discussion regarding positive or negative outcome, and any recommendations regarding treatment decisions and/or any medical/legal issues involved in the case. This conference should be a vehicle to improve the quality of care of patients and should function as a learning tool for both residents and faculty.

## **PSYCHOPHARMACOLOGY SEMINAR**

### **Topics Covered:**

Pharmacokinetics of Psychotropic Drugs  
Pharmacodynamics of Antipsychotic Drugs  
Maintenance Treatment of Schizophrenia  
Pharmacotherapy of Violence  
Management of Antidepressants and Lithium Side Effects  
Bipolar Disorders-Therapeutic Opportunities  
Bipolar Depression  
Recognition and Treatment in OCD  
Sleep Disorders  
ECT  
Social Anxiety Disorder/Social Phobia  
Antidepressants: Basics  
Post-Traumatic Stress Disorder  
Traumatic Brain Injury  
Treatment of Aggression in the Elderly  
Recognition and Treatment of Panic Disorders  
Psychopharmacology in the Emergency Room  
Efficacy and Side Effects of Antipsychotics  
Introduction to Child and Adolescent Psychopharmacology, ADHD, Tourette Syndrome,  
and Conduct Disorder  
Child and Adolescent Depression  
Treatment Resistant Depression  
Eating Disorders  
Atypical Depression  
Combining Pharmacotherapy and Psychotherapy  
Pediatric Psychopharmacology  
Dementia  
Psychosis and Agitation in Dementia  
Depression in the Elderly  
Personality Disorders  
Body Dysmorphic Disorder  
Mood Disorders in Women of Childbearing Age  
Psychopharmacology in the Primary Care Setting  
Psychopharmacologic Treatment of Sexual Dysfunction  
Generalized Anxiety Disorder  
Childhood OCD  
Pervasive Developmental Disorders  
Psychopharmacology and the HIV patient  
Child and Adolescent Anxiety Disorders

**SECTION FOUR:**  
**PATIENT CARE**

## MEDICAL RECORDS REQUIREMENTS

Medical records are critical for the proper documentation of the provision of medical care. They provide a communications medium for different staff working with the same patient. It is increasingly important as a means of validating patient treatment and progress, since patient records are used to determine allowed hospital stays and justification for admission. Residents play a central role in record keeping for patient care. Your records will be inspected by attendings, and you will receive feedback as to their adequacy. The following are helpful guides:

### A. Admission Note

When a new patient is admitted, the resident on duty (either on call or assigned) performs a psychiatric history (utilizing information from family members and other collateral sources, whenever possible), a medical history and a physical examination. For adult and child/adolescent inpatients, this information is recorded on the respective **Psychiatry Inpatient Service Initial Psychiatric Evaluation** form.

### B. Progress Notes

Daily progress notes should be maintained for each patient. These are done electronically in CareCast. Notes should reflect changes in patient condition (psychiatric or physical), achievement of treatment plan goals, results of testing, laboratory results, consults, changes in treatment, and any new information gained regarding the patient.

Progress notes should be in the standard SOAP format:

S: Subjective information

O: Objective information (behavioral observations, physical findings, mental status examination, laboratory and testing data and current medications)

A: Assessment (differential diagnosis, formulations)

P: Plans

### C. Discharge Summary

**Discharge summaries should be dictated on the day of discharge and in no event later than 24 hours after discharge.** In order to dictate you must dial 6-1777, you will be given prompts. Once the dictation is transcribed, you need to review and edit the discharge summary on Noteslink. You must sign off on each summary on Noteslink and send it electronically via Noteslink to the supervising attending, who will then review it and make any necessary changes. Finally, the attending will sign off on the discharge summary.

## GUIDELINES FOR WRITING PSYCHIATRY NOTES

### All notes should include the following elements:

1. Identification of the procedure being performed.  
*Examples:*
  - i. Psychiatric diagnostic interview
  - ii. Admission note
  - iii. Progress note
  - iv. Psychotherapy note
2. Identification of the supervising attending physician.  
*Example:* Patient's case was discussed with Dr. David, Psychiatry attending.
3. **DO NOT** copy and paste whole notes. This is considered fraud.
4. **DO NOT** copy and paste Mental Status Exams. This is the same as copying a physical exam from a previous note and is also considered fraud.
5. Abnormal lab tests and/or imaging studies should be discussed and a follow-up plan should be outlined.
6. Consult responses should be acknowledged.

### All psychotherapy notes should include the following specific elements:

1. A statement about the specific psychotherapy procedure performed, and whether it included medication management or not.  
*Example:* Patient was seen for supportive psychotherapy (or insight-oriented, or cognitive-behavioral, etc) and medication management. This is due to the fact that an event encounter will be generated by the attending and/or clinic staff that will document the specific procedure performed for coding, workload and billing purposes.
2. A statement about the time spent with the patient. In general, there are two types of psychotherapy intervention used - the shorter one used for supportive therapy with/without medication management (20-30 minutes) and the longer one used for insight-oriented or at times cognitive therapy (45-50 minutes). This is also pertinent to the procedure code.  
*Example of an opening statement:* Patient was seen for 30 minutes, for supportive psychotherapy and medication management.
3. A short Mental Status Exam (MSE). This is required for clinical and billing purposes and should at least include elements of: alertness, orientation, speech pattern, affect, mood, thought process, perception, suicidal/homicidal ideations, insight and judgment.
4. A statement about medication tolerance, side-effects and medication changes.

5. A statement about patient education in regard to their medications and their understanding of their medications.
6. An impression as to their progress in therapy and their current psychiatric diagnoses/status.
7. A follow-up plan, including lab tests, medication changes, individual and group therapy attendance, and medical referrals, as needed.

**DISCHARGE SUMMARY FORMAT  
FOR ADULT PSYCHIATRIC INPATIENT UNIT**

Resident's name  
Patient's name (spelled)  
Unit number  
Location (Adult or Child Inpatient Psychiatry Unit)  
Attending's name  
Admission date  
Discharge date  
Dictation date  
Referral source/address  
Chief complaint  
Reason for admission (HPI)  
Current medications  
Past psychiatric history  
    Age of onset; age first seen by mental health professional; hospitalizations; medications prescribed with results and side effects, suicide attempts, other dangerous or violent behaviors  
Past medical history  
    Allergies  
Family history  
    Psychiatric and medical  
Past personal and social history  
Substance abuse history  
Review of systems  
Physical exam  
Mental status exam  
Neuromotor exam  
Mini-Mental State Exam  
Rating scales (initial and serial updates)  
Admission Laboratory data/Radiologic studies  
Admitting diagnoses: Axis I-V  
Procedures (ECT, lumbar puncture, amytal interview, etc.)  
Hospital course  
    Problem 1 → n with lab results  
Discharge diagnoses : Axis I-V  
Discharge medications  
Disposition  
Discharge instructions  
    Diet, Activity level  
Follow-up appointments  
Resident's name (spell)  
Attending's name  
cc (who should receive copies for continuity of care)

## ADMISSION PROCEDURES FOR PSYCHIATRY PATIENTS

### WFUBMC: NO SMOKING POLICY

On July 1, 2007, in order to comply with the standards of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), WFUBMC became a smoke-free facility. All patients should be informed about this policy prior to admission. While on the unit, the patient may have the option of nicotine gum, transdermal patches or an inhaler.

### VOLUNTARY ADMISSION

Patients are typically admitted to the WFUBMC psychiatry inpatient unit on a voluntary basis. Prior to admission each patient must sign a **Request for Voluntary Admission** form. This form should be thoroughly explained to the patient and he or she should be given the opportunity to ask questions about the meaning and content of the form. This includes the right of the hospital to detain the patient for up to 72 hours (or 3 working days) if, and only if, the patient's physician feels there is a reasonable probability that commitment will be instituted should the patient request early discharge. The hospital is potentially legally liable if the patient has not signed the request form. Therefore, it is very important to ensure that all patients admitted voluntarily sign this form prior to being brought to the unit.

### INVOLUNTARY COMMITMENT PROCEDURES

- I. Two criteria must be met to hospitalize a patient against his or her will:
  - A. Patient must be mentally ill, mentally retarded or a substance abuser **and**
  - B. Patient must be dangerous to self or others. Dangerousness to self encompasses anything from suicidal ideation/behavior to significant neglect of self-care resulting in deterioration of daily functioning.
- II. Legal Paper Work
  - A. If a patient is seen in the ED for an evaluation, and the patient needs to be involuntarily committed, the resident will fill out the (1) **Examination and Recommendation to Determine Necessity for Involuntary Commitment** and (2) **Certificate**. Both forms need to be notarized by security (6- 3305). This same procedure applies to patient's that need to be transferred to other facilities.

*Note: there is a case manager available to psychiatry residents 24 hours per day. He/she can be reached by pager 806-6013 to assist the resident with patient transfers.*

- B. **EMTALA: Emergency Medical Treatment and Active Labor Act form**  
This form **must** be completed for any patient to be transferred out of our ED to any other facility (e.g. Forsyth Memorial Hospital, John Umstead Hospital, etc.). Failure to properly complete this form is a violation of federal EMTALA legislation.

### III. Commitment of Minors

- A. Minors (under age 18) are treated as if they are incompetent to consent to admission and treatment. That is, the terms “voluntary” and “involuntary” apply to the willingness of the parent/guardian and not the minor.

If the parent or guardian agrees to hospitalization, regardless of the patient’s wishes, they will need to sign the **Request for Admission on the Child-Adolescent Psychiatric Inpatient Service**. Also, the form called the **Evaluation for Admission/Continued Stay-Voluntary Minors and Incompetent Adults** will need to be filled out by the resident.

- B. If the parent or guardian refuses to cooperate or is unavailable, and you deem it necessary to hospitalize the minor, you will follow the standard involuntary commitment procedures.

### IV. Some Pointers

- A. Avoid abbreviations and use simple and non-technical language when completing forms. Remember that non-medical personnel are reading and basing their decisions on your information.
- B. Always send copies of ER and consult sheets, along with any laboratory/x-ray results with the patient when he or she is going elsewhere. This will, of course, enable the receiving facility to treat more effectively. If the patient has any physical conditions, make sure you note these on the chart or else the receiving facility may return the patient to you. If the patient has required sedation or received other medication in the ER, make sure it is made clear to the receiving facility or else they may be misled into dismissing the petition based on the temporary cooperativeness of the patient.
- C. Remember that commitment is a legal process. Care should be taken to fill out all the forms correctly and completely. Be sure to thoroughly discuss all cases in which there is a question of dangerousness with your attending prior to making a decision on disposition, as these cases pose the highest medico-legal liability.

## **MEDICAL-LEGAL INFORMATION**

### **MALPRACTICE COVERAGE**

The Medical Center, its residents, and faculty are amply covered on a group policy. This policy provides “occurrence” (or “tail”) coverage for any suit which might be brought to court after you leave the program. Malpractice coverage covers you for all rotations on site and away from the Medical Center. However, it **does not** provide coverage for extra-residency practice (i.e. moonlighting). You must provide your own coverage if it is not offered by your second employer.

### **PROVISION OF PATIENT INFORMATION TO ATTORNEYS**

If a house officer receives a request from an attorney for information on a patient, the following steps should be taken:

1. The request must be in writing and be from the patient or accompanied by a written authorization from the patient.
2. The attending physician and residency director should be notified immediately of the request and be consulted.
3. Any answer to the request must be discussed and approved by the attending physician.
4. Upon receipt of the written request and authorization for release signed by the patient, only the medical record should be furnished. This should be done by the medical records department.
5. If the request goes beyond the written medical record, any questions should be answered in writing to avoid misunderstanding.
6. Contact attendings and the Residency Training Director regarding subpoenas for records, depositions, and court appearances.

### **RISK AND INSURANCE MANAGEMENT**

Residents will have times when they are contacted by Risk Management staff in regard to potential medico-legal problems, e.g. patient falls, escapes, etc. Remember that they are here to protect the resident, the attending and the hospital. Should any medico-legal issue arise, you should not hesitate to contact Risk Management.

**SECTION FIVE:**  
**MISCELLANEOUS**

**FACULTY ADVISOR PROGRAM**  
**(Updated 7/11/07)**

**DESCRIPTION:**

Each resident will be assigned a faculty advisor from the beginning of the residency. This is to be considered a permanent assignment for the duration of residency training, subject to change by mutual agreement and at the discretion of the director of residency training. The role of the faculty advisor is expected to be primarily advisory, supportive, and non-evaluative. The advisor is expected to act primarily as advocate for the resident as he sees fit with respect to interfacing with residency programs and personnel. Should the advisor feel that any material brought up in the context of the relation would seriously affect the performance of the resident, such as drug abuse, this material should be discussed (hopefully jointly) with the director of residency training. The relationship is not confidential in the same sense as the therapeutic relationship. Frequency of contact is at the discretion of the advisor, but is expected to be more frequent during the initial months of residency and diminish as confidence grows. Certainly, extra time may be required during stressful periods for the resident.

**OBJECTIVES:**

To provide support for the resident, particularly early in residency and during periods of stress. To advise the resident in terms of his present learning role as resident and future roles within psychiatry. To mediate and, if necessary, advocate in conflicts with the teaching hierarchy. To facilitate the learning process with advice as to extra learning materials.

**IMPLEMENTATION:**

Faculty advisors will be assigned each year. Assignments will be made by the director of residency education. Changes may be requested either by the advisor or resident and should be presented to the director of residency education.

The program faculty advisor will be evaluated via the resident survey every year.

## **RESIDENT MENTORSHIP PROGRAM**

Beginning with this new academic year, the Educational Policy Committee has instilled a Resident Mentorship Program for residents/interns entering their first year in the Psychiatry Residency Program. Each new resident/intern is assigned a resident mentor with an upper classman on their first day in the program.

The responsibilities for both the resident mentor and new resident/intern are:

- Establish E\*Value prompt
- The resident mentor will check in with the new resident/intern weekly for the 1st month and then monthly for the next 3 months.
- Faculty advisor will meet with the new resident/intern within the first two weeks with the program, and again at 6-8 weeks. (*Please see Faculty Advisor Memo for assigned Faculty Advisor*)
- Assigned PGY-2 will shadow the new resident/intern for their first 2 calls.

The objective of the mentorship program is to provide support from upper classman for the new resident/intern during their first year in Psychiatry residency. To help ease the transition into residency and become familiarize with the internal structures, policies, guidelines and technology the new resident/intern will become acquainted with. The mentorship program will compliment the learning process of the new resident/intern as well as provide critical support and teamwork from fellow peers.

## **Night Call and Beeper Coverage (Refer to Section Six: On-Call Coverage):**

Monday through Thursday night call begins at 5 pm and runs until 8:00 am. Night call on Fridays and on days preceding hospital holidays begins at 4 p.m. Weekend call is typically 8:00am to 8:00 am; however some attendings may wish to round earlier than 8:00 and the resident on call that day is obligated to attend.

The amount of call for each class is dependent on the number of residents available to take call. Currently, interns take all weekend and holiday call, in addition to some weeknight call which equals to approximately 4-5 days per month. PG-2 residents have taken four calls per quarter but can take 2-3 calls per month if there is a need for coverage. PG-3 residents have taken two calls per quarter but can take one call per month if needed. PG-4 residents generally do not take primary call unless there is an emergency. PG-4 residents are assigned to cover emergency room consults on Friday mornings in order for the second and third year residents to have protected time for seminars.

Residents on call are responsible for coverage of the Emergency Department, psychiatry floors, general floor consult requests and phone calls. **All admissions and discharges to and from the ED, any hospital consults, and any significant occurrences on the psychiatry floors are to be staffed with the attending on call.** If the attending cannot be contacted in a timely manner, the resident on call should contact the residency training director for advice and direction.

### **On-Call Coordination/Continuity of Care:**

#### **I. At the beginning of the shift, the on call resident will contact:**

- the hospital operator to verify the correct information is in the system.
- the attending and back-up resident to verify they are on call and verify how they want to be contacted.
- the inpatient admissions coordinator to verify bed status and any issues such as potential or pending admissions.
- the C/L service secretary prior to 4:30pm on the night of call and get the name of the resident covering the Emergency Department starting at 8am the following morning. If a call comes in at 8am for a patient to be seen in the ED and you have been working 24 consecutive hours, you will have to page the psychiatry resident assigned to the ED at 8:00am to avoid duty hour violations.
- at the change of shift, inpatient residents should contact the on-call resident if there are pressing issues or concerns on the inpatient unit.

#### **II. Coordination of care:**

- all consult notes (ED and inpatient) are to be turned in to the C/L service secretary at the end of each shift (before leaving for the day). The consult resident will turn in the consult notes in the afternoon and the on call resident will turn them in the following morning.
- if any department clinicians' patients are seen, that clinician should receive a copy of the consult note in their box.

#### **III. Weekend call:**

- **inpatient residents** (adult and child) will leave brief summaries in the attending weekend note file for each patient on the inpatient service. Notes should include labs to check, medical issues to monitor, behavior to monitor and recommendations for managing them.
- **consult residents** will leave for the Friday on call resident a list of consults seen during the week and any pressing issues or possible complications with patients still in the hospital or likely to come back to the ED.
- the **on-call residents** will pass the consult list to the next resident on call. They will check out to each other concerning any pressing issues with inpatients, consults, and/or ED patients.
- the **Sunday on call resident** will leave a summary of issues addressed or problems with the inpatients in the attending folder. The resident will leave a summary of issues with **consults seen, any consults called in but not seen, and ED/inpatient notes** with the C/L service secretary on Monday morning **before leaving**.

#### **Back-Up Call:**

A backup call system was instituted on April 1, 2003. Like the call schedule, backup call is assigned by the chief resident. For the academic year 2010-2011, PG-4 take one weekday backup call per quarter, PG-3 take two weekday backups and one weekend per quarter, PG-2 take four weekday and two weekend back-ups per quarter. PG-1 took the remainder back-up calls. The amount of back-up call is

not fixed per class and is up to the chief resident and training director to allocate back-up calls per class as needed.

The primary resident will call in the back up resident after there are 3 or more patients FOR FIRST AND SECOND YEAR RESIDENTS, AND 4 OR MORE PATIENTS FOR THIRD AND FOURTH YEAR RESIDENTS that have not been evaluated yet. This includes ED consults, floor consults, and direct admissions to the inpatient units. The transfer coordinator in the ED will assist the resident to ensure timely response to patient needs.

The primary on-call resident is encouraged to call in the backup resident if fatigue begins to jeopardize patient care. The backup should also be called if the workload becomes heavy, preventing timely response to patient needs. Residents on 1<sup>st</sup> and back-up call may take call from their homes, provided they can be physically present at the scene of emergency calls within 30 minutes.

***Emergency Call - In the event the primary on-call person is unable to take call due to serious illness, accident, bereavement, or other unforeseen circumstances, then the back-up person is obligated to take primary call. If this occurs, then the new back-up resident will be chosen from a master list of residents, beginning with the PGY-4 class and working down by class year. Although PGY-4 residents do not have to sign up for back-up call, they must be on the emergency back-up list. Once the PGY-4 resident has been called in for emergency back-up, their name will be removed from the list for the remainder of the year. PGY-4s can volunteer to sign up for one back up date of their choosing at any time during the year and be removed from the emergency back-up list.***

***If a resident refuses to come in for an emergency back up call, they will automatically be called in for the next emergency situation; if they refuse a second time, they may be subject to disciplinary action that may include additional back up or primary calls. PGY-5s do not take primary, back-up or emergency back-up call.***

#### **The ACGME Standards of Duty Hours (Refer to Section Six: Duty Hours):**

- Call scheduled no more than every third night\*
- One (24-hour) day in seven free of patient care\*
- Limit of 80 duty hours per week\*  
\*Averaged over four weeks
- 24-hour limit on continuous duty and up to 6 additional hours for transfer, debriefing, didactic activities
- Defined by each RRC, includes required continuity clinics, "first cases"
- A 10-hour minimum rest between duty periods
- In-hospital hours during call from home count toward 80-hour limit

### **POST CALL POLICY**

Post call days are not automatic comp days. The duty hour rule was designed to protect patients from fatigued doctors making decisions and to protect residents driving home after call. It isn't a mechanism by which residents get to leave work as soon as call is over. The ACGME limits the total number of hours worked to 30 consecutive hours. After 24 consecutive hours, residents should not take new patients, but they are allowed to participate in continuity of care with established patients.

*Please note that other than the 30 hour limit, the above guidelines do not apply to educational activities or other non-clinical activities.*

If you are post call and have lectures/seminars/supervision, you are expected to be there. Patients are not at risk if you are tired during lecture or psychotherapy supervision. If you feel that you are so fatigued that you are at risk driving home, you should contact the lecturer/supervisor ( and notify Sheila) to let them know why you will be not be able to attend. However, skipping morning lectures or supervision or clinical activities should be the exception and not the rule.

If you are the back-up resident and are called in for a substantial number of hours (not just to go in and see one or two patients) and/or are too fatigued to see patients the following day, you should:

1. reschedule all NEW patients.

2. go home at 12pm after seeing your scheduled follow-up patients and/or transferring care of your inpatients.
3. DO NOT drive to an off-site rotation if you are scheduled. We do not want residents at risk for accidents. However, you should plan to see follow-up patients and arrange for care of the patients you are scheduled to see. The 4-6 hours after call is over, is expressly for that purpose.
4. You MUST CALL your supervisor where you are scheduled to work/see patients and explain that you were called in for an extended time for back-up call, that you are not able to see new patients, and that you must leave by 12pm.

If you feel you are in no condition to even see follow-up patients or to stay until 12pm, you should page Dr. Kimball or me directly to let us know what is going on. That way we can arrange for coverage if needed.

If you don't make adequate arrangements and contact your supervisor, the day could be counted as a sick or vacation day.

We want to adhere to the duty hour guidelines and to make sure that residents are not excessively fatigued or at risk to have an accident or medical error. But, we also want to take care of patients. scheduled in clinic and do the right thing by them.

**Leave Policies (Refer to Section Six: Resident Leave Policy):**

PG-1 residents receive two weeks paid vacation; PG-2 and above receive three weeks. In addition to the two weeks of official paid leave, PG-1 residents may receive, at the discretion of the department chairman, a paid “reading week” during the winter holiday season. ***Vacation may not be taken during the last 2 weeks of June or the first 2 weeks of July.***

*NOTE: Vacation Requests MUST be turned in at least one month in advance with the exception of those residents rotating with the Pediatrics Department, which requires 90-day advanced notice. Vacation requests handed in later than the appropriate deadline will be considered unpaid leave unless special permission is granted by the training director. Also, residents handing in vacation requests later than the one-month deadline are required to cancel/re-schedule any patient clinic appointments that they will miss while out on vacation.*

**Book Funds:**

All residents receive \$300 each year in “book money” from the department, which may be spent in any academically related manner. Unspent funds accumulate annually, but funds unspent at the end of the residency remit back to the department.

**Travel Fund/Scholarship:**

Departmental Money is set aside for residents to attend educational activities like the American Psychiatric Association conference. The amount of money allocated each year will be determined by the Training Director and Department Chairman.

Travel Fund money is awarded based on the following priority:

- a. Chief Resident
- b. PRITE scores
- c. Evaluations
- d. Research, presenter at the conference, Associate Chief Resident, or other special circumstance.

If a resident is interested in obtaining a travel scholarship, he/she must apply and submit a request to the Training Director.

**Dress Recommendations (Refer to Section Six: Dress Recommendations):**

Residents are expected to dress in a professional manner. Please confer with your attending if you have additional questions about proper attire.

**Medical Student Teaching:**

Medical student teaching is an integral part of all inpatient and outpatient rotations. Third year medical students are assigned to both inpatient services and the consultation-liaison service. Senior medical students may select from several electives offered in the department. The education of medical students is a vital part of the residency experience. Being the closest in training to the medical student, the resident stands in a unique position to provide a quality teaching experience to assigned medical students during their psychiatric rotation. Clinical learning is very much an apprenticeship experience. Whenever possible, the medical student should follow you, gaining “hands on” experience in history taking, physical examination, neurological examination, talking with patients, and dealing with other staff members. If you are on call, make every effort to get the medical student out to see patients with you. Where it is possible, observe the medical student interview patients and give feedback on his or her work. Read all medical student work-ups and progress notes. Review them with the student and critique his or her efforts. You are clearly the role model for the medical student, especially in the process of diagnosis and treatment planning. PG 2-3 residents will also participate in the delivery of medical student lectures during the noon time throughout the year. Typically, each PG 2-3 will chose a topic from the following: mental status examination, suicide, mood disorders, psychotic disorders, anxiety disorders, substance abuse, eating disorders, and psychopharmacology to lecture on throughout the year. The residents play a major role in evaluation of medical student performance at the end of each rotation. This is done in a grading conference supervised by the Director of Medical Student Education. Your input is absolutely necessary for accurate evaluation of student performance.

Teaching should be an enjoyable experience for you. Articulating your psychiatric knowledge to students is one of the best ways of firming it up for yourself.

**Institutional Email Accounts:**

Each resident will be given an institutional email account. Information is communicated to the residents by the hospital and department through email. **The resident will be expected to check emails daily.** The resident can access email from an off campus site by going to:

<https://owa.wfubmc.edu>

**Telecommunications Information:**

All upper-level residents (PG-2,3,4) are assigned a voicemail account and are expected to check their voicemail daily for any important messages. The voicemail system can be programmed to page residents when they receive messages. See the following section on AUDIX for details. Of note, interns are not assigned voicemail accounts, since they do not see psychiatry patients in clinic during the internship year.

**Introduction to AUDIX:**

In order to access/log in to AUDIX, please do the following:

Dial your AUDIX number and wait for the system to answer

- a. *In-house* dial 6-2100, 6-2101 or 3-2102.
- b. *Local* dial 716-2100, 6-2101 or 3-2102.

c. *Long distance* dial 1-800-237-2100.

1. Press # (if calling from your extension), or enter your extension and press #.
2. Enter your password and press #. (# is the password until you assign yourself a password. Your new password must be at least four digits. For security purposes we recommend that you do not use your extension, or numbers such as 1111 or 1234 as your password.)

AUDIX has a comprehensive help system that "talks you through" its layers of menu options. If you need more information, simply listen to the system prompts or press \*H to get HELP.

Once you have logged in to the AUDIX system, you will be at the main activity menu. By pressing the buttons on your touch-tone telephone, you can perform tasks from AUDIX. After you have performed these tasks, you may disconnect from AUDIX by simply hanging up.

If you have any questions please call the Help Desk at 64357, prompt 2.  
AUDIX Out calling

**Instructions for users to set up/program out calling to a pager:**

Press 6 out-calling administration

Press 1 change

9\*\_\_\_\_\_\*\*\*\*62100\*##

(Pager #)

Press 2 to set out-calling time

Press 2 to select time for prime/business hours

Press Y to turn on

Press 1 to activate for all messages

**Instructions for Recording Multiple Greetings:**

Dial into Audix and choose option 3 from the main menu.

Press 4 to administer call types. At the prompt, press 1 for internal/external, press 3 for out-of-hours. You will then be returned to the main menu for option 3.

Press 1 to create a greeting. Enter the greeting number (choose 1 first and make it your working hours message – with or without a zero option). Press # to approve the message. Do not follow instructions to activate yet. Instead, press # again.

Press 1 to create a greeting. Enter the greeting number (choose 2 and make it your after hours message with or without a zero option). Press # to approve the message. Do not follow instructions to activate yet. Instead, press # again.

Press 3 to activate a greeting. Enter greeting 1 and press 1 for internal calls; Audix will confirm your choice. Enter greeting 1 again and press 2 for external calls. Audix will confirm that greeting 1 is active for internal and external calls.

You will then hear the prompt to activate another greeting. Enter greeting 2 and press 3 to activate for our-of-hours. Audix will then confirm that greeting 2 is active for out-of-hours. To approve your choice, press # and then # again. You will be returned to the main activity menu.

**SECTION SIX:**  
**RESIDENT POLICY MANUAL EXCERPTS**

## PSYCHIATRY RESIDENCY POLICY

**AREA:** *DISMISSAL OR DISCIPLINE OF RESIDENT AND APPEAL PROCESS*

**DATE:** *7/12/88; revised 10/00; 1/03; 09/05*

**Description:** Resident dismissal or discipline (such as requirement that a year be repeated) is determined by the Educational Policy Committee and is passed by a 2/3 vote of the full membership. Dismissal or discipline recommendations are made to the Chair for final action. In all cases, the resident in question is invited to meet with the committee to present his or her case before such a recommendation is in order. He or she may invite the faculty advisor to assist. The circumstances leading to the action will be explained in full to the resident by the committee or its representative at the time of action.

Residents will be provided with at least four (4) months written notice of departmental intent to not renew a training program agreement. If the primary reason for nonrenewal occurs within this time period, the resident will receive as much written notice of the intent to not renew as circumstances reasonably allow.

The decision may be appealed by the resident to the Department Chair, again with the help of the faculty advisor if desired. Decisions made on this departmental appeal are final. Review at the institutional level is available as outlined in the House Officer Contract distributed to all residents, and includes an Appeals Committee (NCBH-HSS-15) and a Grievance Policy (NCBH-HSS-29).

**Objectives:** The use of a representative faculty committee that is familiar with teaching methods and resident performance allows as equitable a hearing as possible. The permission of the faculty advisor to support the resident allows a potential advocate for the resident. An appeal route to the committee decision is available via the chairperson. A broad-based decision process with appeal is the final end, subject to institutional review and appeal.

**Implementation:** The above policy is effective as of 7/1/88 with revisions as required.

**Effectiveness Evaluation:** No effectiveness evaluation is planned at present. Should the policy be used, the entire department will judge as to its effectiveness.

**PSYCHIATRY RESIDENCY POLICY**

**AREA:** *SEXUAL INVOLVEMENT BETWEEN OR HARASSMENT OF  
TRAINEE BY FACULTY OR SUPERVISOR*

**DATE:** *11/6/89; revised 10/00; 09/05; 3/07*

**Description:** The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry state that sexual involvement between faculty members or supervisors and trainees or students, in situations in which the inequity in the working relationship may lead to an abuse in power, may be unethical. The following specific means to report sexual abuse or harassment by teacher or supervisor are available. (See Grievance Policy) Protection from reprisal for the involved resident/student is guaranteed. No reprisals will be taken against the involved resident unless it can be shown that the charge was brought maliciously, capriciously, or in retribution for some action taken by the charged party but not associated with sexual abuse or harassment. Appropriate investigation and disciplinary action for the alleged offense will be determined by the Chairperson or other appropriate supervisory body.

**Objectives:** To provide a safe and equitable mechanism for the reporting and investigation of sexual abuse or harassment of resident/student trainees by faculty.

**Implementation:** The departmental policy is meant to be entirely consistent with the current institutional policy.

**Effectiveness Evaluation:** Specific incidents will be reviewed by the Educational Policy and Clinical Faculty for policy effectiveness, should the situation arise.

## PSYCHIATRY RESIDENCY POLICY

**AREA:** *ON-CALL COVERAGE*

**DATE:** *7/10/88; revised 4/95; 10/00; 1/03; 09/05; 07/10*

**Description:** Hours for being "on call" are as follows:

Monday - Thursday nights: 5:00 p.m. - 8:00 a.m.

Friday - Sunday: 4:00 p.m. Friday - 8:00 a.m. Monday

Weekend is split, and Saturday and Sunday call begins at 8:00 a.m.

Holiday call begins at 8:00 a.m.

Residents are on call for the NCBH inpatient psychiatric services, the Emergency Room, incoming phone calls requiring a psychiatrist, and emergency consults for non-psychiatric units. Residents do not leave the medical center premises for patient evaluations. After the evaluation of any patient, the attending on call must be contacted and the case and its potential disposition discussed. In the event that the attending on call is not available, the following persons should be contacted if back up is needed:

1. Inpatient Attendings currently on services
2. Director of Residency Training
3. Any other attending
4. Department chair

Residents must keep the Page Operator (ext 6-4881 or 6-2011) informed of where they are at all times when on call. If the call schedule is changed, it is the responsibility of the resident requesting the change to notify the Residency Program Assistant who will notify all necessary parties, including but not limited to:

1. The Page Operator
2. The Emergency Room.
3. The NCBH Inpatient Units.

All residents must carry a beeper during hours that they are on duty.

Fourth year residents routinely are not scheduled for call except for an emergency. They also may be asked to come in to assist a more junior resident. All residents will be expected to take "beeper" or home call and be prepared to come in to the medical center if requested to provide appropriate back-up support (see page 73 for back-up call procedure) and when patient care responsibilities are especially difficult or prolonged. If a resident is fatigued or overwhelmed and cannot get adequate back-up coverage, she/he should contact the following persons in order:

- (1) Attending on call
- (2) Chief residents or other senior residents
- (3) Director of Resident Education
- (4) Inpatient attendings

**Objectives:** To provide a first hand experience of psychiatric coverage in a supervised

environment. To develop clinical judgment in emergent situations and then have performance critiqued by an attending. To reduce fatigue level, medical errors, and improve patient and staff safety.

**Implementation:** The described policies are effective the academic year 1988-1989 with revisions based on Resident Review Committee requirement that took effect on July 1, 2003.

**Effectiveness Evaluation:** Adequacy of resident coverage will be judged by the attending on call and direct feedback given to the resident on call. Resident fatigue on post-call days will be monitored by faculty and staff. The system is effective if it provides quality psychiatric management to the patient population served.

## PSYCHIATRY RESIDENCY POLICY

**AREA:** *DUTY HOURS*

**DATE:** *November, 2003*

**DESCRIPTION:** It is the intent of the Department of Psychiatry and Behavioral Medicine to maximize patient safety and minimize the potential detrimental effects of duty hours on House Staff. This policy is intended to be consistent with institutional policy and with the ACGME requirements that took effect in July, 2003.

**RESIDENT EDUCATION:** Residents will receive formal educational experiences on the importance of duty hour management, the effects of fatigue on clinical decision making, and the physiology of sleep and its potential disturbances in the following venues:

1. PG-1 Seminar
2. Psychopharmacology Seminar
3. Sleep Selectives and Electives

In addition, informal education will occur during the monthly meetings with the department chair and the training director.

**FACULTY EDUCATION:** The importance of adhering to the duty hour requirements and methods for departmental monitoring of resident service provision will be reviewed with all new faculty members at the training director=s orientation, and at faculty meetings (Senior Staff) of the department. This will also be reinforced during the training director=s contacts with all rotational sites (site supervisors).

**DUTY HOUR MONITORING:** The Department will monitor resident duty hour exceptions by use of a report form that will identify the specific resident, rotation assignment, and dates incurred. The form will be completed by the resident, and faculty or other supervisory personnel will also be solicited for specific instances. The following items will be assessed:

- a) 1 day off in 7
- b) limitations of shift to no greater than 24+ 6 hours
- c) call frequency no greater than every third night
- d) minimum of 10 hour rest periods between shifts
- e) 80 hour work week limit
- f) presence of fatigue affecting clinical assignment.

The training director will review the forms at least quarterly and intervene when necessary.

**CROSS REFERENCES MADE TO THE DEPARTMENT'S POLICIES ON ON-CALL COVERAGE AND MOONLIGHTING:** The resident call schedule is to include a backup resident to assist when patient care responsibilities become unusually difficult or prolonged. Residents, faculty, and staff can initiate a request for the backup resident to assist. The

duty hours policy will be distributed annually by way of the resident handbook, business and staff meetings, and mailings to site supervisors.

**IMPLEMENTATION:** Duty Hour restrictions were put into effect by the department on April 1, 2003. The ACGME requirements went into effect on July 1, 2003. The monitoring system went into effect on November 1, 2003.

**EFFECTIVENESS EVALUATION:** The Educational Policy Committee will be made aware of duty hour exceptions and will recommend clinical or administrative corrective action to the training director and department chair when necessary. Alternative monitoring systems will be considered as departmental and institutional circumstances dictate.

## PSYCHIATRY RESIDENCY POLICY

**AREA:** *RESIDENT LEAVE POLICY*

**DATE:** *7/1/94; revised 1/03; 09/05*

**Description:** For the purposes of this policy, Departmental Leave Time refers to scheduled time away from an assigned rotation for the following reasons: Vacation, Administrative Leave (e.g. interviews), and Educational Leave (e.g., conferences).

In addition to Departmental Leave, all residents are allowed 10 days of sick leave per contract year for personal illness or medical needs.

Residents with children are also allowed four hours of leave annually to attend meetings at their child's day care, pre-school, or school as required by North Carolina law.

Unauthorized absence from the training program is a serious breach of professional conduct and may adversely affect the application process for certification by the American Board of Psychiatry and Neurology. Any such absences may be referred to the Educational Policy Committee for review and potential disciplinary action.

**EXTENDED LEAVES:** leaves which extend beyond 21 consecutive days are addressed by the North Carolina Baptist Hospital (NCBH) Family and Medical Leave Policy. The circumstances addressed by this policy include: on job injury, employee illness/pregnancy, military enlistment, new child (newborn, adopted, foster), seriously ill family members, or personal situation.

Residents requiring extended leaves should inform the Residency Training Director as soon as possible and contact the NCBH Department of Human Resources to work out the specifics of the leave (e.g. documentation requirements, benefits, etc.).

The Educational Policy Committee will review all cases of extended leave from an educational perspective and notify the resident about the effect on training and potential for extended training time. In general, residents may miss one (1) week of a rotation for each month of assigned service up to six (6) weeks for a contract/training year. In addition, extended leave may also affect the time in training requirements of the American Board of Psychiatry and Neurology regarding examination eligibility.

## DEPARTMENTAL LEAVE ALLOWANCES

### *Vacation*

PGY-I residents are allowed 2 weeks of vacation yearly. An additional "reading week" during the December holidays may be granted by the Senior Staff (departmental faculty). The provision of the "reading week" relies on upper level residents providing coverage and utilizing vacation time. A proposal will be submitted to the Residency Training Director by the chief resident by December 1, annually.

Residents beyond the PGY-I year are allowed 3 weeks of vacation yearly. Residents are expected to take vacation during the contract year in which it is accrued. Exceptions will require the approval of the department chairperson and any other program or service that may be involved at the time the vacation is scheduled.

### ***Administrative Leave***

PGY-4 residents and PGY-3 residents planning to pursue child fellowship training are allowed up to 5 days administrative leave to attend interviews. **Other trainees may be allowed administrative leave by the training director for legitimate absence from the training program. All administrative leave requests must be approved in advance.**

### ***Educational Leave***

All residents, except PGY-I residents on inpatient psychiatry, may request educational leave. There is no specific allowance. Educational leave requires the advance approval of the Chief Resident and the Residency Training Director.

## **GUIDELINES FOR DEPARTMENTAL LEAVE REQUESTS**

- Requests for Departmental leave time should routinely be submitted at least one month in advance. Exceptions will be allowed when unforeseeable events or circumstances preclude the one month notification and adequate coverage for clinical assignments can be arranged. Exceptions will be reviewed on a case by case basis by the Chief Resident and the Residency Training Director.
- The resident requesting Departmental Leave Time should obtain a Resident Notice of Leave form from the Chief Resident. It is the individual resident's responsibility to complete this form including making arrangements for coverage of clinical responsibilities, obtaining the signature of the covering resident, and obtaining the approval (and signature) of the service attendings. Completed forms should be returned to the Chief Resident for final approval.
- Any conflicts or concerns (raised by a resident, faculty member, service attending, or the Chief Resident) about Departmental Leave, will be brought to the attention of the Residency Training Director for review and a final decision.
- Only one resident from each of the following services may take Departmental Leave at any given time: Adult inpatient, Child/Adolescent inpatient, and Consultation/Liaison.
- Generally, no more than 5 consecutive week days should be taken for Departmental Leave. This will be the rule for all inpatient assignments (including VAMC) and the Consultation/Liaison service. Exceptions will be considered on a case by case basis by the Chief Resident.
- Generally, only one week of Departmental Leave should be taken per academic quarter. Exceptions will be considered on a case by case basis by the Chief Resident.
- Because of the arrival of new residents and the need to transition responsibilities, *vacation will not be granted during the last two weeks of June* (with the exception of residents who will be completing their training at the end of June) *or the first two weeks of July*. The residency training coordinator will maintain records of Departmental Leave for all residents.

**PSYCHIATRY RESIDENCY POLICY**

**AREA:**            *SICK AND EMERGENCY LEAVE POLICY*

**DATE:**           **07/10**

Each resident is allowed ten (10) paid sick days per fiscal year (July – June). Sick time can be used in

- Personal illness;
- Accident or illness in the immediate family;
- Pregnancy or childbirth;
- Medical and dental appointments;
- Additional days required in the event of a death in the family;
- An emergency situation where no vacation leave is available. *(The program director has the authority to decide validity of the emergency.)*

Unused sick time cannot be rolled over into the next fiscal period and cannot be borrowed.

**Procedure\***

Should a resident require sick or emergency leave, the following is expected:

- 1) No later than 8:00am on the day of sick or emergency leave, the resident should contact the following personnel depending upon his/her schedule:
  - a. Onsite Clinics: the front desk at 716-6312 and Clinic Central at 717-4524
  - b. Offsite rotations: the site supervisor, site coordinator and/or point of contact. Contact information for offsite rotations is located on SharePoint <http://sp4.wfubmc.edu/sites/psychiatry/> under your program.
  - c. Outpatient Child rotation: Sandy at 716-9606 and/or Marti at 716-9677
- 2) Direct conversation with the chief resident or his/her designee of the impending leave, such that the chief resident can arrange clinical and/or call coverage.
- 3) Contact the training director, the service chief and the Administrative Secretary who coordinates the medical student rotation schedules, if appropriate.
- 4) Email the residency program coordinator, Sheila Leach, at [saleach@wfubmc.edu](mailto:saleach@wfubmc.edu) and list in the subject line "Sick". All leave, in partial or in whole, taken during the normal work week of Monday thru Friday should be reported to the coordinator. *(It is mandatory to notify the program coordinator of all leaves even in the event of the coordinator's absence. Failure to notify the coordinator of your absence may result in your leave being attributed as vacation and/or brought forth to the Educational Policy Committee (EPC)*

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**BEREAVEMENT**

Each resident is allowed five (5) paid bereavement days per fiscal year for immediate family members. Immediate family members are defined as a spouse, parents, stepparents,

siblings, children, stepchildren, grandparent, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, or grandchild. *(The Program Director has the authority to decide bereavement pay for extended family members.)*

\*Residents should follow the procedure as outlined above when taking bereavement leave.

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### **FMLA (Family and Medical Leave Act)**

FMLA leave must be approved by the Program Director. Information and forms on FMLA are located on SharePoint <http://sp4.wfubmc.edu/sites/psychiatry/> under Shared Documents.

## PSYCHIATRY RESIDENCY POLICY

**AREA:** *SYSTEM FOR TRACKING RESIDENT CASE LOADS*

**DATE:** *7/10/88; revised 4/95; 09/05; 09/10*

**Description:** A computerized system of record keeping for residents' assessment and treatment cases has been developed. This database contains pertinent information as to patient demographics, supervisor, diagnosis and treatments administered. This is also necessary for legal protection of the supervisor who bears some legal responsibility for supervised patients.

The data can be retrieved by any of the entered parameters, thus getting a demographic and diagnostic profile for the resident's patient contacts by service.

**Objectives:** It is necessary to monitor the types of patients with whom the resident works with in order to assess the adequacy of patient experience provided by the training program. This is particularly important for the therapy patients followed by the residents. A balance of patients of varying age, gender, race, and diagnosis seen in a variety of clinical situations is desirable. A representative catalog is necessary if we are to implement the appropriate patient assignments and document the training experience for future privileging and credentialing.

**Implementation:** The above system of tracking patient contact was implemented as of July 1, 1988, and revised periodically. Beginning in June, 2005, the case log function was transferred to the institution's electronic program management suite called E\*Value.

**Effectiveness Evaluation:** Data from the collected patient records will be reviewed by the Training Director and discussed with the resident at least semiannually. Using this system, the data can be analyzed by any of the variables collected.

**PSYCHIATRY RESIDENCY POLICY**

**SUBJECT:** *MOONLIGHTING*

**DATE:** *8/16/88 revised 10/00; 1/03; 09/05; 1/19/10*

**Aims:** To permit a reasonable amount of supplementary work of some educational value for second through fourth year residents for the purpose of earning extra income.

**Description:** Institutional policy documented in the House Officer Contract and distributed to all residents state that **written** permission from the Department must be obtained for all such activities. Residents who choose to pursue outside professional activities must have a full unrestricted license to practice medicine. Moonlighting hours must not interfere with any duties of the resident program, including on call responsibilities. The total number of work hours per month, including 40 hour work week, call time, and moonlighting, must not exceed 80 hours per week or 300 hours per month.

**\*\*Moonlighting IS monitored by the Program Director\*\***

It should be noted that professional liability coverage of the hospital covers residents only when on assigned rotations. Liability coverage for moonlighting must be obtained by the resident.

Residents who are placed on probation by the department's Educational Policy Committee may not participate in outside professional activities.

**Effectiveness Evaluation:** Effectiveness of the policy will be evaluated jointly with the resident staff and faculty for impact on the educational program and potential gains from the moonlighting experience.

**DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL MEDICINE  
ADULT RESIDENCY PROGRAM  
MOONLIGHTING PRIVILEGE REQUEST FORM**

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**MOONLIGHTING START DATE REQUESTED:** \_\_\_\_\_

**RESIDENT NAME:** \_\_\_\_\_

I have not been moonlighting in the past 12 months and do not plan to moonlight during the coming 12 months. *(If this block is marked, no need to complete the remainder of the form.)*

I plan to moonlight during the month and understand the WFUSM policy on moonlighting. *(If this block is checked, the fellow requesting moonlighting privileges, agrees to complete the following information upon completion of his/hers moonlighting session each month).*

**LOCATION:** \_\_\_\_\_  
\_\_\_\_\_

**CONTACT PERSON:** \_\_\_\_\_

**LENGTH OF SHIFTS:** \_\_\_\_\_

**APPROXIMATE # OF SHIFTS EACH MONTH:** \_\_\_\_\_

I attest I have a separate malpractice insurance policy/coverage that will cover my moonlighting activity outside of the University's insurance.

**WAIVER:**

***I hereby give permission for the program director or his/her designee to contact the site and verify the above information.***

**RESIDENT SIGNATURE:** \_\_\_\_\_

**Date** \_\_\_\_\_

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**APPROVED BY PROGRAM DIRECTOR:** \_\_\_\_\_

**Date** \_\_\_\_\_

**PSYCHIATRY RESIDENCY POLICY**

**AREA:** *DRESS CODE*

**DATE:** *1/30/89: revised 10/00; 1/03; 09/05; 3/07: 10/07*

**Description:** The Medical Center requires that all personnel wear photo ID badges. Residents must wear them when in the hospital and at all clinical rotation sites.

With respect to dress, we expect the psychiatric resident to dress neatly and to maintain a reasonable personal appearance. White coats with ID badge attached should be worn while in the hospital or while on consultation-liaison.

Dress shirt with or without tie and dress or casual pants should be minimum for male residents. Relatively conservative clothing is encouraged for female residents.

*Jeans, shorts, mini skirts, sweat pants, bib overalls, spandex pants, spaghetti-strap dresses, t-shirts, halter tops, bare midriff, visible undergarments, hats, caps, and flip flops are prohibited at all times.*

Ultimately, appropriate dress is determined by attending responsible for each clinical rotation. If a resident is wearing clothing not appropriate for the clinical rotation, he or she should be instructed to either: (a) change into scrubs and lab coat or (b) cover clothing with white lab coat. Repeated dress code infractions will be brought to the Director of Resident Education for appropriate action.

**Objective:** To foster a professional concern for personal appearance by the resident. To make patients as comfortable as possible in the treatment situation with the resident.

**Implementation:** Effective 7/1/89; revised 10/00, 1/03, 09/05, 10/07.

**Effectiveness Evaluation:** The Director of Resident Education is responsible for enforcement and evaluation of the general effectiveness of this policy.

**PSYCHIATRY RESIDENCY POLICY  
AREA: *GRIEVANCE POLICY***

**DATE: IMPLEMENTED NOVEMBER 1, 2006**

**PURPOSE**

The purpose of the Resident Grievance Policy is to provide residents with a fair and reasonable means of addressing concerns or grievances involving their work and educational environments. Grievance areas include (but are not limited to) issues of harassment, discrimination, personal safety, concerns with individual rotations, staff conflicts, policy disputes, conflicts with attending physicians, conflicts with other residents, appeals of performance evaluations, and appeals of disciplinary action. This policy is intended as a guideline for resolving disputes and does not supersede or invalidate hospital or medical school policies regarding harassment or discrimination.

**POLICY**

**Step 1:** A resident with a grievance contacts his/her supervising faculty to discuss the specific concern or complaint. The resident and attending physician then work to address the resident's grievance.

**Step 2:** If the resident is unable to address the grievance with his/her faculty with a resolution acceptable to the resident or if the resident does not feel comfortable discussing the matter directly with the attending, the resident should contact his/her designated faculty advisor and/or the chief resident to discuss the grievance. The faculty advisor and/or chief resident then should contact the supervising attending within 5 working days to discuss the grievance.

**Step 3:** If the resident feels that the grievance has not been appropriately addressed with the intervention of his/her faculty advisor and/or chief resident, he/she contacts the residency training director to address the specific concern. The training director should meet or talk to the resident within 5 working days of the resident requesting the meeting.

**Step 4:** If the resident meets with the training director and feels that the grievance has not been sufficiently addressed, he/she should schedule to meet with the department's Educational Policy Committee (EPC) at the next scheduled meeting. The resident has the option of having the chief resident and/or faculty advisor accompany him/her to the EPC.

**Step 5:** If the concern is not satisfactorily addressed by the EPC, the resident and the chair of the EPC will contact the chair of the department to inform him/her that the issue has not been resolved to the satisfaction of the resident. The resident should meet or talk with the chair of the department within 10 working days of the EPC meeting.

**Step 6:** If after meeting with the chair of the department the resident continues to feel that the grievance has not been properly addressed, he/she, with the help of either the faculty advisor or the chief resident, contacts the chair of the Graduate Medical Education Committee (GMEC) to discuss the grievance. At this point, follow-up of the resident's grievance has extended outside of the department, and the Graduate Medical Education Committee's own rules and policies take effect.

**PSYCHIATRY RESIDENCY POLICY**  
**AREA: *TRAINEE DISCIPLINARY POLICY***

**DATE: IMPLEMENTED MAY 19, 2009**

***Wake Forest University School of Medicine***  
***Department of Psychiatry and Behavioral Medicine***

***Title: Trainee Disciplinary Policy***

***Purpose:***

The purpose of this policy is to describe procedures by which deficiencies in performance and misconduct of participants in the Psychiatry residency program at the Wake Forest University School of Medicine may be addressed. This policy provides guidance to training program faculty and outlines procedures by which procedural fairness is afforded to trainees subject to disciplinary actions.

***Policy Statement:***

***Procedure(s) for Implementation:***

**I. Actions in Response to Performance Deficiencies or Misconduct**

**A. *Preliminary Academic Actions***

The Psychiatry Residency Program Director is encouraged to use the following preliminary measures to resolve minor instances of poor performance or misconduct. In any case in which a pattern of deficient performance has emerged, preliminary measures available to the Program Director shall include notification of the resident in writing of the nature of the pattern of deficient performance and remediation steps, if appropriate, to be taken by the trainee to improve his/her performance. If these preliminary measures are unsuccessful or where performance or misconduct is of a serious nature, the Program Director may initiate formal disciplinary action (see below).

**1. Counseling Letter**

A counseling letter may be issued by the Program Director to a Trainee to address an academic or professional deficiency that needs to be remedied or improved. The purpose of a counseling letter is to describe a single instance of problematic behavior and to recommend actions to rectify the behavior. The Program Director will review the counseling letter with the Trainee. Failure to

achieve immediate and/or sustained improvement or a repetition of the conduct may lead to other disciplinary actions. These actions are determined by the professional and academic judgment of the Program Director and need not be sequential. For the purposes of this policy and for responses to any inquiries, a counseling letter does not constitute a disciplinary action.

## **2. Notice of Concern**

A notice of concern may be issued by the Program Director to a Trainee who is not performing satisfactorily. Notices of concern should be in writing and should describe the nature of the deficiency and any necessary remedial actions required on the part of the Trainee. A Notice of concern is typically used when a pattern of problems emerges. The Program Director will review the notice of concern with the Trainee. Failure to achieve immediate and/or sustained improvement or a repetition of the conduct may lead to additional actions. This action need not follow counseling letter nor precede other academic actions described later in this document, and does not constitute a disciplinary action.

## **B. *Formal* Disciplinary Actions**

### **1. Causes**

Formal disciplinary action may be taken for any appropriate reason, including but not limited to any of the following:

- a. Failure to satisfy the academic or clinical requirements or standards of the training program;
- b. Professional incompetence, misconduct or conduct that might be inconsistent with or harmful to patient care or safety;
- c. Conduct that is detrimental to the professional reputation of the Medical Center;
- d. Conduct which calls into question the professional qualifications, ethics, or judgment of the trainee, or which could prove detrimental to the Medical Center's patients, employees, staff, volunteers, visitors or operations;
- e. Violation of the policies or procedures of the Medical Center, or applicable department, division or training program;
- f. Scientific misconduct.

### **2. Specific Procedures:**

Formal disciplinary action may include, but is not limited to:

#### **a. Probation**

Trainees who are in jeopardy of not successfully completing the requirements of the training program may be placed on academic probation by the Program Director.

- i. Probation is a temporary modification of the trainee's participation in or responsibilities within the training program; these modifications are designed to facilitate the trainee's accomplishment of program requirements. Generally, a trainee will continue to fulfill training program requirements while on probation, subject to the specific terms of the probation.
- ii. The Program Director shall have the authority to place the trainee on probation and to determine the terms of the probation. A trainee shall be paid while on probation.
- iii. Probation may include, but is not limited to, special requirements or alterations in scheduling a trainee's responsibilities, a reduction or limitation in clinical responsibilities, or enhanced supervision of a trainee's activities.
- iv. The Program Director shall notify the trainee in writing of the probation. Written notification should include:
  - a) reasons for the probation,
  - b) required method and timetable for correction,
  - c) date upon which the decision will be re-evaluated, and
  - d) A statement regarding the trainee's right to request a review of the probation in accordance with the procedures outlined below.
- v. Failure to correct the deficiency within the specified period of time may lead to an extension of the probationary period or other academic sanctions. Probation should be used instead of a notice of concern when the underlying deficiency requires added oversight.

**b. Suspension**

- i. The Program Director or his/her designee may temporarily suspend the Trainee from part or all of the Trainee's usual and regular assignments in the training

program, including, but not limited to, clinical and/or didactic duties, when the removal of the Trainee from the clinical service is required for the best interests of patients, staff and/or Trainee due to seriously deficient performance or seriously inappropriate conduct. Suspension may be coupled with or followed by other academic actions. The Trainee's stipend will not be paid while the Trainee is on suspension status.

- ii. The suspension will be confirmed in writing by the Program Director, stating the reason(s) for the suspension and its duration. Suspension generally should not exceed sixty (60) calendar days. Written notification should include:
  - a) reasons for the suspension,
  - b) required method and timetable for correction,
  - c) date upon which the decision will be re-evaluated, and
  - d) A statement regarding the trainee's right to request a review of the suspension in accordance with the procedures outlined below.

This notice shall precede the effective date of the suspension, unless a serious risk to patient care or the health or safety of an employee warrants immediate suspension, in which case the notice shall be provided at the time of the suspension, or as soon thereafter as is practicable.

- iii. To initiate a review of a suspension decision, a trainee must submit a written request for a review of the suspension to the Program Director within three (3) business days of the trainee's receipt of the notification. If the trainee requests review of the suspension, the Program Director shall meet with the trainee within the next three (3) business days and afford the trainee an opportunity to provide any information in his or her defense. After this meeting, the Program Director, following consultations with the appropriate individuals, if any, will render a decision.

The trainee shall receive written notification of the decision of the Program Director and the reasons for and consequences of the decision.

**c. Requirement that Trainee Must Repeat an Academic Year:** A Trainee may be required to repeat an academic year in lieu of dismissal from a Program due to unsatisfactory progress in the training program or for other problems. The decision whether to permit the Trainee to repeat an academic year is at the discretion of the Program Director, in consultation with funding sources.

**d. Denial of Certificate of Participation:** If the Program Director decides not to award the Trainee a certificate of participation/completion, the Program Director will notify the Trainee as soon as reasonably practicable of this intent.

**e. Termination**

The Program Director shall have the authority to terminate a trainee from a training program for reasonable cause, including but not limited to:

- i. A failure to achieve or maintain programmatic requirements or standards in the training program;
- ii. A serious or repeated act or omission compromising acceptable standards of patient care including, but not limited to, an act that constitutes a disciplinary cause or reason;
- iii. Unprofessional, unethical or other behavior that is otherwise considered unacceptable by the training program;
- iv. A material omission or falsification of a training program application, a medical record, or a WFUBMC document, including billing records.

A termination occurs when a trainee is (i) dismissed during the academic year, and/or (ii) not continued in the program beyond the current academic year because of the trainee's performance, conduct and/or other similar cause. A trainee has the right to request formal review of the termination decision.

A decision not to continue a trainee in a program beyond the current academic year for reasons other than performance and/or conduct does not constitute a disciplinary action, and the trainee shall have no right to appeal such actions.

Written notice of a recommendation of termination from a program including the reasons for the decision and the effective date of termination shall be provided by the Program Director to the trainee.

When appropriate, the Program Director may afford the trainee an opportunity to resign voluntarily.

When a decision has been made not to renew a trainee's contract, whether the reason for non-renewal of the contract is the trainee's performance, conduct or other similar cause or for other reasons unrelated to performance, conduct or similar cause, e.g. loss of financial support, the Program Director must give written notice of nonrenewal of the contract no later than four (4) months prior to the end of the trainee's current contract period. However, if the primary reason for the nonrenewal occurs during that four (4) month period, as much notice as is reasonably possible under the circumstances should be provided.

## **C. Administrative Actions**

### **1. Automatic Suspension**

The trainee will *automatically* be suspended from the training program for any of the following reasons:

- a. Failure to complete and maintain medical records as required by the medical center or affiliation site, in accordance with the Medical Center's policies; or
- b. Failure to comply with state licensing requirements of the North Carolina Board of Registration in Medicine; or
- c. Failure to obtain or maintain proper visa status; or
- d. Unexcused absence from the training program for more than twenty-four (24) hours.

The period of automatic suspension should not exceed ten (10) days; however, other forms of administrative or academic action may follow the period of automatic suspension.

The Program Director or the Trainee's supervisor will promptly notify the Trainee of his/her automatic suspension in writing, providing the facts upon which the suspension is based and a written notice of the intent to consider the Trainee to have automatically resigned at the end of the suspension period (see below).

Whether the basis of the automatic suspension is (a), (b), (c) or (d), the Trainee shall respond by correcting the deficiency when possible and by submitting a written explanation of the reasons for the circumstances resulting in automatic suspension. In all cases, the Trainee shall submit a written response to the Program Director within the ten (10) day suspension period.

The Trainee will not receive any academic credit during the period of automatic suspension. The Trainee stipend will not be paid while the Trainee is on automatic suspension status.

## **2. Automatic Resignation**

The Trainee may be considered to have automatically resigned under the following circumstances:

### **a. Failure to Provide Visa or License Verification**

Failure of the Trainee to provide verification of an appropriate and currently valid visa or verification of current compliance with state licensing requirements of the North Carolina Board of Registration in Medicine during the 10-day automatic suspension period may result in the Trainee's automatic resignation from the training program.

### **b. Failure to Address Delinquent Medical Records**

The trainee should you use the suspension period to complete all delinquent medical records. Failure to complete medical records or to respond in writing with an acceptable plan to complete delinquent medical records may result in the Trainee's automatic resignation from the training program.

### **c. Absence without leave**

A trainee who is absent from the training program for any reason, for any period of time, must contact his or her supervisor immediately or as soon as feasible.

Trainees must communicate directly with the Program Director in the event he or she is unable to participate in the training program for any period of time in excess of twenty-four (24) hours. The Program Director may grant a leave in times of exceptional circumstances.

If a Trainee is absent without leave for twenty-four (24) hours or more, he or she may be considered to have resigned voluntarily from the program unless he or she submits a written explanation of any absence taken without leave. This written explanation must be received by the Program Director within ten (10) days of the first day of absence without leave. This ten (10) day period is concurrent with the automatic suspension period. The Program Director or his or her designee will review the explanation and any materials submitted by the Trainee regarding the absence without leave in question. The Program Director or designee will notify the Trainee in writing of his or her decision within ten (10) days of submission of the trainee's written explanation.

Failure to respond to the written notice of intent or failure to explain adequately or to document the unexcused absence to the satisfaction of the Program Director or his/her designee will result in the Trainee's automatic resignation from the training program. The Trainee's stipend will continue to be paid for twenty (20) days after the first day of absence without leave.

Whether due to the trainee's failure to respond to the notice of automatic suspension and intent during the ten (10) day automatic suspension period or to the Program Director's decision after reviewing the trainee's written explanation of the absence without leave or the plan to address delinquent medical records, or due to the trainee's failure to provide verification of appropriate license and/or visa, the program director may consider the trainee to have automatically resigned. The Program Director will provide written notice of the trainee's automatic resignation.

The trainee shall receive payment of his/her usual stipend for a period of twenty (20) days after the effective date of the automatic resignation.

**Policy Disclaimer:** The policies outlined in this document are subject to the rules and regulations outlined by the Graduate Medical Education Committee (GMEC) of Wake Forest University School of Medicine.

Date of implementation:

Prepared by: The Disciplinary Policy Subcommittee  
of the Educational Policy Committee:  
Hal Elliott, M.D.  
James Kimball, M.D.  
Joseph Williams, M.D.

**SECTION SEVEN:**

**PHONE NUMBERS AND CONTACT  
INFORMATION**

**IMPORTANT PHONE NUMBERS**

<b>NC Baptist Hospital Security</b>	<b>6-3305</b>
Clerk of Court's Office	(336) 761-2372
PO Box 1411 (room 215, Hall of Justice)	(336) 761-2340
Winston-Salem, NC 27101	
 Ms. Pamela M. Marion	 (336) 386-3700
Surry County Clerk of Court's Office	
PO Box 345	
Dobson, NC 27107	
 Davidson County Clerk of Court	 (336) 249-0353
 Winston-Salem Police Department	 (336) 773-7700
 Forsyth County Sheriff's Department	 (336) 727-2112
 CenterPoint Human Services Access Line	 (888) 581-9988

**Wake Forest University School of Medicine and  
The North Carolina Baptist Hospitals, Incorporated  
Phone Numbers (Prefix is 716 or 713)**

Dr. Hal Elliott	6-9228
Sheila A. Leach, Residency Program Assistant	6-3601
Psychiatry Inpatient Units:	
	Adult: 3-8100/ 3-8136
	Child/Adol: 3-8700
 Emergency Room	 3-9100
ED Psychiatry Transfer coordinator	3-5747
	Pager 6013
Page Operator	6-4881
WFUBMC Operator	6-2011
OPD Appointments	6-9692
Psychiatry Office	6-4551
Psych. Referral and Admissions Coordinator (Adults)	6-4635
Psych. Referral and Admissions Coordinator (Child & Adol.)	6-6992
Ala Jo Koonts, House Staff Affairs	6-3465

## Other Facilities & Service Providers

<b>STATE PSYCHIATRIC HOSPITALS</b>		
<b>NAME</b>	<b>CITY</b>	<b>PHONE</b>
Central Regional Hospital	Butner	Admissions: Phone 919-764-7400 Faz 919-764-7420
Broughton State Hospital	Morganton	Admissions Phone 828-433-2071 Fax 828-433-2082
Cherry Hospital	Goldsboro	Admissions: Phone 919-731-3349 Fax 919-731-3513
<b>OTHER FACILITIES</b>		
CONTACT Helpline Winston-Salem (staffed 24 hours)		722-5153
Forsyth County Department of Social Services	Winston- Salem	703-3899
Forsyth Medical Center's Psych. Unit	Winston- Salem	718-2500
Downtown Health Plaza (not MHC)	Winston- Salem	713-9800
VA Clinic	Winston- Salem	768-3296
Winston-Salem Health Care Plan	Winston- Salem	718-1000
<b>FOR ADOLESCENTS:</b>		
Youth Opportunity Shelter (Runaway)	Winston- Salem	748-0003
Catholic Social Services	Winston- Salem	727-0705

If you are having difficulties with the Sheriff's Department for transport of patients, call the Watch Commander at 727-2112 or 727-2113.

Please note the **DIRECTORY OF COMMUNITY RESOURCES**, an excellent source book for local and state services and facilities, may be found in the department OPD office or may be requested from First Line (a city-sponsored information service) at 727-8100.

## Other Useful Numbers:

Al-Anon/Alateen		(336) 723-1452
Alcoholics Anonymous	Winston-Salem	(336) 725-6031
	Greensboro	(336) 854-4278
	High Point	(336) 885-8520
	Burlington	(336) 228-7611
	Asheboro	(336) 629-7167
Amos Cottage		(336) 744-2400
Battered Women's Shelter		(336) 723-8125
Covenant House (Runaways)		(800) 999-9999
Crisis Control Ministry (shelter, emergency funds, pharmacy, etc.)		(336) 724-7453
Daymark Recovery Services		(336) 607-8523
Greensboro Veterans Center (outpatient only)		(336) 333-5366
Family Services Agency		(336) 722-8173
Narcotics Anonymous		1-800-721-8225
Sexual Assault Line		(336) 722-4457
Rescue Mission Shelter		(336) 723-1848
Salvation Army Shelter		(336) 722-8721
Stop Child Abuse Now (SCAN)		(336) 748-9028
Veteran's Administration		(336) 768-3296

### **Student Health Service**

Mackie Health Center – Lower Level, Reynolds Gymnasium

P.O. Box 7386

Winston-Salem, NC 27109-7386

Phone: During Clinic Hours (M-F 8:30 am – 5:00 pm): 336-758-5218 Fax: 336-758-6054  
After Clinic Hours, Nights, Weekends: 336-758-5882

Psychiatric services (including follow-up for post-hospitalization care)

Dr. Hal Elliott (Wednesday afternoons)

Dr. Theresa Burgess (all day Mondays and Fridays)

Dr. Jen Wildpret (all day Wednesdays)

**NOTE: There is no charge to Wake Forest – Reynolda Campus students for visits with the psychiatrists at the Student Health Service.**

Director: Dr. Cecil Price (Cell phone: 336-655-2278)

### **University Counseling Center**

118 Reynolda Hall

P.O. Box 7838

Winston-Salem, NC 27109-7838

Phone: 336-758-5273 (M-F 8:30 am – 5:00 pm) Fax: 336-758-1991

The staff of the University Counseling Center can be reached for crisis intervention after clinic hours by calling the Student Health Service nurse on duty (336-758-5882).

**NOTE: There is no charge to Wake Forest – Reynolda Campus students for visits at the University Counseling Center.**

Staff:	Marianne Schubert, Ph.D. (Director)	Johnne Armentrout, MA (Ed)
	Alan Cameron, Ph.D.	Maria Paredes, MS
	Rob McNamara, Ph.D.	James Raper, MA (Ed)
		Amy Shuman, MA (Ed)

### **Learning Assistance Center and Disability Services**

117 Reynolda Hall

P.O. Box 7283

Winston-Salem, NC 27109-7283

Phone: 336-758-5929 Fax: 336-758-1991

Learning support including assistance for ADHD and learning disabilities

Academic accommodations for documented disabilities (see <http://www.wfu.edu/lac/>)

Staff: Dr. Van Westervelt, Ph.D. (Director, licensed psychologist)  
Michael Shuman, Ph.D.

**NOTE: There is no charge to Wake Forest – Reynolda Campus students for visits at the Learning Assistance Center**

Shared managers/shs administration/Mental Health Resources/cdp/6-12-09

## Other Inpatient Facilities:

Alamance Regional Medical Center – Burlington	Main:	(336) 538-7893
Annie Penn Memorial Hospital Reidsville, NC	Main:	(336) 951-4000
Asheville VA Medical Center		(828) 298-7911
Carolinas Medical Center - Charlotte		(704) 358-2700
Duke University Hospital	Main:	(919) 684-8111
	Psychiatry:	(919) 684-3151
	Psychiatry OPD:	(919) 684-0100
Durham Regional Hospital		(919) 470-4000
Durham VA Medical Center		(919) 286-0411
Fellowship Hall - Greensboro		(336) 621-3381
High Point Regional Hospital		(336) 878-6000 ext 2976
Holly Hill-Raleigh		(919) 250-7000
Moses Cone Hospital - Greensboro	Main:	(336) 832-7000
	Psychiatry:	(336) 832-9600
University of North Carolina Hospital	Main:	(919) 966-4131
Northern Hospital of Surry Mt. Airy, NC		(336) 719-7000
Old Vineyard Behavioral Health		(336) 794-4956
Pitt County Memorial Hospital Greenville, NC		(252) 847-4100
Presbyterian Hospital - Charlotte		(704) 384-4000
Randolph County Hospital		(336) 625-5151
Thomasville Medical Center		(336) 472-2000
VA Medical Center-Salisbury		(704) 638-9000

**SUBSTANCE ABUSE TREATMENT CENTERS**

Center	City	Phone
Black Mountain	Black Mountain	(828) 669-3417
R. J. Blackley	Butner	(919) 575-7928
Insight	Winston-Salem	(336) 725-8389
New Dawn	Yadkinville	(336) 679-6718

Counties	Local Management Entities	Director
Alamance Caswell	<a href="#">Alamance-Caswell-Rockingham LME</a>	<a href="#">Daniel Hahn</a> Executive Director
Rockingham  <i>*Rockingham Co will authorize indigent beds at Moses Cone or Alamance (must refer there before JUH auth will be given)</i>	319 N. Graham-Hopedale Road, Suite A Burlington, NC 27217 (336) 513-4200 (336) 513-2097-FAX (336) 513-4444 or Emergency Phone Number (888) 543-1444 Access to Services	
Camden  Chowan Currituck Dare Hyde Martin Pasquotank Perquimans Tyrell Washington	<a href="#">Albemarle MH Center &amp; DD/SAS</a>  PO Box 2367 Elizabeth City, NC 27906-2367 (252) 338-8352 (252) 338-8193-FAX (888) 627-4747 or Emergency Phone Numbers	<a href="#">Charles Franklin, Jr.</a> Area Director
Edgecombe Greene Nash Wilson	<a href="#">The Beacon Center</a> 500 Nash Medical Arts Mall Rocky Mount, NC 27804 (252) 937-8141- Phone/Emergency (252) 443-9574- Fax (888) 893-8640 Access Toll Free	<a href="#">Karen Salacki</a> Area Director
Catawba Burke	<a href="#">Mental Health Services of Catawba County</a> 1985 Tate Blvd. SE Suite 529 Hickory, NC 28602 (828) 327-2595 (828) 325-9826-FAX (877) 327-2593 Emergency Phone Number	<a href="#">John Hardy</a> Area Director
Davie Forsyth	<a href="#">CenterPoint Human Services</a> 4045 University Parkway	<a href="#">Betty Taylor</a> CEO/Area

Stokes	Winston-Salem, NC 27106 (336) 714-9100 (336) 714-9111-FAX (888) 581-9988 Emergency Phone Number	Director
Iredell Surry	<a href="#">Crossroads Behavioral Healthcare</a> 200 Elkin Business Park Drive	<a href="#">David Swann</a> CEO/Area Director
Yadkin	Elkin, NC 28621 (336) 835-1000 (336) 835-1002 or 835-2075 FAX (888) 235-4673 Access to Care	
Cumberland	<a href="#">Cumberland County Mental Health Center</a> PO Box 3069 Fayetteville, NC 28302-3069 (910) 323-0601 (910) 323-0096-FAX (877) 223-4617 Emergency Number	<a href="#">Hank Debnam</a> Area Director
Durham	<a href="#">The Durham Center</a> 501 Willard Street Durham, NC 27701 (919) 560-7100 (919) 560-7250-FAX (800) 510-9132 Emergency Phone Number	<a href="#">Ellen S. Holliman</a> Area Director
Beaufort Bertie Craven Gates Hertford Jones Northampton Pamlico Pitt	<a href="#">East Carolina Behavioral Health</a> PO Box 1636 New Bern, NC 28563 (252) 636-1510 (252) 633-1237 (877) 685-2415 Emergency Phone Number	<a href="#">Roy Wilson</a> CEO
Duplin Lenoir Sampson Wayne	<a href="#">Eastpointe</a> 100 S. James St. Goldsboro, NC 27530 (919) 731-1133 (919) 731-1333-FAX (800) 913-6109 Emergency Phone Number	<a href="#">Ken Jones</a> Area Director
Franklin Granville Halifax Vance Warren	<a href="#">Five County Mental Health Authority</a> 134 South Garnett St. Henderson, NC 27536 (252) 430-1330 (252) 430-0909-FAX (877) 619-3761 Emergency Phone Number	<a href="#">Foster Norman</a> Area Director
Alexander Caldwell	<a href="#">Foothills Area MH/DD/SA Authority</a> 115 Wamsutta Mill Road	<a href="#">Don Pagett</a>

McDowell	Morganton, NC 28655 (828) 430-7148  (828) 430-7958-FAX (866) 327-4968 Emergency Phone Number	Interim Area Director/ CEO
Guilford	<a href="#">Guilford Center for Behavioral Health and Disability Services</a> 232 N. Edgeworth Street, 4th Floor Greensboro, NC 27401 (336) 641-4981 (336) 641-7761-FAX (336) 641-4993 Emergency Phone Number (800) 853-5163 Access to Care Phone	<a href="#">Billie M. Pierce</a>  Area Director
Johnston	<a href="#">Johnston County Area MH/DD/SA Authority</a> PO Box 411, 521 N. Brightleaf Blvd. Smithfield, NC 27577-0411 (919) 989-5500 (919) 989-5532-FAX (888) 815-8934 Toll Free (919) 989-5500 After Hours Crisis Phone Number	<a href="#">Janis Nutt</a>  Area Director
Mecklenburg	<a href="#">Mecklenburg County Area MH DD &amp; SA Authority</a> 429 Billingsley Road Charlotte, NC 28211-1098 (704) 336-2023 (704) 336-4383-FAX Emergency (704) 336-6404 or (877) 700-3001	<a href="#">Grayce Crockett</a>  Area Director
Onslow Carteret	<a href="#">Onslow Carteret Behavioral Healthcare Services</a> 165 Center Street Jacksonville, NC 28546 (910) 219-8000 (910) 219-8072-FAX (888) 737-0327 24 Hr. Emergency Services	<a href="#">Daniel Jones</a>  Area Director
Chatham Orange Person	<a href="#">Orange-Person-Chatham MH/DD/SA Authority</a> 100 Europa Dr. Suite 490 Chapel Hill, NC 27517 (919) 913-4000 (919) 913-4003-FAX (800) 233-6834 Emergency Phone Number	<a href="#">Judy Truitt</a>  Area Director
Cleveland Gaston Lincoln	<a href="#">Pathways MH/DD/SA</a> 901 S. New Hope Rd. Gastonia, NC 28054 (704) 884-2501 (704) 854-4809-FAX (800) 898-5898 Access/Care Management	<a href="#">W. Rhett Melton</a>  Area Director
Cabarrus	<a href="#">Piedmont Behavioral Healthcare</a>	<a href="#">Dan Coughlin</a>

Davidson Rowan Stanly Union	245 LePhillip Court Concord, NC 28025 (704) 721-7000 (704) 721-7010-FAX (800) 939-5911 Access Call Center	Area Director  <i>*Contracts with High Point, Crisis Recover, Stanley, Old Vineyard</i>
Anson Harnett Hoke Lee Montgomery Moore Randolph Richmond	<a href="#">Sandhills Center for MH/DD/SAS</a> PO Box 9 West End, NC 27376-0009 (910) 673-9111 (910) 673-6202-FAX (800) 256-2452 Emergency Phone Number	<a href="#">Michael Watson</a> <a href="#">CEO</a>
Alleghany Ashe Avery Cherokee Clay Graham Haywood Jackson Macon Swain Watauga Wilkes	<a href="#">Smoky Mountain Center</a> PO Box 127 Sylva, NC 28779 (828) 586-5501 (828) 586-3965-FAX (800) 849-6127 Emergency Phone Number  <i>*Wilkes Daytime 336-667-5151</i>	<a href="#">Tom McDevitt</a> Area Director
Brunswick New Hanover  Pender	<a href="#">Southeastern Center for MH/DD/SAS</a> 2023 S. 17th St., PO Box 4147  Wilmington, NC 28406 (910) 251-6440 (910) 796-3133-FAX (910) 251-6551 or (866) 875-1757 Emergency Phone Numbers	<a href="#">Art Costantini</a> LME Area Director
Bladen Columbus  Robeson Scotland	<a href="#">Southeastern Regional MH/DD/SA Services</a> 450 Country Club Road  Lumberton, N. C. 28360 (910) 738-5261 (910) 738-8230-FAX (800) 672-8255 Crisis/Emergency Phone Number (800) 670-6871 Access Line (800) 760-1238 Customer Services	<a href="#">Sharen Prevatte</a> Area Director & CEO
Wake	<a href="#">Wake County Human Services</a> 220 Swinburne St., PO Box 46833 Raleigh, NC 27620-6833 (919) 212-7301	<a href="#">Ramon Rojano</a> Director

	(919) 212-7309-FAX (919) 250-3133 or (800) 682-0767 Emergency Phone Numbers	
Buncombe Henderson Madison Mitchell Polk Rutherford Transylvania Yancey	<a href="#">Western Highlands Network</a> 356 Biltmore Avenue Asheville, NC 28801-4594 (828) 225-2800 (828) 252-9584-FAX (800) 951-3792 Emergency Phone Number	<a href="#">Arthur D Carder, Jr.</a> CEO

<b>MENTAL HEALTH CENTERS</b>		
<b>County</b>	<b>City</b>	<b>Phone</b>
Alamance/Caswell Rockingham <small>*Rockingham co will authorize indigent beds at Moses Cone or Alamance (must refer there before CRH auth will be given)</small>	Burlington	(336) 513-4200
Albermarle	Elizabeth City Edenton Manteo	(252) 335-0803 (252) 482-7493 (252) 473-1135
Western Highland (Buncombe, Madison, Mitchell, Yancey)	Asheville	(828) 225-2800
Catawba	Hickory	(828) 327-2595
Cumberland	Fayetteville	(910) 323-0601
Davidson	Lexington	(336) 242-2450
Duplin, Sampson, Lenoir, Wayne		(800) 913-6109
Durham	Durham	(919) 560-7200
Edgecombe/Nash	Rocky Mount	(252) 937-8141
Cawtaba Valley Behavioral Burke Caldwell McDowell Cawtaba	Morganton Lenoir Marion Hickory	(828) 438-6228 (828) 757-5685 (828) 652-5444 (828) 695-5900

<b>County</b>	<b>City</b>	<b>Phone</b>
Behavioral Health Plaza CenterPoint Human Services (Forsyth, Stokes, Davie) Daymark Recovery Services(Forsyth, Davie, Stokes, Davidson, Rowan, Stanly, Union, Cabarrus) Triumph( Forsyth, Davie, Stokes)		(336) 725-7777  (888) 581-9988 (888) 581-9988  (336) 725-7777
Gaston/Lincoln	Gastonia	(800) 898-5898
Guilford	Greensboro High Point	(336) 641-4981 (336) 845-7946
Halifax, Vance, Granville, Franklin, Warren	Roanoke Rapids	(877) 619-3761
Johnston	Smithfield	(919) 989-5500
Lee Harnett	Sanford Buies Creek	(919) 774-6521 (910) 893-5727
Mecklenburg	Charlotte	(704) 336-2023
Neuse MHCs (Carteret, Craven, Jones, Pamlico)	New Bern Morehead City	(252) 636-6105 (252) 726-0515
New River MHCs Alleghany Ashe Avery Watauga Wilkes	Sparta Jefferson Newland Boone North Wilkesboro	(336) 372-4095 (336)246-4542 (828) 733-5889 (828) 264-8759 (336) 667-5151
Onslow	Jacksonville	(252) 353-5118
Orange, Person, Chatham		(919) 913-4100
Piedmont MHCs (Cabarrus, Stanley, Union)		(704) 721-7000
Pitt	Greenville	(252) 413-1600

Randolph	Asheboro	(336) 633-7200
Roanoke/Chowan MHCs (Bertie, Gates, Hertford, Northampton)	Ahoskie	(252) 332-5709
Rockingham	Wentworth	(336) 342-8316
Rutherford	Spindale	(828) 287-6110
Polk	Tryon	(828) 859-6661

<b>County</b>	<b>City</b>	<b>Phone</b>
Sandhills MHCs		
Moore	Pinehurst	(910) 295-6853
Hoke	Raeford	(910) 875-8156
Richmond	Rockingham	(910) 895-2462
Montgomery	Troy	(910) 572-3681
Anson	Wadesboro	(704) 694-6588
Lee	Sanford	(919) 774-6521
Randolph	Asheboro	(336) 633-7000
Randolph	Archdale/Trinity	(336) 431-0700
Smokey Mountain MHCs (Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain)	Dillsboro	(828) 586-5501
Southeastern Regional MHCs (Bladen, Columbus, Robeson, Scotland)	Lumberton	(910) 738-5261
ASAP (Surry)	Mt. Airy	(336) 786-7079
New River (Surry, Iredell)	Mt. Airy Elkin	(336) 783-6919 (336) 526-8335
Insight Services (Yadkin)	Yadkinville	(336) 679-8805
Tideland MHCs (Beaufort, Hyde, Martin, Tyrell, Washington)	Washington Plymouth Swanquarter Williamston	(252) 946-8061 (252) 793-1154 (252) 926-3751 (252) 792-5151
Trend MHCs (Henderson, Transylvania)	Hendersonville	(828) 692-5741
Vance, Warren, Granville, Franklin	Henderson	(252) 430-1330
Wake	Raleigh	(919) 250-3133
Wayne	Goldsboro	(919) 731-1133
Beacon Center (Wilson, Greene, Edgecombe, Nash)		Expected opening 7/1/07

**SECTION EIGHT:**  
**READING LIST**

## A READING LIST AND REFERENCE GUIDE FOR PSYCHIATRIC RESIDENTS

**Disclaimer:** *The following is not a comprehensive list. It also is not an endorsement of any particular author or publisher, and no author received or will receive any compensation or consideration for including books on this list. Some of the textbooks may have newer editions in press, so be sure to check the publication date before buying.*

### Reference Texts

- Diagnostic and Statistical Manual of Mental Disorders DMS-IV-TR. American Psychiatric Press; 4th edition (2000)
- American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders. Compendium 2006

### Comprehensive Texts

- The American Psychiatric Publishing Textbook of Psychiatry. Hales, Yudofsky, Gabbard Fifth Edition, April 2008
- Kaplan and Sadock's Comprehensive Textbook of Psychiatry (2) Volumes). Benjamin J. Sadock, Virginia A. Sadock. Lippincott Williams & Wilkins; 10th edition (May 2007)
- Treatments of Psychiatric Disorders. Glen O. Gabbard. American Psychiatric Publishing; 4th edition (2007)

### Board Preparation/General Study

- Massachusetts General Hospital Psychiatry Update & Board Preparation. Theodore A. Stern, John B. Herman. McGraw-Hill Professional, 2nd Edition (2003).
- Clinical Study Guide For The Oral Boards in Psychiatry. Nathan R. Strahl. American Psychiatric Publishing; 2nd edition (2005)
- Boarding Time: The Psychiatry Candidate's New Guide to Part II of the ABPN Examination. James R. Morrison, Rodrigo A. Munoz. American Psychiatric Publishing; 3rd edition (2003)
- The American Psychiatric Publishing Board Prep and Review Guide for Psychiatry. James A. Bourgeois, Robert E. Hales, Stuart C. Yudofsky. 1st edition (2006)
- Psychiatry Test Preparation and Review Manual. John C. Spiegel, John M. Kenny. Mosby (2006)

### Review Books

- Mnemonics & More for Psychiatry. David J. Robinson. Rapid Psychler Press; 3rd edition (2001)
- Psychiatry Pearls. Alex Kolevzon, Daniel Stewart. Hanley & Belfus (2004) (*Full disclosure: A. Garakani is an author of this textbook*)

### Forensic Psychiatry

- The Psychiatrist in Court: A Survival Guide. American Psychiatric Press, 1998
- Clinical Manual of Psychiatry and Law Simon Shuman 2007 American Psychiatric Publishing

### Psychopharmacology

- Essentials of Clinical Psychopharmacology. Alan F. Schatzberg, Charles B. Nemeroff. 2nd Edition 2006
- Manual of Clinical Psychopharmacology. Alan F. Schatzberg, Jonathan O. Cole, Charles DeBattista. American Psychiatric Publishing; 6th edition (2007)
- Essential Psychopharmacology: Neuroscientific Basis and Practical Applications. Stephen M. Stahl. Cambridge University Press; 2nd edition (2000)
- Clinical Handbook of Psychotropic Drugs. (Spiral-bound). K. Z. Bezchlibnyk-Butler, J.J. Jeffries, A.S. Virani. Hogrefe and Huber Publishers, 17th Edition (2007)

- Handbook of Psychiatric Drug Therapy. Jerrold F. Rosenbaum, George W. Arana, Steven E. Hyman, Lawrence A. Labbate, Maurizio Fava. Lippincott Williams & Wilkins; 5th edition (2005)
- Electroconvulsive Therapy: A Programmed Text. John L. Beyer, Richard D. Weiner, Mark D. Glenn. American Psychiatric Publishing; 2nd edition (1998)

### Neuroscience/Neuropsychiatry

- American Psychiatric Publishing Textbook of Neuropsychiatry and Clinical Neurosciences. Stuart C. Yudofsky, Robert E. Hales, 5th edition (2008)
- Windows to the Brain. Hurley and Taber American Psychiatric Publishing 2008
- Neuropsychiatric Assessment, Review of Psychiatry Volume 23. Yudofsky & Kim American Psychiatric Publishing 2004
- Clinical Neurology for Psychiatrists: David Myland Kaufman. Saunders; 6th edition (2006)

### Emergency/On Call Psychiatry

- Emergency Psychiatry. Randy Hillard, Brook Zitek., McGraw-Hill Professional; 1st edition (2003)
- On Call Psychiatry. Carol A. Bernstein, Ze'ev Levin, Molly E. Poag, Mort Rubinstein. Saunders; 3rd edition (2006)
- Handbook of Emergency Psychiatry. Jorge R. Petit. Lippincott Williams & Wilkins (2003)
- Assessment and Treatment of Suicidal Patients, Chiles & Strosahl APPI 2005

### Child Psychiatry

- The American Psychiatric Publishing Textbook of Child And Adolescent Psychiatry. Jerry M. Wiener, Mina K. Dulcan. 3rd edition (2003)
- Child and Adolescent Clinical Psychopharmacology. Wayne Hugo Green. Lippincott Williams & Wilkins; 4th edition (2006)
- Child and Adolescent Psychiatry. Sandra Sexson. Blackwell Publishing Limited; 2nd edition (2005)
- Clinical Manual of Child and Adolescent Psychopharmacology Findling. APPI 2008
- Concise Guide to Child and Adolescent Psychiatry. Dulcam, Martini, Lattae, AAPI 2003

### Geriatric Psychiatry

- Essentials of Geriatric Psychiatry Blaser, Steffens, Busse, APPI 2007
- Comprehensive Textbook of Geriatric Psychiatry. Joel Sadavoy, Lissy F. Jarvik, George T. Grossberg, Barnett S. Meyers, W.W. Norton & Company; 3rd edition (2004)
- Clinical Manual of Geriatric Psychopharmacology. Sandra A. Jacobson, Ronald W. Pies, and Ira R. Katz. American Psychiatric Publishing (2007)

### Addiction Psychiatry

- The American Psychiatric Publishing Textbook of Substance Abuse Treatment. Marc Galanter., Herbert D. Kleber. 4th edition 2008.
- Substance Abuse: A Comprehensive Textbook. Joyce H. Lowinson, Pedro Ruiz, Robert B. Millman, John G. Langrod. Lippincott Williams & Wilkins; 4th edition (2004)
- Clinical Manual of Addiction Psychopharmacology. Henry R. Kranzler. Domenic A. Ciraulo. American Psychiatric Publishing, Inc. (2005)

### General Interest

- Wyatt's Practical Psychiatric Practice. Terms and Protocols for Clinical Use. Chow. APPI 2005
- Neurotic Styles. David Shapiro. Basic Books (1999)

- The Practical Art of Suicide Assessment: A Guide for Mental Health Professionals and Substance Abuse Counselors. Shawn Christopher Shea. Wiley (2002)
- The Psychiatric Interview in Clinical Practice. Roger A. Mackinnon, Robert Michels, Peter J. Buckley. American Psychiatric Publishing; 2nd edition (2006)
- Night Falls Fast: Understanding Suicide. Kay Redfield Jamison. Vintage; 1st edition (2000)
- Psychiatry and the Cinema. Glen O. Gabbard, Krin Gabbard. American Psychiatric Publishing; 2nd edition (1999)
- Bad Men Do What Good Men Dream. Simon, APPI 2008
- How Doctors Think. Groopman Houghton Mifflin 2007
- Better Than Well: Elliott W. W. Norton 2003
- Rethinking Psychiatry: From Cultural Category to Personal Experience. Arthur Kleinman. Free Press (2005)
- Brave New Brain: Conquering Mental Illness in the Era of The Genome. Nancy C. Andreasen. Oxford University Press, USA; New edition (2004)

### Psychopathology

- Dementia Praecox or the Group of Schizophrenias. Eugene Bleuler. International Universities Press (1950)
- General Psychopathology, Volumes 1 & 2. Karl Jaspers (Author), J. Hoenig, Marian W. Hamilton (Translators). The Johns Hopkins University Press; Reprint edition (1977)
- The Mask of Sanity: An Attempt to Clarify Some Issues About the So Called Psychopathic Personality. Hervey Cleckley. Emily S. Cleckley; 5th edition (1988)
- Symptoms in the Mind: An Introduction to Descriptive Psychopathology. Andrew C. P. Sims. W. B. Saunders Company; 3rd edition (2002)
- Disorders of simulation: Malingering, Factitious Disorders, and Compensation Neurosis. Grant L. Hutchinson. Psychosocial Press (2001)

### Psychological Therapies

- Psychodynamic Psychiatry in Clinical Practice. Glen O. Gabbard. American Psychiatric Publishing; 4th edition (2005)
- Ego and Mechanisms of Defense. Anna Freud. International Universities Press (1971)
- The Freud Reader. Sigmund Freud (Author), Peter Gay (Editor). W. W. Norton & Company (1995)
- A Primer for Beginning Psychotherapy. William N. Goldstein. Brunner-Routledge (2001)
- Supportive Therapy: A Psychodynamic Approach. Lawrence H. Rockland. Basic Books (2003)
- Theory and Practice of Group Psychotherapy. Irvin D. Yalom. Basic Books; 4th edition (1995)
- Interpersonal Psychotherapy of Depression. Gerald L. Klerman, Eve S. Chevron, Myrna M. Weissman, Bruce Rounsaville. Basic Books (2001)
- Motivational Interviewing; Miller Rollnick Guilford Press. 2nd Edition (2002)
- Becoming a Therapist. Bender and Mossner. Guilford Press (2004)
- Psychoanalytic Psychotherapy: A Practitioner's Guide. Nancy McWilliams. Guilford Press (2004)
- Psychodynamic Diagnostic Manual. Alliance of Psychoanalytic Organizations (2006)
- Cognitive Therapy: Basics and Beyond. Judith S. Beck. The Guilford Press; 1st edition (1995)
- Cognitive-Based Treatment of Borderline Personality Disorder. Marsha Linehan. The Guilford Press (1993)
- Existential Psychotherapy. Irvin D. Yalom. Basic Books (1980)

### Memoirs/Personal Accounts

- Darkness Visible: A Memoir of Madness. William Styron. Vintage Books, 1st edition (1992)
- An Unquiet Mind: A Memoir of Moods and Madness. Kay Redfield Jamison. Vintage (1997)
- A Beautiful Mind: The Life of Mathematical Genius and Nobel Laureate John Nash. Sylvia Nasar. Simon & Schuster (2001)
- Girl, Interrupted. Susanna Kaysen. Vintage; Reprinted (1994)

- I Never Promised You a Rose Garden. Joanne Greenberg Signet (1989)
- The Quiet Room: A Journey Out of the Torment of Madness. Lori Schiller, Amanda Bennett. Warner Books: Warner Books (1996)
- Love's Executioner & Other Tales of Psychotherapy. Irvin D. Yalom Harper Perennial (2000)
- A Fan's Notes, Frederick Exley

<b>Novels</b>
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- When Nietzsche Wept: A Novel of Obsession. Irvin D. Yalom. Harper Perennial (2005)
- Lying on the Couch: A Novel. Irvin D. Yalom. Harper Perennial (1997)
- Mount Misery. Samuel Shern. Ballantine Books (2003)
- One Flew over the Cuckoo's Nest. Ken Kesey. Penguin Books (2003)
- The Bell Jar. Sylvia Plath. Perennial (1999)
- Spectacular Happiness. Peter Kramer
- The Moviegoer. Walker Percy
- Love In the Ruins. Walker Percy