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SECTION ONE:

INTRODUCTORY MATERIAL
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 University, 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, the single-A baseball team an affiliate of the Chicago White Sox, the Winston-Salem Dash, 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, and several retail projects in the financial section of the inner city.
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 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 it was 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 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 medical school consists of 120 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.” In addition, our medical center is now recognized as Wake Forest Baptist Health after a merger between hospital and the medical school.
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 and is currently under expansion.

Today the Medical Center boasts the most advanced technologies available including the positron emission tomography [PET] center, a magneto encephalography [MEG] suite and a gamma knife facility. The center has 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, Tox-line, 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.
SECTION TWO:

WELCOME TO WAKE FOREST PSYCHIATRY RESIDENCY PROGRAM
# HISTORY LINE

<table>
<thead>
<tr>
<th>BGSM</th>
<th>YEAR</th>
<th>WFUBMC</th>
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<tbody>
<tr>
<td>Founding of School of Medicine</td>
<td>1902</td>
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<tr>
<td></td>
<td></td>
<td>1923 NCBH opens with 88 beds; Rev. Lumpkin, Super.</td>
</tr>
<tr>
<td>Dr. Coy C. Carpenter, Dean</td>
<td>1936</td>
<td></td>
</tr>
<tr>
<td>School moves to Winston-Salem and becomes four-year Bowman Gray</td>
<td>1941</td>
<td></td>
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<tr>
<td>School of Medicine; joins NCBH to form the medical center, Bowman</td>
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<tr>
<td>Gray’s Department of Clinics opens.</td>
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<tr>
<td></td>
<td></td>
<td>1942 Hospital expands - 300 beds</td>
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<td></td>
<td></td>
<td>1945 Reed Holmes – President</td>
</tr>
<tr>
<td>Department of Neuropsychiatry opens</td>
<td>1946</td>
<td>Outpatient department opened</td>
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<tr>
<td>Department of Neuropsychiatry becomes the Department of Psychiatry</td>
<td>1953</td>
<td></td>
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<tr>
<td>and Neurology</td>
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<tr>
<td>Lloyd J. Thompson, M.D. (1953-1956) Chairman of the Department of</td>
<td>1953</td>
<td></td>
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<tr>
<td>Psychiatry and Neurology</td>
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<tr>
<td>Angus C. Randolph, M.D. (1957-1959) Interim Chairman of the</td>
<td>1957</td>
<td>Hospital Expands-450 beds</td>
</tr>
<tr>
<td>Department of Psychiatry and Neurology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Richard C. Proctor, M.D. (1960-1985) Chairman of the Department of</td>
<td>1960</td>
<td></td>
</tr>
<tr>
<td>Psychiatry and Neurology</td>
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<tr>
<td>Dr. Richard Janeway, Dean</td>
<td>1971</td>
<td></td>
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<tr>
<td></td>
<td>1973</td>
<td>Hospital expands - 701 beds (Reynolds Tower)</td>
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<td></td>
<td>1974</td>
<td>Dr. Manson Meads becomes Director of the Medical Center</td>
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<td></td>
<td>1974</td>
<td>John Lynch – President</td>
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<tr>
<td>The Department of Psychiatry and Neurology becomes the Department</td>
<td>1979</td>
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<td>of Psychiatry and Behavioral Medicine</td>
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<td>of Psychiatry and Behavioral Medicine</td>
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<tr>
<td>Period</td>
<td>Event</td>
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<tr>
<td>1987</td>
<td>1990 Clinical Sciences Building opens</td>
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<tr>
<td>1992</td>
<td>PET Center opens</td>
<td></td>
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<tr>
<td>1995</td>
<td>Dr. James Thompson, Dean</td>
<td></td>
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<tr>
<td>1996</td>
<td>1996 Ardmore Tower Opens (Emergency Department and Cafeteria)</td>
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<tr>
<td>1996</td>
<td>Comp Rehab Plaza Opens</td>
<td></td>
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<tr>
<td>2001</td>
<td>2004 Comprehensive Cancer Center</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>Name change: Wake Forest Baptist Health</td>
<td></td>
</tr>
<tr>
<td>2012-Present</td>
<td>Stephen I. Kramer, M.D. (2012-Present) Interim Chairman of the Department of Psychiatry and Behavioral Medicine</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>Outpatient Psychiatry moves from Janeway Tower to Jonestown Road Location.</td>
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</table>
CHAIRMAN

DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL MEDICINE

Interim Chairman

Stephen I. Kramer, M.D., accepted the appointment as Interim Chair in July, 2012. A native of Hartford, Connecticut, he obtained this undergraduate education at the University of Pennsylvania and his medical degree from the Jefferson Medical College of Thomas Jefferson University. Dr. Kramer completed his residency in psychiatry at Yale University School of Medicine and a fellowship in consultation-liaison psychiatry (now called psychosomatic medicine) at Yale-New Haven Medical Center where he was also chief resident in psychiatry.

Dr. Kramer joined the full-time faculty of the Department of Psychiatry and Behavioral Medicine in 1989 and his career path grew as a dedicated clinician-educator with promotion to Professor. For 14 years he served as the department’s residency training director of the general psychiatry program and received national recognition on the Executive Council of the American Association of Directors of Psychiatric Residency Training where he chaired the Information Committee and designed the model curriculum project.

A Distinguished Fellow of the American Psychiatric Association, he is an active member of the North Carolina Psychiatric Association and served as its president in 2008-2009. Dr. Kramer is a substantial contributor to the efforts of the American Board of Psychiatry and Neurology, contributing his time as Chief of Staff of an oral examination team and sitting on three test writing and test assembly committees. He is certified by that board in psychiatry and forensic psychiatry.

Dr. Kramer’s subspecialty practice areas are neuropsychiatry and forensic psychiatry. He is medical director of our adult inpatient service and is director of our neuropsychiatry and forensic psychiatry services. His research interests include new drug and brain stimulation development, neuroimaging, and bedside neuropsychiatric testing.

A conservatory-trained musician, in his spare time Dr Kramer enjoys playing his violin, made in 1778 by Caron for Marie Antoinette’s orchestra.
CORE FACULTY AND THEIR SPECIALTIES

Elizabeth M. Arnold, Ph.D.
Associate Professor
Adolescent Health
Mood Disorders
Risk Behaviors
HIV Prevention
Suicidal Behavior

Katherine Atala, M.D.
Associate Professor
Perinatal and Reproductive Psychiatry
Women's Issues in Psychotherapy
Psychiatry Disorders in relation to hormonal concerns

Gretchen Brenes, Ph.D.
Associate Professor
Geriatrics
Behavioral Medicine
Anxiety and Stress
Psychotherapy
Women's Health Issues
Grief

Thomas Brown, M.D., J.D.
Assistant Professor
Medical Director, Substance Abuse Services

Tereia S. Cook, LCAS LPC CCS
Addiction Counselor

Larry W. Freeman, D.Min. LCAS
Assistant Professor
Continuing Education
Area Health Education Center

Marcus M. Gulley, M.D.
Associate Professor Emeritus
General Adult Psychiatry

Matthew G. Hough, D.O.
Assistant Professor
Director, Child/Adolescent Outpatient Services
General Child Psychiatry

Robin A. Hurley, M.D.
Professor
Neuropsychiatry
Research

Sebastian Kaplan, PhD
Assistant Professor
Child/Adolescent Psychiatry
Adult Psychiatry
Family Therapy
Trauma
School-Based Mental Health

James N. Kimball, M.D.
Assistant Professor
Director, Adult Resident Education
Director, Consultation-Liaison Services
Director, Adult Outpatient Services
Director, Electroconvulsive Therapy
Electroconvulsive Therapy
Psychosomatic Medicine
Mood Disorders
Substance Abuse

Tim King, M.D.
Assistant Professor
Child & Adolescent Medicine
Pervasive Developmental Disorders
Anxiety Disorders in children

Yelena Komissarova, M.D.
Assistant Professor
Adult Inpatient Services
Child/adolescent Outpatient Services

Stephen I. Kramer, M.D.
Professor and Chairman
Medical Director, Adult Inpatient Services
Director, Neuropsychiatry Service
Director, Forensic Psychiatry Consultants
General Adult Psychiatry
Neuropsychiatry
Forensic Psychiatry
Psychiatry Education
Research

Dean Melton, LCAS
Instructor
Director of Addiction Programs
Guy K. Palmes, M.D.
Associate Professor
Section Head, Child/Adolescent Psychiatry
Medical Director, Child/Adolescent Inpatient
Child & Adolescent Psychiatry
Developmental Disorders
Psychiatry Education
College Medicine / Student Health

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

Amy Singleton, M.D.
Assistant Professor, Department of Psychiatry
Assistant Professor, Department of Emergency Medicine
Director, Emergency Psychiatry Services
Assistant Director, Adult Residency Education

Bryan Smith, MD
Assistant Professor
General Adult Psychiatry

Charlie Suttenfield, Ph.D.
Assistant Professor
Psychological Consultant to Burn Center and Cardiac Transplantation Team
Rehabilitation Psychology
Chronic Pain Management
Trauma
Geriatric Psychology
Cognitive Behavioral Psychotherapy
Emergency Consultation/Liaison Services
VOLUNTEER CLINICAL FACULTY

Chris Aiken, MD
Clinical Instructor

David Branyon, MD
Clinical Instructor

Iverson Brooks Carter, MD
Clinical Instructor

Stephanie Daniel, PhD
Adjunct Assistant Professor

Palmer Edwards, MD
Clinical Associate Professor

Anthony Frasca, MD
Clinical Associate Professor

David Goldston, PhD
Adjunct Associate Professor

Kim Hutchinson, EdD, APRN
Clinical Associate Professor

J. Ray Israel, MD
Clinical Associate Professor

Mary Jacobsen, PsyD
Clinical Associate Professor

Ali Jarrahi, MD
Clinical Associate Professor

Edward C. Jones, MD
Clinical Associate Professor

Beverly N. Jones, MD
Clinical Associate Professor

Arthur Kelley, MD
Clinical Associate Professor

Kevin A. Kilbride, MD
Clinical Assistant Professor

Lea H. Kirkland, MD
Clinical Assistant Professor

George Krebs, MD
Clinical Assistant Professor

Saule E. Kulubekova
Adjunct Instructor

Philip H. Lavine, MD
Clinical Assistant Professor

Jessica U. Lay, MD
Clinical Assistant Professor

Steven L. Mahorney, MD
Clinical Assistant Professor

W. Vaughn McCall, MD, MS
Adjunct Professor

William L. Michielutte, PhD
Clinical Assistant Professor

Eugene D. Mindel, MD
Clinical Assistant Professor

German Molina, MD
Clinical Assistant Professor

Mary Patricia Moore, MD
Clinical Instructor

Philip A. Nofal, MD
Clinical Instructor

David Patterson, MBA
Adjunct Assistant Professor

Frantz E. Pierre, MD
Clinical Assistant Professor

Pamela Pittman, MD
Clinical Assistant Professor

Rommel Ramos, MD
Clinical Assistant Professor

Randy Readling, MD
Clinical Associate Professor

Chris Rodriguez, MA
Clinical Instructor

Peter B. Rosenquist, MD
Clinical Professor

Jared A. Rowland, PhD
Adjunct Instructor

Jeff Smith, PhD
Clinical Assistant Professor

Rebecca Valla, MD
Clinical Instructor
RESIDENTS AND CHILD/ADOLESCENT FELLOWS 2012-2013

CHILD AND ADOLESCENT PSYCHIATRY FELLOWS:
- William Carson Felkel II, M.D. - Loyola University of Chicago Stritch School of Medicine
- Ijaz Rasul, M.D. - Ziauddin Medical College
- Shahzad K. Ali, MBBS (2nd Year) - King Edward Medical University, Lahore, Pakistan
- Debbie Davis, M.D. (2nd Year) - Saba University School of Medicine, Netherlands Antilles
- Tara Ferren, M.D. (2nd Year) - Wake Forest University School of Medicine

FOURTH-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. (co-chief) - Marshall University School of Medicine
- Omar Rana, D.O. - Edward Via Virginia College of Osteopathic Medicine
- Steven Sand, M.D. (co-chief) - Case Western Reserve University School of Medicine
- Lao Yang, M.D. - University of Minnesota Medical School

THIRD-YEAR GENERAL PSYCHIATRY RESIDENTS:
- Lee Bourgeois, M.D. - Ross University School of Medicine
- Heather Clark, M.D. - Wake Forest University 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

SECOND-YEAR GENERAL PSYCHIATRY RESIDENTS:
- Xavier Belcher, M.D. - Virginia Commonwealth University School of Medicine
- Tiffani Bell, M.D. - Virginia Commonwealth University School of Medicine
- Patrick Harmon, M.D. - Medical University of South Carolina School of Medicine
- Richard Jackson, M.D. - Wake Forest University School of Medicine
- Ryan McQueen, M.D. - Virginia Commonwealth University School of Medicine
- Sandarsh Surya, M.D. - Kempegowda Institute of Medical Sciences
- David Tatum, D.O. - Touro University-California College of Osteopathic Medicine

FIRST-YEAR GENERAL PSYCHIATRY RESIDENTS:
- Oluseun Daniel Ayanga, M.D. MPH - University of Lagos
- Frederick Austin Boyer, D.O. - Kansas City University of Medicine
- Christian Cespedes, D.O. - Edward Via Virginia College of Osteopathic Medicine
- Kelechi Emereonye, M.D. - Abia State University
- Catherine Green, M.D. - University of North Carolina Chapel Hill
- Raunak Khisty, M.D. MPH - Krishna Institute of Medical Sciences
- Olga Thompson, M.D. - Moscow Medical Academy
LORETTA Y. SILVIA TEACHING AWARD

Eligibility: All clinical faculty members are eligible.

Criteria: This award is presented to a 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, her 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.

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

Occurrence: The award is presented at the Senior Graduation Banquet each spring.

PREVIOUS AWARD RECIPIENTS:

2006: Loretta Silvia, Ph.D.
2007: Harold Elliott, M.D.
2008: Eugene Mindel, M.D.
2009: Donald Peters, M.D.
2010: Stephen I. Kramer, M.D.
2011: Eugene Mindel, M.D.
2012: Rommel Ramos, M.D.
SECTION THREE:
OVERVIEW OF THE
PSYCHIATRY RESIDENCY PROGRAM
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, or neuropsychiatry. A Child/Adolescent Psychiatry Fellowship Program began in 1993.

Clinical rotations include the following experiences:

1. Inpatient adult psychiatry at Wake Forest Baptist Health
2. Inpatient geriatric psychiatry at the Veterans Administration Medical Center in Salisbury, NC
3. Outpatient primary care at the Veterans Administration in Winston-Salem and Salisbury, NC
4. Suboxone clinic at Wake Forest Baptist Health
5. Addiction Psychiatry at the Veterans Administration Medical Center in Salisbury, NC
6. Emergency medicine experience at Wake Forest Baptist Health
7. Outpatient pediatrics at Wake Forest Baptist Health
8. Outpatient neurology at Wake Forest Baptist Health and at the Veterans Administration in Salisbury, NC
9. College student mental health experience at Wake Forest University
10. Child/adolescent outpatient psychiatry at Wake Forest Baptist Health
11. Assertive Community Treatment (ACTT) program
12. Medication management clinic at the Samaritan Homeless Shelter for at risk populations
13. Forensic psychiatry rotation at Wake Forest Baptist Health
14. Consult Liaison psychiatry and Emergency Psychiatry at Wake Forest Baptist Health
15. Neurobehavioral Psychiatry at Wake Forest Baptist Health
16. Geriatric outpatient psychiatry at Wake Forest Baptist Health
17. Adult outpatient psychiatry at Wake Forest Baptist Health and the Veterans Administration in Winston-Salem
18. Electives in rural mental health, inpatient child psychiatry, research, geriatric home-bound programs
19. Selectives at the Veterans Administration Medical Center in Salisbury in a variety of outpatient and inpatient psychiatry experiences

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 psychotherapy supervision are required for the PG-II, PG-III and PG-IV years of training. This may be a combination of individual or individual and group psychotherapy supervision. 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 series provides weekly instruction in fundamentals of 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 series, and the Advanced Test-Taking Skills Seminar. Journal club takes place in a monthly seminar and Forensic Psychiatry didactics take place during 4 Grand Round Lectures during the year. Practical Life Skills seminar is provided for graduating residents their final year. This lecture is designed to get graduates ready for the start of their careers after graduation.
DIRECTOR OF ADULT RESIDENCY EDUCATION

James N. Kimball, M.D. is the Director of Residency Education as well as the Director of the Consultation /Liaison Service in the Department of Psychiatry and Behavioral Medicine at Wake Forest Baptist Health. Dr. Kimball grew up in Bellmar, 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 also the director of outpatient services and is responsible for coordinating psychotherapy supervision.

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

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. Duties also include interviewing all prospective applicants for the program and leading the residency selection committee.

2. Developing and maintaining a comprehensive training program of the highest quality, including:
   a. Maintaining clinical rotations with excellent supervision and of a variety of clinical experiences to reflect psychiatry as it is practiced today
   b. Being a liaison between Wake Forest and other rotation sites
   c. Helping to assign faculty supervisors for residents
   d. Performing exit interviews for graduating residents and signing off on letters for ABPN
   e. Having weekly meetings with the assistant training director and the chief residents to foster program communication
   f. Planning and overseeing educational seminars to ensure coverage of basic knowledge in the field of psychiatry and neurology – specifically responsible for biological seminar curriculum and content
g. 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 and assisting in disciplinary issues

h. Being aware of and enforcing ACGME requirements for psychiatric residency education in the curriculum

i. Directly involving the residents in curriculum development and evaluation

j. Orienting new residents to the training program

k. Performing semi-annual reviews on PGY 2-4 residents

l. Organizing annual graduation dinner

3. Being a member of the Educational Policy Committee

   a. Organizing the semi-annual retreat for EPC

4. Maintaining membership in the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry

   a. Going to the annual AADPRT meeting and participating in various committees

**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, core competency examinations, and other competency measures.
ASSOCIATE DIRECTOR OF ADULT RESIDENCY EDUCATION

Amy Singleton, M.D. is the Assistant Director of Adult Residency Education in the Department of Psychiatry and Behavioral Medicine at Wake Forest University Health Sciences. She is board certified in Emergency Medicine and General Psychiatry and has dual appointments as Assistant Professor in both the Department of Emergency Medicine and the Department of Psychiatry and Behavioral Medicine at Wake Forest.

She received her Doctor of Medicine degree at East Carolina University, Brody School of Medicine and completed her Emergency Medicine internship and residency at Pitt County Memorial Hospital, East Carolina University. She practiced emergency medicine for five years before returning for a second residency in psychiatry at Wake Forest University. After completing her psychiatry residency, she went into a hospital based private practice setting where she worked in both inpatient and outpatient psychiatry until she decided to join the psychiatry faculty at Wake Forest in 2011.

Presently, Dr. Singleton’s faculty responsibilities include seeing patients in an outpatient faculty private practice combined with teaching and administrative duties as Assistant Training Director. She is a suboxone provider, supervises two resident outpatient teaching clinics, and is the Director of Emergency Psychiatry Services where she oversees emergency department consult-liaison services. Additionally, she provides resident seminars and didactics and is actively involved in curriculum development for the program.

RESPONSIBILITIES:
The following areas are the direct responsibilities of the Assistant Program Director:

1. Work with EPC to oversee and ensure the quality of the didactic and clinical education in all sites that participate in the program

2. Collaborate with local directors at each participating site who are responsible for resident education to assure that resident supervision is occurring. Handle issues that arise related to clinical site supervision

3. Oversee the evaluation process of clinical rotation sites and handle issues related to feedback about clinical sites

4. Participate in semiannual resident reviews for PGY-1s

5. Assist in applicant selection to determine which candidates are granted interviews and assist in conducting applicant interviews during interview season

6. Work with EPC for determining that resident promotion requirements are met

7. Work with chief residents for resolution of resident conflicts and disciplinary actions when needed

8. Work with FTC Outpatient Director, Residency Program Coordinator, EPC, and Chief Residents for creating resident schedules for each academic year
CHIEF RESIDENT SELECTION PROCESS

PURPOSE: The position of Chief Resident is designed to provide the assigned resident an experience in administrative psychiatry. The experience provides an opportunity to exercise leadership skills and act as a liaison between the residents and faculty.

QUALIFICATIONS FOR CHIEF RESIDENT:

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

- Only residents who wish to be considered for appointment will be candidates for Chief resident.

- A resident who wishes to be considered for Chief should have no active disciplinary actions or letters of concern in his/her file, should be caught up on documentation and clinical duties, and should be in good standing with moonlighting, supervision hours, and duty hour requirements.

NOMINATION AND APPOINTMENT PROCEDURE: The residents will nominate and vote via secret ballot for 2 potential chief residents from the rising PGY4 and PGY5 classes. These nominees will then be submitted for consideration to the Director and Assistant Director of Psychiatry Resident Education for approval. The names will then be given to the EPC for approval and finally to the Department Chair for final approval and appointment.

In the event that there is only 1 PGY 4-5 candidate for Chief, then an Assistant Chief can be nominated and voted on by the residents from the rising PGY3 class. If no PGY4 or 5 residents are available to serve as chief, then 2 rising PGY3 residents may be appointed to serve in the positions.

The Department Chair will appoint the Chiefs in the spring of the academic year and the currently active chiefs will use this time for orientation of the new appointees. The currently appointed chiefs will end their duties June 30 of each year and the new Chiefs will assume their roles July 1 of each academic year.

Child psychiatry residents (fellows) may not serve as the department’s Chief Residents while actively participating in the fellowship program.

COMPENSATION: Chief residents receive an additional $500.00 annually. The funds are distributed equally in his/her paycheck throughout the academic year.
CHIEF RESIDENT DUTIES:

1. Assigns back-up coverage for the unexpected absence of an assigned resident or for work load reduction where needed

2. Orient new residents or rotating residents from other departments or institutions

3. Oversees preparation of the call schedule for residents by the required date (one and a half months before next quarter begins). This duty may be delegated to other residents for completion but requires approval of chief residents for final publication.

4. Prepares the clinical rotation assignments at the start of an academic year and when revisions are needed

5. Works with Department Chair or other designated faculty to schedule speakers for Ground Rounds held on the 1st and 3rd Friday of each month (September through June)

6. Orient medical students on clinical rotations

7. Participates as a member of the Educational Policy Committee and attends Senior Staff meetings

8. Participates as a 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 the 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

12. Provides appropriate/necessary yearly up-dates to the Resident Handbook

13. Functions as a mediator between residents, faculty and staff

14. Prepares the clinic on-call schedule one week prior to the first of every month and distributes a copy to those residents in clinic as well as secretaries, phone triage, and scheduling coordinators

15. Works with program directors on resident discipline issues

16. Meets weekly with program directors and runs resident meetings twice a month
SECTION FOUR:

SCHEDULING AND ROTATIONS
OVERVIEW OF 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, 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 exposure to primary care including emergency medicine, internal medicine/family medicine, and pediatrics 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 Wake Forest Baptist Health, 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, with one month at Wake Forest Baptist Health and one at the VA Medical Center in Salisbury 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 USMLE or COMLEX board exam by the end of the PGY-2 year of the resident’s training.

EFFECTIVENESS EVALUATION: Individual rotations are evaluated with 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 rotations will be dropped.
## Overview of Clinical Rotations

<table>
<thead>
<tr>
<th>YEAR</th>
<th>ROTATION</th>
<th>DURATION</th>
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<tbody>
<tr>
<td><strong>First Year</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Outpatient Neurology WFUBMC</td>
<td>1 month</td>
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<tr>
<td></td>
<td>Outpatient Neurology VA Salisbury</td>
<td>1 month</td>
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<tr>
<td></td>
<td>Primary Care: Outpatient Family Medicine/Internal Medicine – VA Sites</td>
<td>2 months</td>
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<tr>
<td></td>
<td>Emergency Medicine WFUBMC</td>
<td>1 month</td>
</tr>
<tr>
<td></td>
<td>Outpatient Pediatrics WFUBMC</td>
<td>1 month</td>
</tr>
<tr>
<td></td>
<td>WFUBMC Adult Inpatient Services</td>
<td>5 months</td>
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<tr>
<td></td>
<td>Salisbury VA Inpatient Geriatric Services</td>
<td>1 month</td>
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<tr>
<td><strong>Second Year</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Consultation-Liaison &amp; Emergency Psychiatry Service WFUBMC</td>
<td>5-6 months</td>
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<tr>
<td></td>
<td>Child Outpatient Psychiatry/Geriatric</td>
<td>5-6 months</td>
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<tr>
<td></td>
<td>Outpatient Psychiatry/Suboxone Clinic/Neurobehavioral Clinic/ECT/Geriatric Outreach (GO) Program</td>
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<td></td>
<td>Addictions – VA Salisbury</td>
<td>1 month</td>
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<td><strong>Third Year</strong></td>
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<tr>
<td></td>
<td>Adult Outpatient Psychiatry, WFUBMC</td>
<td>12 months</td>
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<tr>
<td></td>
<td>Student Health/VA Adult Outpatient Clinics – Salisbury or Winston-Salem</td>
<td>1-2 days/week for 12 months</td>
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<tr>
<td><strong>Fourth Year</strong></td>
<td></td>
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<tr>
<td></td>
<td>WFUBMC Adult Inpatient Service</td>
<td>1 month</td>
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<tr>
<td></td>
<td>HOT/Child Outpatient/ACTT/SA IOP</td>
<td>2 months</td>
</tr>
<tr>
<td></td>
<td>VA Selectives</td>
<td>3 months</td>
</tr>
<tr>
<td></td>
<td>Forensic</td>
<td>1 month</td>
</tr>
<tr>
<td></td>
<td>Electives</td>
<td>5 months</td>
</tr>
</tbody>
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CORE FACILITY NARRATIVE:
W.G. (Bill) Hefner VAMC (Salisbury VAMC)

Rural Site Overview and Populations Served: The Salisbury VAMC, located in Salisbury, NC, opened its doors for patient care in 1953. The main hospital encompasses over 1.2 million square feet of building space on 155 acres. Salisbury’s primary service area includes ~262,000 Veterans, covering a 24 county area of NC’s Central Piedmont Region. In 2012, Salisbury advanced to a Level 1C tertiary care hospital with 484 authorized beds: Community Living Center (CLC, 270), medical (31, 5 in ICU), surgical (13), psychiatric (115), domiciliary (55).

In addition to the hospital, Salisbury has four Community Based Outpatient Clinics (CBOC, Winston-Salem x 2, Hickory, Charlotte) and the Substance Abuse Intensive Outpatient Program (IOP). The Salisbury VAMC is in design phase for two 300,000 square feet Health Care Centers (HCCs, Charlotte and Winston-Salem, to be operational by FY2015).

Many exciting construction projects are currently in progress at the Salisbury campus including a 3-phase project for the Geriatrics (LTC) Center of Excellence (CoE).

Phase 1, to be completed in summer 2012, includes a freestanding 12-bed Hospice, renovations to the current LTC space creating a Main Street area with shops and activities, and a 6-bed Hotel that will provide overnight lodging for eligible Veterans.

Phase 2 (began April 2012) and 3 will involve full renovation / expansion of the current inpatient CLC spaces to create private rooms / baths, along with many other improvements. The following projects are approved for design in FY 2012 / construction in FY 2014: new laboratory building (25,000 sq ft); new 8-bed ICU located near surgical suites; and residential care for substance abuse/homeless.

Additionally, a new 69 bed Mental Health (MH) CoE is now in 3-phase construction, to be completed by FY2015 (See Appendix 1 for further details and photographs.) In FY 2011, the Salisbury VAMC treated over 84,248 unique Veterans, a 10.2% increase from FY 2009.
As of March 2012, FY12 numbers indicate that Salisbury is continuing to grow at 3.2% rate for unique Veterans and 8.3% for total visits. Although one of eight hospitals in the Mid-Atlantic Healthcare Network (VISN 6), in FY11 Salisbury VAMC had 20% of the VISN 6 total workload and remains one of the fastest growing medical centers in VHA. To date, Salisbury has 16,353 enrolled OIF/OEF Veterans (19%). Polytrauma clinics, caregiver support, case management, brain injury and rehabilitation clinics as well as specialty research programs are in place for this population.

Salisbury is a small town, situated ~ 50 miles from both Winston-Salem and Charlotte. The population is ~ 27,000. According to the National Rural Health Office and Bureau of Labor Statistics, the four surrounding counties to Salisbury have higher poverty rates, more unemployment, lower educational levels, and a lower per capita income. With the current economic recession, more patients are uninsured and seeking state and federal assistance. This trend has included many formerly privately insured Veterans now seeking Salisbury VAMC care.

The VHA Driving Time criteria indicate that additional rural clinics will be needed, as only 59% of Veterans in the Salisbury Patient Service Area (PSA) are within the 30-minute drive time goal to a VA clinic. The threshold criterion is to have 70% of Veterans within this 30-minute drive time. All 24 of Salisbury PSA counties have an IMU (Index of Medical Under service) score of 62.0 or less indicating that either the entire county or portions of the county are medically underserved. Nineteen (79%) of Salisbury catchment counties are identified as a HPSA (Health Professional Shortage area). These are Alexander, Alleghany, Anson, Ashe, Cabarrus, Forsyth, Gaston, Guilford, Iredell, Mecklenburg, Montgomery, Randolph, Rowan, Stanly, Stokes, Surry, Watauga, Wilkes and Yadkin. Only five counties are not considered to be a HPSA: Catawba, Davidson, Davie, Lincoln and Union.

### Comparison Data

<table>
<thead>
<tr>
<th>Comparison Data</th>
<th>Poverty Level</th>
<th>Not High School Graduate</th>
<th>Current Unemployment</th>
<th>Per Capita Income (2005-2009); USA-2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Population</td>
<td>13.80%</td>
<td>15.00%</td>
<td>9.6%</td>
<td>$38,846.00</td>
</tr>
<tr>
<td>4-County area*</td>
<td>14.91%</td>
<td>21.50%</td>
<td>10.99%</td>
<td>$22,682.00</td>
</tr>
</tbody>
</table>

*Davidson, Davie, Randolph, and Rowan counties (primary counties served)

For FY11, the top five Salisbury diagnoses are hypertension, diabetes mellitus Type II, posttraumatic stress disorder, hyperlipidemia and depression. The largest outpatient services are PC and MH with Salisbury serving as a national teaching site for the PACT model of care delivery. Both the medical and surgical subspecialties have grown tremendously over the last three years with surgical volume averaging approximately 200 cases per month (largely outpatient).

### History of Facility Affiliations:

Salisbury VAMC’s primary academic affiliation with Wake Forest School of Medicine/Baptist Medical Center (WFSM) began in 1995 with an extraordinary increase in collaborations in 2008-09. The outcome of this strategic planning included not only a new VAMC ACOS for Research and Education but also a renewed commitment to resident training and collaborative research. The Salisbury VAMC currently has a total of 48.6 training positions with WFSM. The Salisbury VAMC has three secondary affiliates. The newest, East Carolina University (ECU) School of Dentistry, was signed in May, 2012. The other secondary affiliates are Edward Via
College of Osteopathic Medicine (VCOM) in Blacksburg, VA (3.0 resident FTEE), and Carolinas Medical Center (CMC) in Charlotte, NC (1.0 resident FTEE). VCOM provides Salisbury both 3rd/4th year medical students. These have been wonderful collaborative relationships, allowing Salisbury to expand its rural health training mission. As Salisbury VAMC builds the Charlotte HCC (expected completion FY2015), the growing academic ties with CMC will bring additional opportunities, particularly for tele-health to Salisbury’s southern rural communities.

**Participation and Support from Affiliated Academic Institutions:** Salisbury has had very strong support from its affiliates in the last three years. Their enthusiasm is clearly demonstrated in the 2009 and 2010 OAA applications for GME enhancement. These newly awarded GME program enhancements are receiving very positive feedback from trainees, schools, patients, and VA staff attendings. (Data from evaluation measures will be discussed below.)

Further examples of the revitalized relationship include additional joint VA-WFSM faculty, the VAMC ACOS / R&E’s monthly meeting with the Dean, continuation of a WFSM-VA research collaboration task force, and consultations from WFSM faculty in development of the Salisbury’s PACT training center. Other ongoing examples of the affiliation support include continuation of the new initiatives begun in 2009 (e.g. VA ACOS / R&E membership in the faculty executive council and the Dean’s administrative group, graduate school partnership in the MIRECC research fellowships).

WFSM sponsors 58 ACGME fully accredited residency programs and received a 4 year “continued Accreditation” from the ACGME in June, 2009. The majority of the citations related to the Graduate Medical Education Committee’s (GMEC) Internal Review Protocol (all corrected). The school has 1095 full-time faculty, 664 house officers, and 12,850 medical center employees. In additions, 550 physicians are part-time clinical faculty. Responsibility and accountability for their graduate medical education programs falls to their GMEC, chaired by the Associate Dean for GME, Dr. Christopher Godshall, and the ACGME Designated Institutional Official, Ala Jo Koonts, Director of Medical Staff Services. The GMEC is appointed by the Dean and meets monthly, with several subcommittees to fulfill ACGME Institutional Requirements. A Web-based common curriculum, simulation lab, AHEC medical library, and the E*-value curriculum management system are further examples of institutional support.

Carolinias HealthCare System (CHS) is a vertically integrated hospital authority with over 48,000 employees and 600 care locations in NC and SC. Four of the hospitals are teaching institutions that support GME programs approved by the ACGME. The flagship medical center is CMC, an 874 bed facility in Charlotte, NC. CMC sponsors 18 ACGME fully accredited residency and fellowship programs and received an “exemplary” designation in 2004 and 2009. There were no institutional citations by the ACGME for the last two 5-year review cycles. The GME faculty consists of 300 MDs, 23 PhD’s and four dentists, with a ratio of 1.3 physicians to 1.0 resident. In addition, there are in excess of 1,000 CHS physicians who support the teaching program. The Senior Vice President of the academic division of Education and Research, Mary Hall, also acts as the DIO. Also within the Division of Education and Research are an accredited College of Health Sciences, a large simulation center, a fully staffed medical library, and a regional Area Health Education Consortium (AHEC).

As noted, a new affiliation agreement was signed between the Salisbury VA and ECU School of Dentistry, dental residency program in May, 2012. The original ECU General Dentistry Residency program began in 1979 and is fully accredited by the American Dental Association, Commission on Dental Accreditation, with last site visit in 2007. This residency has expanded to add a second tract that offers more advanced education and is newly accredited as of February, 2012. This new tract is a one year program for recent dental graduates to prepare for general practice or subspecialization with a rural health focus. Teaching faculty includes general dentists, pedodontist, oral and maxillofacial surgeons, endodontist, periodontist, and an orthodontist. Goals of the
residency include clinical skills for evaluation system disease, complex hospital-based dental care, consulting for emergencies, expert general dental skills and research, all learned in an interdisciplinary healthcare system focused on the underserved rural populations of NC with training in community clinics.

**Recruitment Plans for Trainees to Rural Training Venues:** There still exist many untapped eager Salisbury clinicians with much to contribute to resident education, areas in which residents can learn to practice state-of-the-art medicine in a rural setting. Physician and dental trainees are recruited through the affiliate residency programs with the national residency matching program and are fully integrated into the school training programs, receiving the same didactic and university teaching as the non-rural health trainees. The pharmacy, optometry, and psychology programs also use a national matching process and have had done very well in past match years. Details are in the individual program narratives and support letters. The sustained growth in workload provides great teaching cases.

A unique strength of VA resident training is exposure to diagnoses and consequences of war-related injuries. In response to the patient growth, VISN 6 leadership expanded Salisbury’s PC and specialty care, staffing the areas with many academically-minded clinicians who desire to teach. This blossoming of services has greatly enhanced Salisbury’s ability to provide high quality diversified interdisciplinary training and serves as a great “draw” for students choosing a residency location. Salisbury has the infrastructure to provide this additional training and has used created solutions to pass the initial struggles of establishing education in a rural area, including: using tele-health, new housing quarters, mentorship for academic projects, and using the previously successful programs (e.g. psychiatry, pharmacy, I.D., ophthalmology, and optometry) to serve as mentors to the new service lines in this RFP.

**Educational Environment and Goals:** As noted above, the tremendous growth has led to a multitude of new construction projects, all designed to accommodate increased trainees. Many areas have one-way viewing mirrors, and videoconferencing spaces / equipment are dispersed liberally throughout the campus with capability for joint supervision sessions, lecture, and/or procedure observation, as well as MOVI teleconferencing installation anytime requested. Salisbury’s new state-of-the-art learning center (~$1,000,000, operational 2010) serves as an education resource for all NC VA hospitals. It has simulation equipment (endoscopy, venopuncture, lifesaving simulation, bronchoscopy, etc.) and Smartboard technology for multiuse collaboration. There is full access to the NC AHEC digital medical library, providing free access to multiple full-text journals and textbooks, multi-resource sites such as M.D. Consult, literature searching OVID / MEDLINE, drug information, document delivery and 24/7 medical librarian access. Salisbury VAMC also has digital access to Medscape and other free accredited CE/CME courses.

The Salisbury Designated Education Officer is the ACOS for R&E with responsible oversight for all education and research programs. This position has been held by Robin A. Hurley, MD since Nov., 2008. Prior to this, Dr. Hurley was ACOS of MH, Salisbury VAMC for five years and has been a VHA employee for over 16. She is a non-paid WFSM Professor of Psychiatry & Radiology. Dr. Hurley has over 17 years of experience in medical education, beginning at Baylor College of Medicine. She has co-authored over 70 peer-review journal publications in neuroanatomy / neuroimaging education and an imaging textbook; was an elected member of Baylor’s Academy of Distinguished Educators; and a rare dual winner of the Fulbright & Jaworski excellence in education awards (Enduring Educational Materials, Teaching/Evaluation). Dr. Hurley is Director of Education for the VISN 6 MIRECC and is considered VHA expert on neuropsychiatric aspects of TBI. In FY09, the VISN 6 and Salisbury leaderships funded 11.3 other full time physician educators with protected teaching time (multiple disciplines) to ensure that all trainees had an excellent education. This rare funding commitment was extraordinary and demonstrated VISN and local level of commitment to education.
Integration and scope of training programs at VAMC: The Salisbury VAMC is committed to providing state-of-the-art care to all patients (urban and rural). Unfortunately, the tremendous dental and medical needs of Veterans in rural areas, when combined with very limited access to public transportation and to major highways and high poverty rate, all too often result in failure of Veterans to take advantage of needed services.

The Salisbury interprofessional model (PACT) provides patient-centered care, a comprehensive approach to assessing, planning, and meeting patients’ needs in which all disciplines partner together with patients to achieve optimal outcomes and work creatively to overcome the challenges of the rural area. Trainees are vital to the tenets of VHA (i.e. to provide excellent health care, research, education) and are easily incorporated into the clinical teams. Trainees are paired with supervising practitioners who are identified in the medical record and responsible for patient care. Team meetings are held frequently (daily for PACT) to ensure effective care coordination and discussions of patients’ physical, psycho-social, spiritual, and other needs, as well as risk for injury and barriers to learning. Other team members include patients / families, nursing, social work, nutrition, physical therapy, chaplain, occupational therapy, respiratory, audiology and speech pathology, and pharmacy. Any discipline that identifies a new problem communicates that problem and goal in an addendum to the plan of care and during team meetings. Members of the interdisciplinary team continually review for progress towards goals and/or treatment responses.

In keeping with this interdisciplinary treatment team model, for academic year 2012, Salisbury has over 710 trainees in many disciplines including nursing (340 RN, NA, MSN-NP), medical students (25), over 250 physician residents from 19 medical specialties, optometry residents (5 FTEE), optometry students (25), pharmacy under-graduates (35), pharmacy residents (4), psychology interns (4), social work interns (8), and physical therapy students. In addition to full integration into clinical teams, trainees participate in a host of interdisciplinary didactics and integrated learning sessions. Examples are: daily inpatient medicine/surgery rounds, M&M, hospital-wide lectures, LTC teaching rounds, and monthly MIRECC lectures.

Clinical Resources: Salisbury VA has ample clinical resources and physical space to support additional trainees. Patient volume, the inpatient bed designations, and outpatient clinics have been highlighted. Staffing levels have greatly expanded to accommodate patient growth and are more than adequate (> 1800 employees) for trainee supervision / education. There is a broad spectrum of disease states and illnesses to provide a thorough and varied resident learning experience. Areas built specifically for the trainees include the learning center and new housing quarters. In addition to the clinical renovations and expansions, Salisbury and its CBOCs have had many infrastructure advances including CPRS I-Site and VISTA displays of radiographic imaging available at all work stations, group and exam rooms with 1-way observation mirrors, multiple conference rooms with videoconferencing capability, and microscopes tied to V-telequipment.

Unique Educational and Clinical Strengths: Salisbury VAMC can provide many unique and valuable educational experiences for additional trainees. The medical center is located in close proximity to multiple military bases thus providing OEF/OIF Veterans for training in conditions that occur in younger post-war veterans (16,353 enrolled). The Level 3 Polytrauma Support Clinical Team (PSCT) provides evaluation and treatment of TBI. This team is interdisciplinary including PM&R, PC, neurology, SW, nursing, neuropsychiatry, psychopharmacology, and neuropsychology. Trainees from all specialties are welcome to complete a PSCT elective.

Salisbury VAMC houses the VISN 6 MIRECC Education component with specialty work in TBI, brain imaging, and neuroanatomy. There are 3 MIRECC fellowships that focus on understanding the
neuropsychiatric, visual, and neuropsychological conditions that develop post-deployment. The Vision Rehabilitation Research Laboratory (VRRL), established in 1995, includes eye movement and lighting/mobility labs. The availability of a strong Eye Clinic with clinical, research and educations programs in Advanced Low Vision and TBI, make the VRRL an ideal training site for all trainees interested in brain rehabilitation. Any trainee who rotates in one of these brain injury labs could write a case report or review paper, learn about the research regulatory process, grant preparation/submission, and production of scientific papers. Other unique educational strengths include the LTC and MH CoEs, new oncology clinic, sleep laboratory, and tele-health services.

**Rural Health Planning Grant Process and Results:** The Salisbury VAMC response to the Rural Health planning grant was submitted with approval in February 2012. This planning grant, which was used to hire a health systems specialist to support development of rural initiatives, was extremely helpful in many ways. Some of the significant accomplishments include: preplanning for the dental residency affiliations agreement with ECU; planning of the dental residency goals, objectives, and rotation details; gaining leadership support for protected time for the dental teaching staff; planning for the portable dental equipment needs; and gathering the large amount of data incorporated into the narratives in this submission.

**Evaluation of Success:** Evaluation strategies follow Office of Academic Affiliations guidelines. These are outlined in station Memorandum 00-205, “House Staff Review Committee”. Evaluation methods include: 1) resident supervision monitors; 2) resident feedback; 3) patient satisfaction surveys; 4) VHA performance measures and initiatives; and 5) VA staff and affiliate feedback. Resident supervision is monitored on a quarterly basis by the ACOS office and includes attending co-signatures, attending progress note addenda and timeliness. Patient satisfaction surveys will be evaluated to determine if increased resident presence translates to increased patient satisfaction.

Salisbury’s ability to meet and exceed performance measures and VHA initiatives are subject to constant monitoring and reporting. Performance improvement activities assure a constant formal process of quality improvement. Finally, VA staff and affiliate faculty feedback are obtained through formal and informal discussions. Results are reported to the Dean’s Committees. The trainees are evaluated in accordance with their accrediting body’s standards and formats. WFSM residents, for example, use the E-value system of evaluation.

In addition to the formal mechanisms listed above, Salisbury’s commitment to rural-health trainee feedback is very strong. The station developed a local survey that focuses on the rural health aspects of training and future practice goals (i.e.in a VA or rural area). Results from last year’s survey (23.3% responded, 37/159): preceptor evaluation, 95% positive; organization and oversight, 89% positive; considerations of VA as a career, 46% yes 24% maybe; consideration of a rural career, 38% yes 38% maybe. The listed strengths were: enthusiastic/knowledgeable preceptors, diversity / volume of pathology, fosters independence, good resources / equipment, and good opportunity for acquiring clinical decision making. Recommendations for improvement included: more interventional procedures and surgical cases, increase number of preceptors/faculty, and more orientation to VA. All graduating rural health trainees are tracked to ascertain if they enter a rural area for practice.
CLINICAL SUPERVISION

Supervision is provided in three basic formats:

- Faculty advisors (reference section seven)
- Supervision of psychotherapy
- 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 Education. 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 Education. 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, to advise the resident in terms of his present learning role as resident and future roles within psychiatry, to mediate and, if necessary, to advocate in conflicts with teaching hierarchy, and to facilitate the learning process with advice as to extra learning materials.

**Supervision of Psychotherapy:** Residents are assigned two supervisors for 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 per supervisor 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 (or 200 for those who do a child & adolescent tract and PGY-2 transfers).
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 points. The attending will also meet the patient when deemed clinically necessary either for the patient or a resident’s benefit. 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 or 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 his requirements on the inpatient unit.

Residents are given the opportunity to evaluate, in writing through E-Value, all rotations, services, educational experiences, and faculty. ALL evaluations completed on educators are anonymous. The educator is NOT able to see who completed his evaluation. Evaluations are designed not to be released until 3 are completed, hence ensuring anonymity. 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 on written and oral evaluations will be compiled and discussed during 2 personal meetings with the Director of Adult Resident Education for PGY2 – 5s and with the Assistant Director of Adult Resident Education for PGY1s. One meeting will be held at the conclusion of the first 6 months of the academic year, and the second meeting will be held at the conclusion of the academic year. 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 Director of Adult Resident Education. 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 annually on the first two Fridays in October. Each resident receives direct feedback on his performance. Cumulative data is given to the Director of Adult Resident Education during the first semiannual review.
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.
PGY-1 Schedule

NCBH ADULT INPATIENT PSYCHIATRY ROTATION

Director: Dr. Stephen Kramer

Team Leaders: Dr. Stephen Kramer
Dr. Thomas Brown
Dr. James Kimball
Dr. Yelena Komissarova

Location: Sticht Center, Wake Forest Baptist Health
Geriatric Inpatient Unit VAMC, Salisbury, NC

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.
14. To learn professional and ethical behavior in the care of their patients and in their interactions with other health care providers.
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. Each 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 for upper level residents with interns having daily lectures on Monday, Tuesday and Wednesday.

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.

**PLEASE REFER TO SECTION 5 MISC: MORNING REPORT / DAILY PATIENT CHECK OUT**

Competency-Specific Objectives:

**Patient Care:** Residents must be able to provide care of inpatients that is compassionate, appropriate and effective for the treatment of severe mental illness. Residents will:

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.

2. Gather accurate and complete information about their patients from the following sources: the patient; the patient’s family, friends and health care providers; the patient’s medical record.

3. Develop comprehensive bio-psychosocial assessments and differential diagnoses that incorporate genetic predisposition, developmental issues, co-morbid medical issues, substance use and abuse, ethnic/cultural/spiritual factors, economic issues, current relationships, psychosocial stressors and current mental status exam.

4. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and clinical judgment.

5. Counsel and educate patients and their families and demonstrate the ability to participate in and lead family meetings.

6. Use information technology to support patient care decisions and patient education, including on-line literature searches, electronic medical records and other computer-based resources.

7. Develop understanding of the use of psychotherapeutic strategies appropriate for an inpatient setting, including supportive techniques, cognitive-behavioral interventions and psychodynamic strategies.
8. Demonstrate competence to recommend the administration of electroconvulsive therapy (ECT). Specifically, residents will be able to:

a. Describe selection of appropriate patients for ECT, including psychiatric indications and medical/psychiatric contraindications

b. Educate patients and their families about the risks and benefits of and alternatives to ECT

c. Obtain informed consent for ECT from patients

9. Demonstrate competence in the management of behavioral emergencies, including verbal and behavioral de-escalation techniques and psychopharmacological management.

10. Work with mental health professionals of other disciplines and with physicians from other specialty services to provide patient focused care.

11. Demonstrate understanding of the mental health system and mental health resources available in the community and use this knowledge to participate in discharge planning and the development of appropriate aftercare plans.

12. Maintain the medical record appropriately, including dictated admission H&Ps, daily progress notes, consent forms and dictated discharge summaries.

Medical Knowledge: Residents must demonstrate knowledge about the neurobiological and psychological underpinnings of mental illness and will apply this knowledge to patient care. Residents will:

1. Demonstrate knowledge of the etiologies, prevalence, diagnosis, treatment, and prevention of the psychiatric conditions most likely to affect psychiatric inpatients.

2. Demonstrate understanding of the psychopharmacological treatment of mental illness, including treatment algorithms, the management of treatment-resistant illness, augmentation strategies and combination therapies.

3. Demonstrate understanding of the indications for and limitations of psychological testing and neuropsychological testing in an inpatient setting.

4. Demonstrate an investigatory and analytic approach to thinking through clinical situations.

Practice-Based Learning and Improvement: Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents will:

1. Seek feedback from their supervising attending and from other health care providers about their own practice and will use this feedback to improve their performance.

2. Use information technology to access on-line medical information and to support their education.

3. Locate, appraise and assimilate evidence from scientific studies related to their patients’ health problems.
4. Apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies.

5. Facilitate the learning of medical students and other health care providers.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families and other health care providers. Residents will:

1. Create and sustain a therapeutic and ethically sound relationship with patients, including the use of open and honest communication, the maintenance of empathic stance and the establishment of appropriate boundaries.

2. Use effective listening skills in interactions with patients, their family members and other health care providers.

3. Demonstrate competence in complex interviewing situations, such as interacting with patients with thought disorganization, cognitive impairment, paranoia, aggressiveness or inappropriate behavior.

4. Recognize and monitor their emotional responses to patients and adjust their practice accordingly.

5. Demonstrate proficiency in conveying difficult information to patients and their families.

6. Demonstrate an ability to work effectively with other health care providers as a member or leader of an interdisciplinary treatment team.

7. Effectively elicit information from and provide information to other health care providers, including nurses, social workers, occupational therapy staff, hospital unit coordinators and consulting physicians.

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

1. Demonstrate respect, compassion and integrity in all their interactions with patients, families and other health care providers.

2. Demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients that supersedes self-interest.

3. Appreciate the ethical issues that can arise in an inpatient psychiatric setting, including: patient autonomy; involuntary treatment; decisional capacity to accept or refuse psychiatric care; informed consent; the challenges imposed by financial constraints; confidentiality of patient information; and the potential for violation of appropriate boundaries.

4. Demonstrate sensitivity and responsiveness to patients’ culture, age, gender and disabilities
**Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value. Residents will:

1. Demonstrate understanding of the way in which their patient care affects and is affected by other health care providers and the mental health care system

2. Demonstrate an understanding of Wake Forest Baptist Medical Center’s mission to the community and to the State.

3. Practice cost-effective health care that does not compromise quality of care.

4. Collaborate with psychiatrists and other mental health providers in the community, medical consultants, and community organizations to provide for the best patient care.

5. Develop an understanding of the economics of inpatient psychiatric treatment and become aware of the impact of differences in health care financing strategies among the various governmental and private insurance programs.

6. Develop an understanding of regulations which affect inpatient psychiatric treatment, including: federal rules on seclusion and restraint; Wisconsin State Law regarding mental health commitment and guardianship; patient confidentiality and HIPAA regulations; and policies and procedures specific to University of Wisconsin Hospital and Clinics.

7. Advocate for quality patient care and assist patients in dealing with the larger mental health system.
GENERAL MEDICINE ROTATION AT SALISBURY VAMC

Director: Frank A. Labagnara, D.O., Internal Medicine/Family Medicine

Location: Internal Medicine/Family Medicine-Salisbury VAMC, located in Salisbury, North Carolina
Primary Care Clinics, Floor 3 and 4 of Building 3 on Salisbury VAMC Campus

Teaching Objectives:

1. Exposure to a diverse range of complex and singular medical problems/medical diagnoses that are likely to be encountered in a psychiatric population in the inpatient or outpatient setting.

2. To acquire the knowledge and the skill to use diagnostic criteria when performing assessments for patients utilizing the laboratory resources, imaging, etc.

3. To learn and practice the principles of medical management of common and complex medical problems.

4. To gain practical experience in the use and appropriateness of Medical and Surgical consultations in continuity of care regarding medical disorders.

5. To gain experience and practice with respect to professionalism, compassion, and empathy in a general medicine setting.

6. To work within a MEDICAL HOME Model (PACT) and learn its philosophy, advantages and goals.

7. To learn maintenance of confidentiality on patient’s behalf in regards to Substance Abuse (including alcohol) and Specific Diagnoses (HIV, Hep C). They will do the VA Clinical Reminders which help in risk assessment, suicide prevention, and disease prevention/screening. They will become acquainted with “duty to report” and Americans with Disability Act during the rotation.

Responsibilities:

1. The resident is assigned to the Salisbury VAMC for a 2 month rotation in the Primary Care Outpatient Clinic. The resident will work with a different preceptor each month to maximize the benefit of their clinical experience.

2. The resident is responsible to see the patient, review past records/notes, evaluate the pt by taking a pertinent history and doing a thorough pertinent physical exam. For new patients a standard History & Physical is expected to be completed with assessment/plan.

3. The resident is responsible for assessing the patient and producing a plan for care based on this visit and available studies, then presenting his recommendations (including lab studies, consults, imaging, etc.) to his attending, who will confirm the findings and approve the plan.
4. The Resident is responsible to notify the attending/preceptor of his schedule, noting if he will be out due to post call or educational duties. The resident is required to attend the educational programs held at Wake on Fridays or if changed to another day, then that day. The resident is encouraged and has ample opportunity to present didactic and clinical cases on this service and attend educational programs pertinent to their discipline while on rotation.

5. The Resident is responsible to report to his preceptor any indication of domestic abuse, elder abuse/neglect for review.

6. Resident is responsible for confidentially of patient’s health information.

7. Resident is responsible to report any perceived errors or omissions of care that become evident as soon as possible to his preceptor for discussion and determination.

**Competency Specific Objectives:**

I. **Patient Care:** At the end of their training, residents are expected to exhibit competency in the following areas:

   A. **Accumulation of data**
      i. Obtain and record a complete history, appropriate to clinical circumstances.
      ii. Make efficient use of both patient and family in gathering information.

   B. **Performance of physical examination**
      i. Recognize clinical situations which require a focused examination and those which require a complete examination.
      ii. Describe ways to modify the approach to the examination when faced with an uncooperative child.

   C. **Diagnosis and management of patients**
      i. Establish a differential diagnosis and assessment plan with appropriate prioritization.
      ii. Arrive at a decision or conclusion when reasonable data are available.
      iii. Complete prescriptions, consider potential document drug interactions, and provide patient education about medications.
      iv. Provide appropriate patient education regarding anticipatory guidance immunizations, development, diagnostic and treatment modalities and expected courses or outcomes.

   D. **Utilization of patient care resources**
      i. Identify the indications for referral.
      ii. Develop and understanding of community services when providing care to families in need.

II. **Medical Knowledge:** At the end of their months of training, residents are expected to demonstrate appropriate knowledge in the following areas:
A. Health maintenance
   i. Discuss knowledge of recommended periodicity schedules for routine health supervision visits and for the content of these visits.
   ii. Recognize normal and abnormal physiology causing the symptom(s).
   iii. Develop a differential diagnosis and plan with appropriate prioritization.
   v. Use of laboratory, x-ray, and ancillary services for diagnostic evaluation.
   vi. Interpret results of common tests.

B. Use of Educational Resources
   i. Use literature, including national 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 months of training, residents are expected to be developing competence in the following areas:

A. Utilization of Educational Resources
   i. Initiate and facilitate group discussion and teaching. Each resident is responsible for presenting 1-2 morning talks. See the schedule for your assigned date.
   ii. Each resident is expected to attend and participate in all of the morning lectures.

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

B. Communication with Members of the Health Care Team
   i. Maintain medical records properly and in a timely fashion. All 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 the month, residents are expected to develop and exhibit the following skills of medical professionalism:
   A. Evaluate and enhance performance based on self-assessment and feedback from others.
   B. Recognize one’s own limits and accept accountability for actions and errors.
   C. 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. Collaborate with other providers and staff to assess and improve clinic flow and quality of services.
   
   B. Develop awareness of financial and organizational structures in the practice of medicine.
   
   C. Consider cost-effectiveness and utilization of limited resources in development of care plans.
EMERGENCY MEDICINE ROTATION

Director: Emergency Medicine Dr. David Story
Location: Emergency Department Wake Forest Baptist Medical Center

Objectives and Responsibilities:

1. **Patient Care**: The resident should become adept at performing a problem-focused history and physical examination based on the patient’s chief complaint. The resident is expected to develop a list of potential diagnoses and an appropriate plan for sorting through that list, including laboratory analysis, imaging techniques, point-of-care testing, medical therapies, and consultation when indicated. Appropriate disposition (discharge, admit, observation, follow-up) is expected to be the final aspect of patient care.

2. **Medical Knowledge**: The resident should develop the acumen of identifying an acutely ill patient (emergent vs. urgent complaints). Developing a broad set of possible differential diagnoses should follow the patient interaction. Formulation and initiation of a treatment plan that will aid in identifying the proper diagnoses and rule out potentially catastrophic maladies, while concurrently treating active issues (pain, VS abnormalities, vomiting). Interpretation of data results, both laboratory and radiographic, is expected in order to properly treat and disposition the patient.

3. **Practiced Based Learning and Improvement**: The resident should show evidence of self-directed learning with an ability to seek out proper sources of information for questions regarding patient care and management.

4. **Interpersonal and Communication Skills**: Establishing rapport with patients to gain trust and provide a caring environment for treatment is a key to good patient care in the emergency department. Additionally, communication amongst members of the treatment team (nursing, physicians, techs, etc.) is paramount. All members of the team should know the basic plan regarding the treatment of the patient. This requires that the resident to effectively communicate what needs to be done for the patient, and in what order and with what urgency that those orders be performed.

5. **Professionalism**: All residents are expected to act in a respectful and responsible manner during their rotation in the emergency department. Residents will report on time for shifts, and missing or skipping shifts will be handled on an individual basis by the director, and will need to be re-scheduled. A courteous attitude towards all members of the patient care team is expected at all times. All should exhibit sensitivity towards the cultural, socioeconomic, and religious issues facing patients.

6. **Systems based Practice**: Residents should understand the confines of working within the system present. A good assessment of an undifferentiated patient is required to generate a plan for that patient’s medical work-up. That evaluation needs to include lab and imaging tests that are available in a timely fashion. Appropriate disposition also requires that the resident understand the options for patients that are under- or uninsured.

The majority of the instruction that occurs during the emergency medicine rotation is direct bedside teaching and discussion. The attending physician must see and evaluate all patients. The
residents generally perform the history and physical initially, develop a differential diagnoses list and plan, and then speak with the attending regarding it. This interaction is tailor made for educating the resident. It also allows the supervising physician to specifically identify areas of strength and weaknesses in the resident’s performance, so that the instruction given will be most beneficial.

Performing emergency medical procedures are also part of the rotation, varying from peripheral intravenous access to lumbar punctures to endotracheal intubation. We welcome the desire of rotating residents to perform these procedures when necessary on their patients, and are eager to teach and/or supervise when needed. Didactic lectures are available for rotating residents, but are not required, and do not comprise the bulk of teaching during this rotation.
DOWNTOWN HEALTH PLAZA
GENERAL PEDIATRIC CLINIC ROTATION

Director: Dr. Anna Miller-Fitzwater

Goals and Objectives for Psychiatry Residents on Pediatric 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 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 an 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. Utilization 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.
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.
   i. Each resident is responsible for presenting 1-2 morning talks. Each resident should check the schedule at the DHP for his assigned date.
2. Each resident is expected to attend and participate in all of the morning lectures (8:00 a.m.— 8:30 a.m.).

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 use interpreters appropriately.
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. Allison Brashear
Supervisor: Dr. Jane Boggs
Location: Wake Forest Baptist Health for one month with a second month at the VAMC in Salisbury, NC

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.

Competency Specific Objectives:

Patient Care: Residents must be able to provide care of patients that is compassionate, appropriate and effective for the treatment of neurological conditions.

1. Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Residents will demonstrate the ability to perform a relevant history and physical exam on culturally diverse patients, including: chief complaint, history of present illness, past medical history, a comprehensive review of systems, a biological family history, a socio-cultural history, a developmental history and a germane general and neurological examination.
3. Residents will develop an understanding of how to determine if a patient’s symptoms are the result of a disease affecting the central and/or peripheral nervous system or of another origin, e.g., somatoform.
4. Based on a comprehensive neurological assessment, residents will demonstrate the ability to determine a formulation, differential diagnosis, laboratory investigation, and management plan.

5. Residents will make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and sound clinical judgment.

6. Residents will demonstrate the ability to counsel and educate patients and their families.

7. Residents will participate in the administration and interpretation of neuropsychological tests and will correlate test findings with clinical data.

8. Residents will use information technology to support patient care decisions and patient education, including on-line literature searches, electronic medical records and other computer-based resources.

9. Residents will work effectively with health care professionals, including those from other disciplines, to provide patient-focused care.

Medical Knowledge: Residents must demonstrate knowledge about the neurobiological underpinnings of neurological illness and will apply this knowledge to patient care.

1. Residents will demonstrate familiarity with the scientific basis of neurology, including neuroanatomy, neuropathology, neurochemistry, neurophysiology and neuroimaging.

2. Residents will demonstrate understanding of the patho-physiology, epidemiology, diagnostic criteria and clinical course for common neurological disorders including:
   a. Dementia, including Alzheimer's disease, vascular dementia, mixed dementia, dementia with Lewy bodies and fronto-temporal dementia
   b. Epilepsy and related disorders
   c. Neuromuscular disorders
   d. Demyelinating disorders of the central nervous system
   e. Cerebrovascular disorders
   f. Infectious diseases of the nervous system
   g. Tumors of the nervous system
   h. Nervous system trauma
   i. Toxic and metabolic disorders of the nervous system
   j. Acute and chronic pain
   k. Sleep disorders
   l. Critical care and emergency neurology
   m. Coma and brain death
   n. Headache and facial pain
   o. Movement disorders including abnormalities caused by drugs
   p. Neurological manifestations/complications of common psychiatric disorders
   q. Psychiatric manifestations of common neurological disorders

3. Residents will demonstrate understanding of neuron-pharmacology, including major medications (e.g., anticonvulsant, anti-parkinsonian agents), side effects (hallucinations, mood changes) and neurological complications of psychototropic medications (e.g., movement disorders.)

4. Residents will be able to select appropriate treatment options, based on:
a. The nature of patients' history and physical findings and the ability to correlate the
findings with a likely localization for neurological dysfunction;
b. Likely diagnoses and differential diagnoses; and,
c. Risks and benefits of potential therapies

5. Residents will be able to describe the indications for and limitations of neuropsychological
testing, as well as psychometric properties such as validity and reliability.

**Practice Based Learning and Improvement**

1. Residents will seek feedback from their supervising attending and from other health care
providers about their own practice and will use this feedback to improve their performance.

2. Residents will apply knowledge of study design, statistical methods and evidence-based
medicine to the appraisal of clinical studies.

3. Residents will use information technology to manage information, access on-line medical
information and support their own education.

4. Residents will facilitate the learning of medical students and other health care providers.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate
interpersonal and communication skills that result in effective information exchange and teaming
with patients, patients' families and other health care providers.

1. Residents will create and sustain therapeutic and ethically sound relationships with patients,
including the use of open and honest communication, the maintenance of an empathic stance and
the establishment of appropriate boundaries.

2. Residents will use effective listening skills in interactions with patients, their family members
and other health care providers.

3. Residents will demonstrate proficiency in conveying difficult information to patients and their
families.

4. Residents will demonstrate an ability to work effectively with other health care providers.

5. Residents will effectively elicit information from and provide information to other health care
providers, including nurses, social workers, occupational therapy staff, hospital unit coordinators
and consulting physicians.

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

1. Residents will demonstrate respect, compassion and integrity in all their interactions with
patients, families and other health care providers.

2. Residents will demonstrate accountability to patients, to other health care providers and to the
medical profession and will demonstrate responsiveness to the needs of patients.

3. Residents will demonstrate a commitment to excellence and on-going professional
development as they prepare for the transition to independent practice.
4. Residents will appreciate the ethical issues that can arise in the care of patients with neurological illnesses, including: decision making capacity of patients with dementia; ability of patients with dementia and epilepsy to drive; end-of-life issues in patients with severe neurological illness; pre-symptomatic genetic counseling for patients with family members with neurological illnesses such as Huntington’s disease; discontinuation of treatment of brain-dead patients; the ethics of the persistent vegetative state.

5. Residents will demonstrate sensitivity and responsiveness to each patient’s age, gender, culture, ethnicity, religion and disabilities.

**Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.

1. Residents will demonstrate understanding of how their patient care affects and is affected by other health care providers, the health care organization and the healthcare system.

2. Residents will know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

3. Residents will practice cost-effective health care that does not compromise quality of care.

4. Residents will advocate for quality patient care and assist patients in dealing with the complex mental health system.

5. Residents will know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

**Evaluations:**

*Mandatory:* To provide the psychiatry resident with an evaluation after completion of the neurology service, it is the resident’s responsibility to submit to Neurology’s Supervisor, Dr. Jane Boggs and the Academic Assistant, Debbie Singleton, their case log MR with the name of their attendings at the completion of the service. This information will be used to create the resident’s evaluation which will then be entered into E*Value by the supervisor in Neurology.
VAMC Geriatric Inpatient Psychiatry- PGY-1

Director: German Molina, MD
Supervisor: Jairo Fernandez, MD
Location: W.G. (Bill) Hefner VA Medical Center

TEACHING OBJECTIVES:

1) To learn the assessment of geriatric patients and to recognize psychiatric illnesses in the context of multiple co-morbid conditions.

2) To develop diagnostic and treatment skills when assessing inpatient geriatric population.

3) To become familiar of geriatric psychopharmacology in theory and clinical practice.

4) To learn how to work in a coordinated fashion with other disciplines gaining experience in the multidisciplinary team approach to comprehensive patient care

RESPONSIBILITIES:

1) Resident will attend morning nurse report from the psychiatric inpatient unit.

2) Resident will be an intrinsic member of the treatment team meeting, and participate in interviewing, presenting, and discussing patient’s clinical case.

3) Residents will write progress notes on their assigned patients, under the supervision of the Attending physician.

4) Residents will follow consults, labs report; discuss patients’ medical aspects with Medical providers.

5) They will present a topic related to Geriatric Psychiatry, to the Attending physicians of the inpatient units, other residents, medical students, nurses and clinical staff of the Geriatric inpatient unit.

Competency Specific Objectives:

1. Medical Knowledge
   A. Identify the biopsychosocial concomitants of aging, including:
      1. Demographic changes in the population, and their implications for health care
      2. Sociocultural, legal, economic, cultural and ethnic aspects
      3. Psychological and sociological models of later life adult development
      4. Organ system specific biological changes with normal aging, and with common age associated diseases.
B. Describe each of the following aspects of each of the following disorders of later life:

1. Aspects
   a. Epidemiology
      Known etiological factors or other contributors to biopsychosocial pathogenesis
   b. Clinical features (phenomenology)
      Differential diagnosis, with particular attention paid to how the probabilities are different in older persons as compared with younger adults, or in conditions of later age of onset as compared with younger age of onset
   c. Course and prognosis
   d. Basic approaches to treatment

2. Disorders
   a. Delirium
   b. Dementia
   c. Secondary disorders, i.e., those due to general medical conditions or substance-induced
   d. Depressive disorders
   e. Bipolar disorder
   f. Psychotic disorders
   g. Anxiety disorders
   h. Substance use disorders
   i. Personality disorders/vulnerabilities
   j. Sleep disorders and sleep-related symptoms
   k. Somatoform disorders and unexplained somatic symptoms

2. Patient Care
   A. Demonstrate ability to successfully interview older patients, including:
      1. Adapting interview technique to account for:
         a. Age-related cohort/cultural differences between the fellow and the patient
         b. Patient sensory impairments
         c. Patient cognitive impairments
         d. Other patient psychopathological phenomena, including mood, psychotic, or anxiety symptoms
      2. Using the interview to accomplish the following:
         a. Build a treatment alliance
         b. Obtain historical information
         c. Conduct a mental status examination, including a detailed cognitive examination
         d. Impart information to the patient
         e. Negotiate a treatment plan

B. Evaluate older patients with psychiatric symptoms and signs, taking into account factors #1-2 above as well as the following:
   1. Comorbid general medical illnesses
   2. Functional assessment
3. Family and psychosocial assessment, including the role of culture and ethnicity
4. Ethical issues
5. Selection and use of clinical laboratory tests, radiological, and other imaging procedures; neuropsychological testing; and appropriate referrals to and consultations with other health care specialists

C. Develop a treatment strategy for older patients with psychiatric symptoms and signs, taking into account the following:
   1. Psychotherapies
      a. Use of psychodynamic, cognitive, behavioral, and other methods
      b. Use of individual, family, and group modalities
   2. Pharmacotherapies
      a. Impact of normal aging, and diseases associated with aging, on drug pharmacokinetics, and on drug choice and dosage
      b. Use of drugs including: traditional and typical antipsychotics; antidepressants; mood stabilizers; benzodiazepines; psycho-stimulants; cholinesterase inhibitors
   3. Electroconvulsive therapy
   4. Social treatments

3. Interpersonal and Communication Skills
   A. Relate respectfully and effectively with team members
   B. Relate respectfully and effectively with patients and families

4. Professionalism
   A. Demonstrate high levels of professionalism at all times, consistently showing respect, compassion, integrity, and honesty, and teaching and role modeling responsible behavior, commitment to self-assessment (with willing acknowledgement of errors), and consideration for the needs of patients, families, and colleagues.

5. Practice Based Learning
   A. Accept feedback and perform self improvement
   B. Incorporate feedback into future work
   C. Teach more junior trainees in psychiatry and colleagues from other specialties and disciplines
   D. Incorporate evidence-based approaches to patient care, including demonstration of skills in critically reviewing the literature and describing relevant research methodologies used in geriatric psychiatry.

6. Systems Based Practice
   A. Describe the organizational and administrative aspects of long-term care, home health care, outreach, and crisis intervention services.
   B. Care for patients in varied settings including inpatient psychiatry and general medicine, outpatient, and residential long-term care facilities, to include functioning as a consultant and as a member of the multidisciplinary health team.
PGY-2 Schedule

ECT AND BRAIN STIMULATION ROTATION

Director: James Kimball, M.D.
Faculty: Yelena Komissarova, M.D.

Core Competency Objectives:

Patient Care:
1. The resident shall demonstrate the ability to perform and document a relevant history and examination of the patient with a treatment-resistant affective disorder.
2. The resident shall be able to evaluate a patient for ECT while weighing the pros and cons and risks and benefits of treatment with ECT.

Medical Knowledge:
1. The resident shall demonstrate rigor in thinking about clinical situations in which ECT might be considered.
2. The resident shall demonstrate knowledge about the history of ECT, as well as the science behind ECT.
3. The resident shall 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.

Interpersonal and Communication Skills:
1. The resident shall create and sustain a therapeutic relationship with patients undergoing ECT.

Practice Based Learning and Improvement:
1. The resident shall be able to manage information in an effort to support clinical care and patient education.

Professionalism:
1. The resident shall demonstrate a commitment to ethical principles pertaining to the provision of ECT related services.

Systems Based Practice:
1. The resident shall partner with other providers to coordinate effective care for the patient getting ECT.

Resident Responsibilities:
1. Residents are assigned to this rotation for a two-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. Beginning in January 2013, 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.
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

7. To perform an adequate psychiatric consultation and present it in an effective manner to the consultation-liaison team

Competency Specific Objectives:

Patient Care: Residents must be able to provide consultative care of patients that is compassionate, appropriate and effective for the treatment of psychiatric conditions in a medical environment.

1. Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.

2. Residents will quickly develop a therapeutic alliance with medically ill patients.

3. residents will comfortably interview patients in a variety of medical settings.

4. residents will evaluate for psychopathologic processes in patients with concomitant medical and surgical conditions.

5. residents will evaluate cognitive ability in medically ill patients.

6. residents will demonstrate the ability to perform a relevant history on culturally diverse patients, including: chief complaint, history of present illness, past medical history, a comprehensive review of systems, a biological family history, a sociocultural history, a developmental history and a germane general and neurological examination. This will be done in a wide variety of medical and surgical patients.
7. Residents will gather data from appropriate sources, including chart, hospital staff, family, and other relevant individuals.

8. Residents will interact effectively with a variety of consultees, including determination of consultation questions, and reporting of findings and recommendations.

9. Residents will recognize the typical signs and symptoms of psychiatric disorders including substance abuse in medical and surgical patients.

10. Residents will assess and interpret laboratory and medical data as it relates to psychiatric illness.

11. Residents will understand the connections between medical and psychiatric illnesses and the special issues that arise in specific patient populations, including cancer, cardiac disease, HIV disease, organ transplantation, and dementia.

12. Residents will write pertinent and useful consultation notes.

13. Residents will monitor the patients’ course during hospitalization and provide continuing input as needed.

**Medical Knowledge and Therapeutics:** Residents must demonstrate knowledge about the medical underpinnings of psychiatric illness in medically/ surgically ill patients and apply this to patient care.

1. Residents will demonstrate an understanding of the pathophysiology, epidemiology, diagnostic criteria and clinical course for common consultation conditions including:

   a. dementia(s)
   b. delirium of multiple etiologies
   c. drug induced psychiatric state
   d. affective change in the face of chronic or life threatening illness
   e. factitious disorders
   f. malingering
   g. chronic pain
   h. assessment of conversion disorders
   i. assess drug-drug interactions germane to psychiatry
   j. assist in competency assessments
   k. anxiety disorders in a general medical population.
   l. psychotic disorders in a general medical population.

2. The resident must be able to:

   a. Advise and guide consultees about the role of the medical disease and medications in the patients’ presenting symptoms

   b. Understand the indications for a variety of somatic therapies in medical and surgical patients

   c. Understand the use of psychotropic medications and ECT in medical/ surgical patients, and appreciate physiological effects, contraindications, drug interactions, and dosing concerns
d. Understand, utilize, and instruct regarding the use of non-organic treatments, including brief psychotherapy, behavioral management techniques, family therapy, and psychoeducation

e. Work as a member of a multidisciplinary team to maximize the care of complex medically ill patients

**Practice-Based Learning and Improvement**: Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

1. Residents will seek feedback from their supervising attending and from other health care providers about their own practice and will use this feedback to improve their performance.

2. Residents will apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies.

3. Residents will use information technology to manage information, access on-line medical information and support their own education.

4. Residents will facilitate the learning of medical students and other health care providers.

This will include, but not be limited to:

1. Seeking appropriate reference material pertinent to consultation/physician duties.

2. Reading articles with critical assessment as recommended by faculty.

3. Continuing to learn to use modern informational systems to identify, information in reference to patient issues.

**Interpersonal and Communication Skills**: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients’ families and other health care providers:

1. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.

2. Residents will use effective listening skills in interactions with patients, their family members and other health care providers.

3. Residents will demonstrate proficiency in conveying difficult information to patients and their families.

4. Residents will demonstrate an ability to work as a member of a multidisciplinary patient care team.

5. Residents will effectively elicit information from and provide information to other health care providers, including nurses, social workers, occupational therapy staff, hospital unit coordinators and consulting physicians.
6. Residents should be able to make a determination regarding the consultation questions, and report findings and recommendations about the role of the medical disease and medications in the patients’ presenting psychiatric symptoms.

7. Residents should be able to advise and guide consultees regarding managing psychiatric disorders in a medical setting including the management of behavioral disorders.

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

1. Residents will demonstrate respect, compassion and integrity in all their interactions with patients, families and other health care providers.

2. Residents will demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients that supersedes self-interest.

3. Residents will demonstrate a commitment to excellence and on-going professional development as they prepare for the transition to independent practice.

4. Residents will appreciate the ethical issues that can arise in the care of patients with concomitant psychiatric and medical/surgical conditions. Such issues include for example, transplant decisions in psychiatric patients and issues of capacity and consent.

5. Residents will demonstrate sensitivity and responsiveness to each patient’s age, gender, culture, ethnicity, religion and disabilities.

**Systems-Based Practice:** Residents must demonstrate an awareness of a responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.

1. Residents will demonstrate understanding of how their patient care affects and is affected by other health care providers, the health care organization and the health care system.

2. Residents will know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

3. Residents will practice cost-effective health care that does not compromise quality of care.

4. Residents will advocate for quality patient care and assist patients in dealing with the complex mental health system.

5. Residents will know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

**Resident Responsibilities:**

1. Covering all psychiatric consultations requested during the working day Monday – Thursday, 8:00 a.m. to 5:00 p.m. Coverage is provided by attending physicians on Fridays to allow
residents to attend didactics.

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. Beginning in January 2013, 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 one 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.

PLEASE REFER TO SECTION 5 MISC: MORNING REPORT / DAILY PATIENT CHECK OUT
EMERGENCY PSYCHIATRY ROTATION

Director:  Amy Singleton, M.D.
           Charlie Suttenfield, Ph.D.

Goals and Objectives for Psychiatry Residents on Emergency Psychiatry Rotation:

I. Patient Care - At the end of the rotation, residents are expected to exhibit competencies in the following areas:

   A. Accumulation of Data
      1. Obtain and record a complete psychiatric history appropriate to the clinical circumstances
         i. Should include review of pertinent labs and imaging
      2. Make efficient use of patient, family, and collateral resources for obtaining information
         i. This should include review of previous records that are available on site as well as attempts to obtain collateral records from outside resources

   B. Performance of Physical Exam and Mental Status Exam in Emergency Setting
      1. Recognize clinical situations that require a focused versus complete examination
      2. Recognize potential safety issues that are possible with emergency psychiatry patients
         i. This should include the identification and assessment of potentially suicidal, violent, or threatening patients
         ii. Learn how to manage situations where imminent danger is present
         iii. Describe ways to modify the approach to the exam when faced with the potentially violent patients

   C. Triage of Emergency Psychiatry Patients
      1. Learn to triage emergency psychiatry patients to appropriate levels of care.
         i. This includes learning to recognize non-urgent psychiatric conditions and make appropriate referrals to community resources as well as learning to recognize acute psychiatric conditions that require inpatient level of care
D. Diagnosis and Management of an Emergent Psychiatry Patient

1. Establish a differential diagnosis and treatment plan with appropriate prioritization of treatment options
   
i. Arrive at a decision when reasonable data is available

2. To understand and utilize the involuntary civil commitment process

3. Understand indications for and appropriate administration of emergency psychopharmacology including the use of antipsychotic, benzodiazepines, and mood stabilizers for psychiatric emergencies

4. Consider potential medication interactions

5. Provide patient with medication education and keep patient updated on treatment recommendations

E. Utilization of Outpatient Patient Care Resources

1. Develop an understanding of available outpatient treatment options for community support, drug rehab, ACTT services, mobile crisis services, therapy options, outpatient medication management options, long-term care services, and social work resources for patients who are discharged

2. Develop an understanding of resources available to families of patients with mental illness

3. Learn when to utilize community resources and agencies to prevent repetitive emergency department visits

II. Medical Knowledge- At the end of the rotation, residents are expected to exhibit competencies in the following areas:

A. Be able to recognize classic presentations of psychiatric illnesses

B. Be able to recognize psychiatric complications from or psychological reactions to general medical conditions

C. To recognize medical complications related to psychiatric illness or psychotropic medications

D. To recognize general medical conditions that may present as psychiatric emergencies
   
   1. Rule out life-threatening medical conditions that mimic psychiatric emergencies

E. Use appropriate ancillary services, x-ray, and labs as needed for medical clearance of psychiatric patients and interpret results of common tests

F. To utilize medical consultants appropriately
G. To coordinate with the ER physicians in the management of co-morbid, non-psychiatric medical issues for patients awaiting psychiatric placement

III. **Forensic Knowledge**: At the end of the rotation, residents are expected to exhibit competencies in the following areas:

A. Risk assessment  
B. Duty to report  
C. Civil commitment  
D. Forced medication

IV. **Use of Education Resources**

A. Use literature, APA guidelines and practice parameters to expand knowledge and develop evidence-based practice patterns.  
B. To be able to utilize psychiatric screening tools and assessment scales

V. **Professionalism**

A. Communicate with patients and families  
   1. Demonstrate respect for patient privacy  
   2. Advocate for patients with mental illness  
B. Communicate with transfer coordinators, ED psychiatry holding unit nurses and ED resident/attendings for coordination of services  
C. Maximize efforts for peer to peer checkouts for continuity of patient care  
D. Maintain medical records properly and in a timely fashion  
E. Recognize one’s own limits and accept accountability for actions and errors

VI. **Resident Responsibilities:**

A. Two residents will be assigned to the Emergency Psychiatry Consultation-Liaison Service each month in 1 month blocks.  
   1. One resident will be responsible for covering the duties from 8am – 5pm, and when available, the other resident will be responsible for covering from Noon – 8pm Monday through Thursday.  
   2. Any consults called into the consult line by 5pm will fall to the ED CL resident to work up.  
   3. Any new consults called in after 5pm will fall to the on-call and back-up resident to complete.
4. During their assigned months, these residents will be responsible for seeing NEW urgent ADULT AND PEDIATRIC consults in the emergency room.

5. Adult consults are to be staffed via phone or in person with Dr Singleton or Dr Suttenfield

6. Pediatric consults are to be staffed via phone with designated child attending.
   i. The resident will need to contact Sandy Harris each day to see which child attending will be staffing for the day.

B. In addition to seeing new consults, the residents will also be responsible for helping re-evaluate, manage, and disposition ADULT patients who are held over in the Emergency Room.
   1. Daily notes should be written for ADULT patients in the ED 24 hours or more
      i. Child Fellows will be responsible for writing daily notes on PEDIATRIC patients in the ER 24 hours or more
   2. Appended daily notes should be written for ADULT patients in the ED who have been held less than 24 hours.
      ii. These notes should outline treatment plan of care, updated mental status exam, and disposition plans.

C. Dr Suttenfield will be available in the ED 8am – Noon, Monday – Thursday.
   1. Dr Suttenfield will primarily be responsible for re-evaluations and dispositions for patients held over in the ED. If no patients require re-assessment, he will be available for bed-side teaching as well as help seeing new ADULT consults.

D. Dr Singleton will be available 1pm-5pm Monday – Thursday.
   1. Dr. Singleton will primarily be responsible for observing resident interviews, supervising medication management, bed-side teaching, and verification of resident findings on exam.

E. Each morning, there will be a 30 minute treatment team led by Dr Suttenfield starting at 9am in the Pediatric ED Staff Lounge. (The purpose of this CL morning treatment team is to triage, delegate duties, and make sure all parties are in the loop of communication.)
   1. Those expected to be present at this meeting include Dr. Suttenfield, the assigned ED CL resident, transfer coordinator, unit manager for adult inpatient unit, referral coordinator (via phone), and ED nurse covering behavioral holding unit.
   2. The daytime ED CL resident should be ready by 9am to report about any overnight issues they learned about from on-call resident.

**PLEASE REFER TO SECTION 5 MISC: MORNING REPORT / DAILY PATIENT CHECK OUT**
F. The ED CL resident should receive updates from Dr Suttenfield prior to his departure for the day on any patients he was handling.

G. At 1pm Dr Singleton will arrive.
   1. She will require that one of the ED CL residents update her briefly on outstanding issues and direct her to patients who require medication changes or verification of findings.

   2. Dr Singleton and the late shift resident will have check out at 4:30 each day to review patients.
      i. The late shift ED CL resident will be responsible for check out to on call resident with any potential issues.

H. Fridays from 8am – Noon:
   1. An assigned rotating resident will cover the NEW consults in the ED along with Dr Singleton who will be present to help with re-evals and new ADULT consults.
   
   2. Dr Suttenfield will cover new ADULT consults on Friday afternoons from Noon-4pm
   
   3. An assigned Child Fellow will cover all NEW PEDIATRIC consults from 1pm-4pm.

**Points to Consider for the Emergency Psychiatry Patient:**

**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.

**Specific Approaches to the Emergency Psychiatric Patient:**

1. It is expected that under ordinary circumstances patients needing a psychiatric consult in the ED should be seen for the initial assessment in 30 minutes.

2. Discuss with the referring physician the specific question or issue to be answered.

3. Confirm with the physician requesting the consult that the patient is aware that a psychiatric consultation will be performed.

4. Carefully consider matters of safety of the patient and others in your assessment.

5. 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.
6. 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.

7. Identify any current treatment providers who can give information relevant to the evaluation and obtain this information whenever possible.

8. Identify social, environmental, and cultural factors relevant to immediate treatment decisions.

9. Determine whether the patient is able and willing to form an alliance that will support further assessment and treatment. Determine what precautions are needed if there is a substantial risk of harm to self or others, and whether involuntary treatment is necessary.

10. 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.

**Specific Approaches to the Emergency Psychiatric Patient Who is Intoxicated:**

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 his/her mental status.
**Triage of Non-Psychiatric Emergencies:**

1. Consults for routine psychiatric issues that are not emergent and have no immediate safety concerns can be referred to an outpatient clinic or provider.

2. Detoxification from substances **without** associated suicidality can be referred to ARCA or Centerpointe. There is a psychiatric social worker in the ED who can assist with disposition and can be reached at 713-5747.

3. Patients who will be admitted to the medical floors for stabilization may not require emergent psychiatric consult unless there is an issue with acute management of agitation/delirium/safety. Generally, psychiatric consultations for patients being admitted to the general hospital should be done by the C/L Service during daytime business hours.

4. Patients who are simply seeking to “expedite” an outpatient referral should be referred to an outpatient clinic or provider.

**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.

*Refer to Admission procedure from ED to Inpatient on page 136*
CHILD & ADOLESCENT PSYCHIATRY ROTATION

Director: Dr. Timothy King

Supervisors: Dr. Matt Hough
           Dr. Guy Palmes

Rotation days/hours: Tuesday 8:30 am – 5:00 pm
                    Thursday 8:30 am – 5:00 pm

Location: 791 Jonestown Rd
          Winston-Salem, NC 27103
          Report to Dr. King

Teaching Objectives:

1. To diagnostically evaluate and treat children and adolescents, under supervision of faculty child psychiatrists

2. To participate in a multidisciplinary diagnostic and treatment team and synthesize information from various disciplines

3. To attend child guidance seminars

Competency Specific Objectives:

Patient Care: Residents must be able to provide care of outpatients that is compassionate, appropriate and effective for the treatment of mental illness.

1. Residents will demonstrate the ability to conduct assessments of a wide variety of child and adolescent patients presenting with the full spectrum of psychiatric disorders commonly seen in outpatient psychiatric settings and attending to development, psychological, biological, social and cultural contributions to their illnesses.

2. Residents will appropriately assess safety issues including risk for suicide or homicide and risk of abuse or neglect, and will address these concerns in an ethical manner that is congruent with state law.

3. Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.

4. Residents will counsel and educate patients and their families and demonstrate the ability to convey difficult information in a developmentally appropriate manner.

5. Residents will develop patient formulations that include the following elements:

   a. DSM-IV diagnoses on all five axis

   b. Developmental aspects

   c. Narrative/psychodynamic aspects

   d. Psychosocial aspects
e. Biomedical/psychopharmacologic aspects

f. Genetic aspects

6. Residents will formulate and carry out treatment plans based on the above diagnostic formulation and define a rationale for specific treatment goals, considering also patient personal and psychosocial resources and ability to participate in the plan. Treatment paradigms will include:
   a. Psychopharmacological treatment and management
   b. Individual psychotherapy
   c. Family and group therapies
   d. Integrated, multidisciplinary treatment

7. Residents will implement biomedical treatment strategies, including psychopharmacological treatment and, when indicated, referral for electroconvulsive therapy.

8. Residents will appropriately and proficiently employ commonly used rating scales during the assessment and follow up of outpatients (e.g. Child Depression Inventory, Achenbach Child Behavior Checklist)

9. Residents will demonstrate the ability to conduct a variety of psychotherapeutic treatment modalities with children and adolescents, including at a minimum:
   a. Cognitive behavioral therapy
   b. Behavioral therapy
   c. Supportive psychotherapy
   d. Brief psychotherapy
   e. Family therapy

10. Within the setting of a supervised clinical experience in the evaluation and treatment of families and groups, residents will demonstrate competence to:
    a. Evaluate families to identify interpersonal and family processes affecting individual members of the relationship in maladaptive or illness causing ways;
    b. Evaluate individuals to determine their appropriateness for participation in interpersonal group therapies;
    c. Conduct treatment of families

11. Residents will demonstrate the ability to identify outpatients who should be referred for psychological and neuropsychological testing to aid with diagnostic assessment.
12. Residents will understand the risks and benefits of and indications for psychiatric hospitalization and will be able to evaluate patients with a view to determining their psychiatric risk (risk of suicide or otherwise) and need for hospitalization.

13. Residents will assess patients for initiation or continuation of outpatient commitment proceedings under the applicable laws of the state of NC, using knowledge of the law for youth of various ages.

14. Residents will demonstrate the ability to conduct and appropriate clinical evaluation and referrals relevant to criminal or civil law, including evaluation of children in custody cases and or will alleged abuse.

15. Residents will collaborate with health professionals, in particular primary care providers, psychotherapists, nurses and case managers, to provide patient focused care, especially in these situations:
   a. Resident provides psychiatric care and another clinician provides primary medical care;
   b. Resident provides medication management services and another clinician performs psychotherapy;
   c. Resident provides medication management services (and perhaps psychotherapy) and another clinician provides case management.

16. Residents will collaborate with school personnel including teachers, counselors, principals, nurses, and other staff during assessment and treatment.

17. Residents will use information technology to support patient care decisions and patient education, including online literature searches, electronic medical records and other computer-based resources.

**Medical Knowledge:** Residents must demonstrate knowledge of the neurobiological, psychological and socio cultural underpinnings of mental illness and will apply this knowledge to the care of outpatients.

   a. Residents will demonstrate advanced knowledge of the epidemiology, prevalence, diagnosis, treatment, and prevention of the psychiatric conditions most likely to affect psychiatric outpatients.

   b. Residents will demonstrate knowledge of the biological underpinnings and modern etiological theories of mental illness that integrate recent findings in neuroscience.

   c. Residents will understand the psychopharmacological treatment of mental illness, including treatment algorithms, the management of treatment-resistant illness, augmentation strategies and combination therapies.

   d. Residents will understand the indications for and limitations of psychological testing and neuropsychological testing, and will understand the nature of various commonly used instruments such as the MMPI-A, Rorschach, TAT/CAT, WISC.

   e. Residents will demonstrate knowledge of general medical disorders that may mimic or complicate psychiatric disorders, and appropriately investigate when appropriate (e.g., blood lead level, TSH, or strep titers)
f. Psychiatry residents will conceptualize mental illness in terms of biological, psychological, and socio cultural factors that determine normal and disordered behavior.

g. Residents will appreciate that psychopharmacological treatment must take into account the wide variety of interactions with other pharmacologic agents, impact on other medical conditions, potential to impact development and full appreciation of all side affect problems including compliance, sleep, weight, cognition, and other organ system difficulties.

h. Residents will appreciate issues arising from the integration of psychopharmacology and psychotherapy, including:

i. the opportunities and challenges presented by “split treatment” (psychotherapy by one provider, medication management by another provider);

j. the practice of medication management with awareness of psychotherapeutic issues, whether or not the resident is performing psychotherapy.

**Practice-Based Learning and Improvement:** Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

a. Residents will seek feedback from their supervising faculty about their own practice and will use this feedback to improve their performance.

b. Residents will locate, appraise and assimilate evidence from scientific studies related to child patients, including participation in “wrap-up” sessions.

c. Residents will demonstrate evidence-based thinking in their formulations and treatment plans.

d. Residents will facilitate the learning of other health care professionals, including psychotherapists and case managers providing services to the residents’ outpatients.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families and other health care providers.

a. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.

b. Residents will use effective listening skills in interactions with patients, their family members and other health care providers.

c. Residents will demonstrate competence in communicating with patients of all ages, including the use of projective modalities as indicated (using drawings or play to communicate with a five-year old).

d. Residents will recognize and monitor their emotional responses to patients and adjust their practice accordingly.

**Professionalism:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population.
a. Residents will obtain informed consent for psychiatric treatment plans, including for the use of psychotropic medications, and will demonstrate understanding of the ethical principles underlying informed consent.

a. Residents will provide care to outpatients that takes into account: (1) medical record keeping, (2) risk management and quality assurance issues, (3) confidentiality, (4) collaboration with other providers, agencies, schools and family members, (5) financial and health system issues, (6) legal and forensic issues and (7) other ethical concerns.

b. Residents will understand issues related to medical disability evaluations, including state regulations regarding such evaluations and the ethical principles involved.

c. Residents will demonstrate sensitivity and responsiveness to each patient’s age, gender, culture, ethnicity, religion and disabilities.

**Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide optimal care to outpatients.

a. Residents will appreciate the model of community-based outpatient care employed at WFUBMC and will understand the difference between this model and others, such as mental health centers, hospital-based practice, residential treatment, private practice group models and solo practice.

b. Residents will understand how their patient care affects and is affected by other health care providers, the health care organizations.

c. Residents will appreciate the economics of outpatient mental health care, including the value of services residents provide and to which they refer their patients; in turn, residents will practice cost-effective health care that does not compromise quality of care.

d. Residents will recognize issues that can arise in outpatient practice, including: (1) interaction with staff members; (2) management of patient records and other information systems; (3) scheduling; (4) cross-coverage among practitioners; (5) various practice styles among practitioners; (6) billing and payers (including Medicare, Medicaid, HMO’s and private insurance); (7) office and space management.

e. Residents will understand the regulation of outpatient psychiatric treatment, including: (1) patient confidentiality and HIPAA; (2) state regulations regarding involuntary treatment; (3) state regulations regarding custody and guardianship; (4) governmental and other regulation of outpatient clinics, including JCAHO and state inspectors; (5) other regulations specific to WFUBMC.

f. Residents will know and, if necessary, utilize the mechanisms by which quality improvement occurs at WFUBMC.

g. Residents will advocate for quality patient care and assist patients in dealing with the complex mental health system.

**Resident Responsibilities:**
1. Residents are assigned to the Child Psychiatry Outpatient Clinic for a day and a half for a five month period during their second year and a ½ day for two months fourth year.

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 for the Medical Knowledge core competency:

   1) ADHD
   2) Mood Disorders
   3) Anxiety Disorders
   4) PDD
   5) Substance Use Disorders
   6) Psychotic Disorders

   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 child faculty to assess patient care and professionalism core competencies.
ADDICTION PSYCHIATRY ROTATION

Director: German Molina, MD
Supervisor: Binoy Shah, MD
Location: W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina

Teaching Objectives:

1. To gain experience in obtaining a detailed Substance Abuse history
2. To learn how to formulate the appropriate DSM-IV-TR diagnoses, specific to Substance-Related Disorders
3. To learn about and gain experience with treatment options, medication-related and psychosocial, for a variety of Substance-Related Disorders
4. To learn about residential Substance Abuse treatment.
5. To learn about Buprenorphine as one option for the treatment of Opioid Dependence.

Competency Specific Objectives

I. Patient Care
   a. Knowledge of the components of a comprehensive history and mental status examination
   b. Knowledge of the methods of evaluating and treating patients with substance use disorders, including diagnostic testing
   c. Knowledge of substance withdrawal treatment standards and protocols as supported in the current medical literature

II. Medical Knowledge
   a. Knowledge of the DSM IV criteria sufficient to identify and diagnose the various substance use disorder
   b. Knowledge of medical co-morbidity that is often associated with substance use disorders
   c. Knowledge of the various psychosocial models of treating addiction, including the 12-Step model of treatment

III. Interpersonal and Communication Skills
   a. Knowledge of psychotherapeutic techniques useful in engaging patients in treatment for substance use disorders, including motivational interviewing
   b. Knowledge of methods of providing effective psychoeducation to patients and families

IV. Practice Based Learning and Improvement
   a. An understanding of the resources available through assigned readings and library and online resources to bring the most current literature to bear on patient care

V. Professionalism
   a. Knowledge of professional standards as they relate to interactions with patients, families and other members of the health care team including the importance of appropriate therapeutic boundaries, compassion and professional integrity

VI. Systems Based Practice
   a. Knowledge of system resources available to arrange outpatient follow up in referrals to rehabilitation and self help groups
b. An understanding of group and individual treatment modalities used in the management of patients with substance use disorders

Duties:

1. Resident(s) performs an Initial Psychiatric Evaluation (IPE), with special focus on Substance Abuse history, for all admissions to the Substance Abuse Residential Rehabilitation Treatment Program (SARRTP). The initial evaluation will also determine whether the patient is medically/psychiatrically stable for admission to the program or whether they require a different level of care.

2. Resident(s) address ongoing Psychiatric needs of the patients who are in SARRTP, on an as needed basis.

3. When not involved in direct 1-on-1 patient care, the Resident(s) will attend and participate in routine SARRTP programming, including, but not limited to a variety of didactics and psychotherapy modalities, as well as, attending treatment team meeting on a daily basis. The resident will learn about tools/skills taught to patients in a residential Substance Abuse treatment setting.
PGY-3 Schedule

ADULT OUTPATIENT PSYCHIATRY CLINICAL ROTATION

Director: Drs. Amy Singleton, Donald Peters, Thomas Brown: General Adult Outpatient Clinic
Dr. Beverly Jones: Geriatric Clinic
Dr. Stephen Kramer: Neurobehavioral Clinic
Dr. Amy Singleton: Suboxone Maintenance Clinic
Dr. Gretchen Brenes, Elizabeth Arnold: 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

Competency Specific Objectives:

Patient Care: Residents must be able to provide care of outpatients that is compassionate, appropriate and effective for the treatment of mental illness.

1. Residents will demonstrate the ability to conduct assessments of a wide variety of patients presenting with the full spectrum of psychiatric disorders commonly seen in outpatient psychiatric settings and attending to development, psychological, biological, social and cultural contributions to their illnesses.

2. Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.

3. Residents will counsel and educate patients and their families and demonstrate the ability to convey difficult information.

4. Residents will develop patient formulations that include the following elements:

   a. DSM-IV diagnoses on all five axes
   b. Developmental aspects
   c. Narrative/psychodynamic aspects
   d. Psychosocial aspects
   e. Biomedical/ neuropharmacology aspects
   f. Genetic aspects
5. Residents will formulate and carry out treatment plans based on the above diagnostic formulation and define a rationale for specific treatment goals, considering also patient personal and psychosocial resources and ability to participate in the plan. Treatment paradigms will include:
   a. Psychopharmacological treatment and management
   b. Individual psychotherapy
   c. Marital/couples, family and group therapies
   d. Integrated, multidisciplinary treatment

6. Residents will implement biomedical treatment strategies, including psychopharmacological treatment with antidepressants, antipsychotics, sedative-hypnotics, mood stabilizing medications, stimulants and agents for treatment of sexual disorders and, when indicated, referral for electroconvulsive therapy.

7. Residents will appropriately and proficiently employ commonly used rating scales during the assessment and follow-up of outpatients, including anxiety and depression scales, cognitive measures (e.g., Folstein Mini-Mental State Examination) and neurological scale (e.g., Abnormal Involuntary Movement Scale).

8. Residents will demonstrate the ability to conduct a variety of psychotherapeutic treatment modalities, including:
   a. Cognitive-behavioral therapy
   b. Behavioral therapy
   c. Dialectical behavioral therapy
   d. Interpersonal psychotherapy
   e. Supportive psychotherapy
   f. Psychodynamic psychotherapy
   g. Brief psychotherapy
   h. Couples and family therapy
   i. Group therapy

9. Residents will conduct long-term psychotherapy (weekly for at least one year) with patients and will be able to manage issues that arise, including (a) establishing and maintaining a therapeutic relationship, (2) managing patient reactions to the therapist and the therapy in a developmental fashion, and (3) conduct psychological interpretation of patient issues in narrative, developmental and cognitive-behavioral terms.

10. Residents will demonstrate the ability to identify outpatients who should be referred for psychological and neuropsychological testing to aid with diagnostic assessment.

11. Residents will understand the risks and benefits of and indications for psychiatric hospitalization and will be able to evaluate patients with a view to determining their psychiatric risk (risk of suicide or otherwise) and need for hospitalization.

12. Residents will assess patients for initiation or continuation of outpatient commitment proceedings under the applicable laws of the State of NC, considering competency issues with regard to the impact mental illness has on the ability to conduct financial and personal decision-making.

13. Residents will demonstrate the ability to conduct a clinical evaluation relevant to the use of psychiatric testimony for the purposes of criminal or civil law.
14. Residents will collaborate with health professionals, in particular primary care providers, psychotherapists, nurses and case managers, to provide patient-focused care, especially in these situations:

   a. Resident provides psychiatric care and another clinician provides primary medical care;

   b. Resident provides medication management services and another clinician performs psychotherapy;

   c. Resident provides medication management services (and perhaps psychotherapy) and another clinician provides case management.

15. Residents will use information technology to support patient care decisions and patient education, including on-line literature searches, electronic medical records and other computer-based resources.

**Medical Knowledge:** Residents must demonstrate knowledge of the neurobiological, psychological and socio cultural underpinnings of mental illness and will apply this knowledge to the care of outpatients.

1. Psychiatry residents will conceptualize mental illness in terms of biological, psychological, and socio cultural factors that determine normal and disordered behavior.

2. Residents will demonstrate advanced knowledge of the epidemiology, prevalence, diagnosis, treatment, and prevention of the psychiatric conditions most likely to affect psychiatric outpatients.

3. Residents will demonstrate knowledge of the biological underpinnings and modern etiological theories of mental illness that integrate recent findings in neuroscience.

4. Residents will understand the psychopharmacological treatment of mental illness, including treatment algorithms, the management of treatment-resistant illness, augmentation strategies and combination therapies.

5. Residents will appreciate that psychopharmacological treatment must take into account the wide variety of interactions with other pharmacologic agents, impact on other medical conditions, and full appreciation of all side affect problems including compliance, sleep, weight, sexual problems, and other organ system difficulties.

6. Residents will appreciate issues arising from the integration of psychopharmacology and psychotherapy, including:

   a. The opportunities and challenges presented by “split treatment” (psychotherapy by one provider, medication management by another provider);

   b. The practice of medication management with awareness of psychotherapeutic issues, whether or not the resident is performing psychotherapy.

7. Residents will understand the indications for and limitations of psychological testing and neuropsychological testing, and will understand the nature of various commonly used instruments such as the MMPI, Rorschach, Thematic Apperception Test, WAIS and Wechsler Memory Scale.
**Practice-Based Learning and Improvement:** Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

1. Residents will seek feedback from their supervising faculty, including clinic supervisors, general supervisors and psychotherapy supervisors, about their own practice and will use this feedback to improve their performance.

2. Residents will locate, appraise and assimilate evidence from scientific studies related to their patients’ health problems, including attendance at the monthly Evidence-Based Medicine conferences.

3. Residents will gain and apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies, including attendance at the monthly Mortality and Morbidity conferences.

4. Residents will facilitate the learning of other health care professionals, including psychotherapists and case managers providing services to the residents’ outpatients.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families and other health care providers.

1. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.

2. Residents will use effective listening skills in interactions with patients, their family members and other health care providers.

3. Residents will recognize and monitor their emotional responses to patients and adjust their practice accordingly.

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

1. Residents will obtain informed consent for psychiatric treatment plans, including for the use of psychotropic medications, and will demonstrate understanding of the ethical principles underlying informed consent.

2. Residents will provide care to outpatients that takes into account (a) medical recordkeeping, (b) risk management and quality assurance issues, (c) confidentiality, (d) collaboration with other providers, agencies and family members, (e) financial and health system issues, (f) legal and forensic issues and (g) other ethical concerns.

3. Residents will understand issues related to medical disability evaluations, including state regulations regarding such evaluations and the ethical principles involved.

4. Residents will have appropriate interactions with representatives of the pharmaceutical industry and will appreciate the ways in which these interactions may affect their clinical practice.
5. Residents will demonstrate sensitivity and responsiveness to each patient's age, gender, culture, ethnicity, religion and disabilities.

**Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide optimal care to outpatients.

1. Residents will appreciate the model of outpatient care employed at WFUBMC and will understand the difference between this model and others, such as mental health centers, hospital-based practice, private practice group models and solo practice.

2. Residents will understand how their patient care affects and is affected by other health care providers, the health care organization and the mental health care system.

3. Residents will appreciate the economics of outpatient mental health care, including the value of services residents provide and of services to which they refer their patients; in turn, residents will practice cost-effective health care that does not compromise quality of care.

4. Residents will recognize issues that can arise in outpatient practice, including: (a) interaction with staff members; (b) management of patient records and other information systems; (c) scheduling; (d) cross-coverage among practitioners; (e) various practice styles among practitioners; (f) billing and payers (including Medicare, Medicaid, HMO’s and private insurance) (g) office and space management.

5. Residents will understand the regulation of outpatient psychiatric treatment, including:
   a. Patient confidentiality and HIPAA;
   b. State regulations regarding involuntary treatment;
   c. State regulations regarding guardianship;
   d. Governmental and other regulation of outpatient clinics, including JCAHO and state inspectors;
   e. Other regulations specific to WFUBMC

6. Residents will know and, if necessary, utilize the mechanisms by which quality improvement occurs.

7. Residents will advocate for quality patient care and assist patients in dealing with the complex mental health system.

**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 psychopharmacology clinic, geropsychiatry, neurobehavioral, and suboxone maintenance clinic.

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. Beginning in January 2013, 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)

7. Residents will provide complete, accurate, and timely documentation of patient contacts and care provided. The attending will review all charts for completeness, accuracy, and quality of patient care.
PSYCHIATRY FACULTY TEACHING (FT) CLINICS
GENERAL INFORMATION FOR RESIDENTS

1. Each week, you (the residents) will be provided with one half-day during which time you will not be scheduled for off-site clinic duties or FT clinic duties. During this time, you are to:
   
   1) See your private psychotherapy patients
   
   2) Meet with your psychotherapy supervisors
   
   3) Attend to clinic-related work, such as returning patient phone calls, charting, or preparing for upcoming clinic patients
   
   4) Attend to other responsibilities, such as personal physician/dentist appointments or having the car serviced (non-work issues)

   During these times you are to have your pager on and with you at all times, 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 have your pager on, 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 8 a.m. to 5 p.m., two residents will be assigned to cover clinic call. One will cover from 8 p.m. to 12 p.m. and the other will cover from 1 p.m. to 5 p.m. 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:

   1) Review any prescription refill requests for residents who are off-site that day

   2) 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)

   3) See emergency patients in the slots provided for emergency patient evaluation and stabilization

   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, scheduling coordinators, and phone triage 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 lab work 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 so that you can remain (reasonably) on schedule in clinic. Patients that must be physically seen by an attending are those with the following insurance types: Medicare, Tri-Care (military insurance) and West Virginia Medicaid. Any patient the resident or attending feels uncertain about safety or other issues should also be physically seen by the attending.

5. Documentation must be made for every patient seen. It is important that you make sure that some type of medical record 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 in the electronic medical record.

7. If the front desk or telephone triage pages you during clinic time (the call-back number will either be 6-6312 or 6-4551), 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 (and the “dot” in Centricity is sometimes lagging). It is not appropriate to ask the front desk secretaries to bring patients back to you, it is your responsibility to go to the waiting area, greet your patient and accompany them back to your office.

9. 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.

10. Whenever possible, be proactive in clinic. For instance, at the end of each week, check in with the medical record system 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 (i.e. post-call dates). 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).

11. It is your responsibility to inform the clinic secretaries, scheduling coordinators, and phone triage of your call/post-call schedule when it is released, so that you will not have any patients scheduled for your post call days. You are not required to be in clinic when post-call as this is a duty hour violation.
12. 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.

13. 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 Department of Psychiatry and Wake Forest Baptist Health. 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.”

14. The appropriate termination policy should be followed in terminating all patients from clinic. This includes sending a warning letter when a patient has not been seen in clinic for 90 days or has multiple no-shows. Forward these letters to your attending for co-signature, and to the WMHS mailbox as staff members will keep track of when the patient needs to be terminated and will speak with risk management about their case. After 30 days, you will receive notice that the patient can be terminated from office staff personnel, and at that time you will print two termination letters and have Dr. Komissarova co-sign these. Risk management should be updated on patients that you are currently seeing that may become deceased. Other terms of termination will be discussed directly with Dr. Komissarova, the FTC Director.

15. If you are absent from FT clinic due to illness, it is necessary that you call or email the residency coordinator, Sheila Leach (saleach@wakehealth.edu), the scheduling coordinators, and also telephone triage to inform them of your absence. They will then inform others in the FT clinic of your absence.

16. If you order labs on a patient, make a note of it, follow up with the results of the labs and call or send a prompt letter to the patient with those results. Do NOT wait until the next scheduled appointment to review labs as this may be two to three months out.
LEARNING OBJECTIVES OF THIS EXPERIENCE

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 sessions 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 every 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 consents 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 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 or Abrupt

2) Patient-initiated or therapist-initiated?

3) When do you try to talk an ambivalent patient into staying in therapy? When don’t you?
COMMUNITY PSYCHIATRY: STUDENT HEALTH

Director: Guy Palmes, M.D.
Coordinator: Carolyn Potts

Rotation Day/Hours: One resident – 8:30 a.m. until 5:00 p.m. on Wednesday
Second resident – 8:30 a.m. until 5:00 p.m. on Thursday

Location: Wake Forest Student Health Clinic, Reynolda Campus
          Report to Carolyn Potts, Office Manager

Director: Guy K. Palmes, MD
Location: Wake Forest University Student Health – Winston Salem

Description: Third year adult residents will rotate through the Wake Forest University Student Health Clinic one-half day per week per semester. The resident will interact with the Medical Director of the Clinic, as well as, participate in multidisciplinary team meetings. Residents will provide direct patient care to college-age patients.

Goals and Objectives of the Rotation:

Patient Care:

Knowledge:
1. Learn to evaluate older adolescents/young adults in a college setting
2. Become acquainted with assessment tools utilized in a student health setting

Skills:
1. Learn to function in a college setting using a co-location model
2. Become familiar with college specific regulations: including athlete medication forms and class withdrawal forms

Attitude:
1. Demonstrate a commitment to mastering the knowledge base and skills necessary to provide care in a college setting

Medical Knowledge

Knowledge:
1. Learn disorders most commonly encountered in a college-age population
2. Become familiar with “leaving the nest” issues as described in the text "Your Adolescent"

Skills:
1. Become familiar with the Learning Assistance Center and the University Counseling Center
2. Become familiar with resources available to help college students succeed
Attitude:
  1. demonstrate motivation to learn to become an effective psychiatrist in the college setting

Systems based practice

Knowledge:
  1. work effectively in consultation with professionals from other disciplines including nurses, primary care physicians and counselors

Skills:
  1. understand group assessment measures of academic performance for students
  2. gain clinical experience in a wide variety of psychiatric problems in school settings

Attitude:
  1. demonstrate a commitment to becoming familiar with resources available in the college setting

Interpersonal and Communication Skills

Knowledge:
  1. learn how to approach university personnel regarding educational problems that surface in psychiatric diagnostic interviews

Skills:
  1. become familiar with the documentation system used in a student health setting
  2. provide education to university personnel on particular psychiatric conditions that affect student learning

Attitude:
  1. demonstrate a commitment to enhancing communication skills in a student health service

Professionalism

Knowledge:
  1. understand and appreciate input from other health care professionals and university staff

Skills:
  1. demonstrate appropriate interactions with patient and school personnel to reflect a respectful attitude towards others and their needs

Attitude:
  1. exemplify personal and intellectual integrity and demonstrate an understanding of ethical values and codes of a member of the medical profession

Practice Based Learning
Knowledge:
1. recognize that the scientific literature is constantly evolving, that no one report of idea is necessarily true for all situations, and that the literature should be critically judged for its methodology and applicability

Skills:
1. locate, appraise, and assimilate the best practices relevant to student health

Attitude:
1. obtain appropriate supervision
COMMUNITY HEALTH SETTINGS IN PSYCHIATRY

Directors:  
Dr. Travis Anderson: Area Services and Programs – Statesville  
Dr. Liz Arnold: Homeless Opportunities and Treatment Project  
Dr. Rommel Ramos: VA Outpatient Clinic - Winston-Salem  
Dr. Burton Reifler: Geriatric Outreach Program (GO Program)

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

Competency-Specific Objectives:

Patient Care: Residents must be able to provide care that is compassionate, appropriate and effective for the treatment of severe and persistent mental illness in a community setting. Specifically, residents will:

Skills

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Cooperate with other members of the Assertive Community Treatment Team (ACT, also known as a Community Support Program) in joining with patients to develop collaborative, comprehensive, recovery oriented treatment plans that integrate psychopharmacology, skill training, case management, emotional support and help with concrete needs of living in the community.
3. Practice in a variety of community settings, including patients’ apartments, community-based residential facilities, public settings such as restaurants, homeless shelters, and the jail.
4. Participate in all aspects of the required treatment plan, including help with housing, shopping, money management, transportation, time management, employment, and obtaining medical care.
5. Make informed decisions about diagnostic and therapeutic interventions based on patient information, preferences, up-to-date scientific evidence and clinical judgment, in collaboration
with the treatment team.

6. Provide psychopharmacologic management for patients that may require complicated interventions, often complicated by co-morbid substance use and medical illness.

7. Integrate the use of medication with skill training, concrete life supports and other interventions to ensure that patients maintain housing, work, structure and social support within the community.

8. Utilize appropriately designed interpersonal support and counseling, skills training, psycho-education and cognitive-behavioral interventions for psychosis.

9. Be involved in the decision when and how to use of the hospital when necessary,

**Attitudes**

1. Appreciate how modern concepts of recovery can aid in more effective treatment of persons with serious mental illness.

**Medical Knowledge:** Residents must demonstrate knowledge about the neurobiological, psychosocial, cultural and economic underpinnings of severe and persistent mental illness and will apply this knowledge to patient care. Specifically, residents will:

**Knowledge**

1. Conceptualize severe and persistent mental illness in terms of the biological, psychological, psychosocial, cultural and economic factors that are thought to be relevant.

2. Demonstrate knowledge of the etiologies, prevalence, diagnosis, treatment, prevention and outcome of the psychiatric conditions most likely to affect patients with severe and persistent mental illness.

3. Understand the significance of co-morbidity, i.e., the interactions among chronic mental illness, substance use disorders and medical illness.

4. Understand state-of-the-art psychopharmacology of person with chronic schizophrenia and mood disorders, including:

   a. Atypical and typical antipsychotics (administration and monitoring of clozapine, in particular)

   b. Depot antipsychotics

   c. Monitoring for antipsychotic side effects using tools such as the AIMS and monitoring of metabolic parameters

   d. Antidepressants

   e. Lithium and anticonvulsants

   f. Rational poly-pharmacy

   g. Algorithms for the treatment of psychotic and mood disorders
5. Describe the recovery model of treating persons with severe mental illness.

6. Describe psychosocial treatment strategies, e.g., cognitive-behavioral therapy for psychosis.

**Attitudes**

1. Demonstrate an investigatory and analytic approach to thinking through clinical situations.

**Practice-Based Learning and Improvement:** Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Specifically, residents will:

**Skills**

1. Seek feedback from MHC staff and their MHC attendings about their own practice and use this feedback to improve their performance.

2. Locate, appraise and assimilate evidence from scientific studies related to their patients health problems, especially studies pertaining to:
   a. Mental health services research
   b. clinical trials involving subjects with severe mental illness, e.g., the CATIE trial

3. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies; this should occur in the context of regular meetings with MHC staff.

4. Use information technology to manage information (i.e., clinical logs), access on-line medical information and to support their own education.

5. Facilitate the learning of other health care professionals, in particular other members of the treatment team.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families and other health care providers. Specifically, residents will:

**Skills**

1. Create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.

2. Use effective listening skills in interactions with patients, their family members and other health care providers.

3. Demonstrate proficiency in complex interpersonal situations, such as interacting with patients with severe mental illness in non-medical settings.

4. Demonstrate proficiency in conveying difficult information to patients and their families.
5. Work effectively with other health care providers as a psychiatric member of an interdisciplinary treatment team.

6. Effectively elicit information from and provide information to other members of the treatment team.

**Attitudes**

1. Recognize and monitor their emotional responses to patients and adjust their practice accordingly.

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

**Knowledge**

1. Appreciate the ethical issues that can arise in a community psychiatry setting, including:
   a. Informed consent
   b. Confidentiality of patient information
   c. Involuntary treatment
   d. Establishing and maintaining appropriate boundaries, and monitoring for and addressing violations of boundaries
   e. The challenges imposed by financial and systems constraints

**Attitudes**

1. Demonstrate respect, compassion and integrity in all their interactions with patients, families and MHC staff.

2. Demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients.

3. Understand that effective treatment requires that the clinician learn to be culturally competent, taking into account each patient’s values, beliefs, cultural background and communication style.

**Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value. Specifically, residents will:

**Knowledge**

1. Understand how their patient care affects and is affected by other health care providers, the public mental health care system, organizations (such as NAMI) and governmental agencies.

2. Understand the mission, function, economics and organization of the Mental Health Center.

3. Describe the model of Assertive Community Treatment of persons with severe and persistent mental illness.

**Skills**

1. Practice cost-effective health care that does not compromise the quality of care.
2. Collaborate with members of various MHCDC programs, other mental health care providers and governmental agencies to provide for the best patient care possible.

**Attitudes**

1. Appreciate the need for advocacy for patients seen in the community mental health system.

**Resident Responsibilities**

1. Hours at mental health centers 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.

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, progress notes and treatment plans as per mental health center policy.
VAMC HIGH INTENSITY ACUTE INPATIENT PSYCHIATRIC UNIT

Director: German Molina, MD
Supervisor: Rajendra Daniel, MD
Location: W.G. (Bill) Hefner VA Medical Center.
1601 Brenner Ave, Salisbury, NC 28144

Teaching Objectives

1. To gain experience in evaluating and treating acute mentally ill patients on the High Intensity inpatient unit (4-3B).
2. To participate in and lead a multidisciplinary treatment team.
3. To observe evaluation for dangerousness and commitment proceedings.
4. To gain experience in group leadership in therapy of acute inpatients.
5. To perform a comprehensive initial psychiatric evaluation, history, review of laboratory findings, medications interactions, and discuss treatment plans for newly admitted patients.

Competency-Specific Objectives:

Patient Care: Residents must be able to provide care of inpatients that is compassionate, appropriate and effective for the treatment of severe mental illness.
Residents will:

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Gather accurate and complete information about their patients from the following sources: the patient; the patient's family, friends and health care providers; the patient's medical record.
3. Develop comprehensive bio-psychosocial assessments and differential diagnoses that incorporate genetic predisposition, developmental issues, co-morbid medical issues, substance use and abuse, ethnic/cultural/spiritual factors, economic issues, current relationships, psychosocial stressors and current mental status exam.
4. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and clinical judgment.
5. Counsel and educate patients and their families and demonstrate the ability to participate in and lead family meetings.
6. Use information technology to support patient care decisions and patient education, including on-line literature searches, electronic medical records and other computer-based resources.
7. Develop understanding of the use of psychotherapeutic strategies appropriate for an inpatient setting, including supportive techniques, cognitive-behavioral interventions and
8. Demonstrate competence to recommend the administration of electroconvulsive therapy (ECT). Specifically, residents will be able to:
   a. Describe selection of appropriate patients for ECT, including psychiatric indications and medical/psychiatric contraindications;
   b. Educate patients and their families about the risks and benefits of and alternatives to ECT;
   c. Obtain informed consent for ECT from patients
9. Demonstrate competence in the management of behavioral emergencies, including verbal and behavioral de-escalation techniques and psychopharmacological management.
10. Work with mental health professionals of other disciplines and with physicians from other specialty services to provide patient focused care.
11. Demonstrate understanding of the mental health system and mental health resources available in the community and use this knowledge to participate in discharge planning and the development of appropriate aftercare plans.
12. Maintain the medical record appropriately, including dictated admission H&Ps, daily progress notes, consent forms and dictated discharge summaries.

**Medical Knowledge:** Residents must demonstrate knowledge about the neurobiological and psychological underpinnings of mental illness and will apply this knowledge to patient care. Residents will:
1. Demonstrate knowledge of the etiologies, prevalence, diagnosis, treatment, and prevention of the psychiatric conditions most likely to affect psychiatric inpatients.
2. Demonstrate understanding of the psychopharmacological treatment of mental illness, including treatment algorithms, the management of treatment-resistant illness, augmentation strategies and combination therapies.
3. Demonstrate understanding of the indications for and limitations of psychological testing and neuropsychological testing in an inpatient setting.
4. Demonstrate an investigatory and analytic approach to thinking through clinical situations.

**Practice-Based Learning and Improvement:** Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents will:
1. Seek feedback from their supervising attending and from other health care providers about their own practice and will use this feedback to improve their performance.
2. Use information technology to access on-line medical information and to support their education.
3. Locate, appraise and assimilate evidence from scientific studies related to their patients’ health problems.

4. Apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies.

5. Facilitate the learning of medical students and other health care providers.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families and other health care providers. Residents will:

1. Create and sustain a therapeutic and ethically sound relationship with patients, including the use of open and honest communication, the maintenance of empathic stance and the establishment of appropriate boundaries.

2. Use effective listening skills in interactions with patients, their family members and other health care providers.

3. Demonstrate competence in complex interviewing situations, such as interacting with patients with thought disorganization, cognitive impairment, paranoia, aggressiveness or inappropriate behavior.

4. Recognize and monitor their emotional responses to patients and adjust their practice accordingly.

5. Demonstrate proficiency in conveying difficult information to patients and their families.

6. Demonstrate an ability to work effectively with other health care providers as a member or leader of an interdisciplinary treatment team.

7. Effectively elicit information from and provide information to other health care providers, including nurses, social workers, occupational therapy staff, hospital unit coordinators and consulting physicians.

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

1. Demonstrate respect, compassion and integrity in all their interactions with patients, families and other health care providers.

2. Demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients that supersedes self-interest.

3. Appreciate the ethical issues that can arise in an inpatient psychiatric setting, including: patient autonomy; involuntary treatment; decisional capacity to accept or refuse psychiatric care; informed consent; the challenges imposed by financial constraints; confidentiality of patient information; and the potential for violation of appropriate boundaries.

4. Demonstrate sensitivity and responsiveness to patients’ culture, age, gender and disabilities
**Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.

Residents will:

1. Demonstrate understanding of the way in which their patient care affects and is affected by other health care providers and the mental health care system

2. Demonstrate an understanding of Wake Forest Baptist Medical Center’s mission to the community and to the State.

3. Practice cost-effective health care that does not compromise quality of care.

4. Collaborate with psychiatrists and other mental health providers in the community, medical consultants, and community organizations to provide for the best patient care.

5. Develop an understanding of the economics of inpatient psychiatric treatment and become aware of the impact of differences in health care financing strategies among the various governmental and private insurance programs.

6. Develop an understanding of regulations which affect inpatient psychiatric treatment, including: federal rules on seclusion and restraint; Wisconsin State Law regarding mental health commitment and guardianship; patient confidentiality and HIPAA regulations; and policies and procedures specific to University of Wisconsin Hospital and Clinics.

7. Advocate for quality patient care and assist patients in dealing with the larger mental health system.

**Resident Responsibilities**

1. The Inpatient psychiatric rotation requires that the resident spend time with the treatment teams during working days Monday through Thursday.

2. The resident is required to be available in the hospital from 8:00 a.m. - 4:30 p.m. Monday through Thursday.

3. The resident is required to complete discharge summaries, maintain current 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 will participate in teaching medical and physician assistant students and do at least 1-2 presentations on a subject related to inpatient acute psychiatric morbidity of their choice.
PGY-4 Schedule

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. Co-lead Group Therapy sessions when not leading Team Meeting
3. On call responsibilities: Recommended 1 weekday every other week
4. 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. 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

PLEASE REFER TO SECTION 5 MISC: MORNING REPORT / DAILY PATIENT CHECK OUT
SUBSTANCE ABUSE INTENSIVE OUTPATIENT PROGRAM

Director: Dean Melton, MA, CCAS
Location: 791 Jonestown Road, Winston Salem

Objectives: Psychiatry residents will have a supervised clinical experience in the assessment, diagnosis and treatment of addiction psychiatry patients that emphasizes a developmental, biopscho-social and culturally sensitive approach to addiction psychiatric practice.

Residents will have an addiction psychiatric experience that includes a wide variety of disorders, patients and treatment modalities, including biological treatments, psychotherapy and psychosocial rehabilitation.

Residents will demonstrate the ability to gather and organize data, integrate these data with a comprehensive formulation of the problem to support well-reasoned differential diagnosis, formulate a treatment plan, and implement treatment care follow-up in an addiction setting.

Residents will demonstrate competence in various pharmacological, psychotherapeutic and behavioral interventions including psychodynamic, cognitive, behavioral, supportive care appropriate for addiction psychiatry.

Residents will demonstrate professional and ethical behavior in the care of their patients and in their interactions with other health care providers and other administrative staff and demonstrate understanding of the various legal and regulations and risk management practices involved in addiction psychiatric care.

Residents are expected to gradually develop higher levels of understanding and skills as they proceed developmentally through this experience.

Competency-Specific Objectives:

Patient Care:

1. Residents must be able to provide care of addiction patients that is compassionate, appropriate and effective for the treatment of mental illness.

2. Residents will demonstrate the ability to conduct assessments of a wide variety of patients presenting with the full spectrum of psychiatric disorders commonly seen in addiction psychiatric settings and attending to developmental, psychological, biological, social and cultural contributions to their illnesses.

3. Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families and other care providers.

4. Residents will counsel and educate patients and their families and demonstrate the ability to convey difficult information.

5. Residents will demonstrate the ability to conduct a variety of psychotherapeutic treatment modalities in an addiction setting, including group therapy and supportive therapy.
6. Residents will understand the risks and benefits of and indications for psychiatric hospitalization and will be able to evaluate patients with a view to determining their psychiatric risk (risk of suicide or otherwise) and need for hospitalization in addiction patients.

7. Residents will collaborate with health professionals to provide patient-focused care.

**Medical Knowledge:**

1. Residents must demonstrate knowledge of the neurobiological, psychological and socio-cultural underpinnings of mental illness and will apply this knowledge to the care of psychiatric emergencies.

2. Psychiatry residents will conceptualize mental illness in terms of biological, psychological, and socio-cultural factors that determine normal and disordered behavior.

3. Residents will demonstrate advanced knowledge of the epidemiology, prevalence, diagnosis, treatment, and prevention of the psychiatric conditions most likely to affect addiction patients.

4. Residents will demonstrate knowledge of the biological underpinnings and modern etiological theories of addiction mental illness that integrate recent findings in neuroscience.

5. Residents will understand the psychopharmacological treatment of addiction and mental illness, including treatment algorithms, the management of treatment-resistant illness, augmentation strategies and combination therapies.

6. Residents will appreciate that psychopharmacological treatment must take into account the wide variety of interactions with other pharmacologic agents, impact on other medical conditions, and full appreciation of all side affect problems including compliance, sleep, weight, sexual problems, and other organ system difficulties.

**Practice-Based Learning and Improvement:**

1. Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

2. Residents will locate, appraise and assimilate evidence from scientific studies related to their patients’ health problems in addiction psychiatric practice.

3. Residents will gain and apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies into addiction psychiatric practice.

4. Residents will use information technology to support patient care decisions and patient education, including on-line literature searches, electronic medical records and other computer-based resources.

**Interpersonal and Communication Skills:**

1. Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families and other health care providers.

2. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance.
and the establishment of appropriate boundaries.

3. Residents will use effective listening skills in interactions with patients, their family members and other health care providers.

4. Residents will recognize and monitor their emotional responses to patients and adjust their practice accordingly.

**Professionalism:**

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

2. Residents will obtain informed consent for psychiatric treatment plans, including for the use of psychotropic medications, and will demonstrate understanding of the ethical principles underlying informed consent and the need for intervention in the addiction psychiatry patient.

3. Residents will provide care to patients that takes into account (a) medical recordkeeping, (b) risk management and quality assurance issues, (c) confidentiality, (d) collaboration with other providers, agencies and family members, (e) financial and health system issues, (f) legal and forensic issues and (g) other ethical concerns.

4. Residents will demonstrate sensitivity and responsiveness to each patient’s age, gender, culture, ethnicity, religion and disabilities.

**Systems-Based Practice:**

1. Residents must demonstrate an awareness of and responsiveness to the larger context of the addiction mental health care system and the ability to effectively call on system resources to provide optimal care to addiction psychiatric patients.

2. Residents will appreciate the model of community-based addiction treatment and long-term care addiction practice and will understand the difference between this model and others, such as mental health centers, hospital-based practice, private practice group models and solo practice.

3. Residents will understand how their patient care affects and is affected by other health care providers, and the health care organization. Residents will appreciate the economics of addiction mental health care, including the value of services residents provide and of services to which they refer their patients; in turn, residents will practice cost-effective health care that does not compromise quality of care.

4. Residents will recognize issues that can arise in addiction practice, including: (a) interaction with staff members; (b) management of patient records and other information systems; (c) scheduling; (d) cross-coverage among practitioners; (e) various practice styles among practitioners; (f) billing and payers (including Medicare, Medicaid, HMO’s and private insurance); (g) office and space management.

5. Residents will understand the regulation of addiction psychiatric treatment, including: (a) patient confidentiality and HIPAA; (b) state regulations regarding involuntary treatment; (c) state regulations regarding guardianship; and (d) governmental and other regulation of addiction clinics, including JCAHO and state inspectors.
6. Residents will advocate for quality patient care and assist patients in dealing with the complex addiction mental health system.

**Resident Responsibilities:**

1. During the time of the rotation, residents are expected to attend AA meetings on Monday nights before the group begins.

2. Residents are expected to be an integral part of the group, helping to co-lead with the group leader.

3. Residents are expected to deliver at least one lecture per week while on the rotation.
ELECTIVE ROTATIONS

**Director:** Assistant Director, Adult Psychiatry Education

**Supervisor:** Resident Choice

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

One month before starting the 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 proposal must also include the means in which the resident will demonstrate that the educational objectives were met (i.e., paper/essay, discussion/lecture, poster presentation, etc). 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 Unit
5. Forensic Psychiatry
6. Emergency Psychiatry
7. Inpatient Psychiatry
8. Medical Student Psychiatry
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
16. GO Program
17. Research
ADVANCED INPATIENT EXPERIENCE AT
BROUGHTON STATE HOSPITAL
(Elective Rotation)

Director: Dr. George Krebs
Supervisors: Dr. Anthony Frasca
Dr. George Krebs

General Goals:
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 mentally ill
4. To perform initial evaluation, history, physical exam and laboratory evaluation, and prepare treatment plans for newly admitted patients

Competency Specific Objectives (see Inpatient Rotation Core Competencies)

Resident Responsibilities
1. Given the distance from Winston-Salem, a comfortable apartment is provided for the resident to use during the rotation if needed.
2. The resident is required to be available in the hospital from 8:30 a.m. -5:00 p.m. Monday through Thursday, Fridays are spent at WFUBMC for didactic seminars and long-term psychotherapy cases.
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 night every other week during the assigned rotation. Backup assistance is available from an assigned attending for emergencies.
SELECTIVES FOR VAMC – SALISBURY

Director: Dr. German Molina

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) Addiction Psychiatry (Substance Abuse Residential Rehabilitation Program (SARRTP))
Salisbury: substance abuse residential program. This 35 bed unit functions as a 30-35 day residential program for patients with substance dependence. You may 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. Supervision is provided by the Attending psychiatrist; and admission evaluation, as well as discharge process are part of this experience.

3) Salisbury VAMC Inpatient Psychiatry Units
The Salisbury VAMC has 2 acute inpatient units with an approximate 9-day length of stay. Residents will function as a “junior attending” with supervision on the inpatient unit of your choice.

a) High Intensity General Acute inpatient psychiatry (4 3B): This unit provides services to 23 veterans, 2 full-time attending psychiatrists provide resident’s supervision during their rotation. Experience provide completion of comprehensive psychiatric evaluations, discharges dictation, medication management, participation in daily morning multidisciplinary treatment team meeting is expected. Residents will be exposed to the involuntary commitment process in some cases.

b) Chronic inpatient psychiatry (4 3A): This ward is a 20 bed unit, providing mental health services for patients beyond their acute phase, pending discharge due to a variety of
reasons. Guardianship, legal history, lack of resources or lack of family involvement are some of the barriers/challenges that the treatment team may need to resolve to accomplish a successful discharge.

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:**

**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. Clozaril as well as long-acting depot medication clinics are available. The resident 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 from 8:00AM to 4:30PM. A fulltime psychiatrist attending is assigned to this unit physically located in the Emergency Department. Residents will evaluate patients in the E.R. setting doing regular business hours under supervision. 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.

**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.
FORENSIC PSYCHIATRY ROTATION

Director: Stephen Kramer, MD

Objective: Provide a forensic psychiatry experience for the general psychiatrist

Resident Responsibilities:

1. Review ICC paperwork for petitioned patients and attend judicial review hearings
2. Serve as liaison to Elderlaw Clinic regarding capacity assessments and attend selected guardianship hearings
3. Review directed readings in forensic topics
4. Assist in open cases involving civil and/or criminal matters
5. Attend and participate in weekly individual supervision and Forensic Grand Rounds
6. Attend selected class sessions at Wake Forest University School of Law when scheduling permits

Description:

This one-month PG-4 level rotation provides a variety of didactic and practical experiences relevant to the general psychiatrist. Directed readings in the regulation of medical practice, involuntary civil commitment, medical malpractice, duty to warn and protect, decisional capacity, disability evaluations and criminal competences are reviewed in weekly individual supervisory sessions. Practical experiences, depending on the resident’s interest and available active cases at the time of each rotation, include liaison work with the medical center’s Elderlaw Clinic, attendance at guardianship hearings, attendance and participation in involuntary commitment hearings, case review, analysis, and research on a variety of civil and criminal actions, participation in relevant Wake Forest University School of Law classes including the Law-Medicine-Bioethics program, assistance in deposition and trial expert witness preparation, and assistance in Forsyth county’s new Mental Health Court. Attendance and active participation at departmental Forensic Grand Rounds is expected.

Core Competencies

Professionalism
- Understand the state Medical Practice Act and Medico-Legal Guidelines
- Demonstrate the expected behaviors in legal consultation conferences, depositions, and trial appearances

Patient Care/Procedural Skills
- Achieve the ability to perform competent and comprehensive commitment, capacity, and dangerousness evaluations

Medical Knowledge
- Become aware of resources for identifying statutory regulation, case law, and legal consultation for clinical practice
- Develop facility in applying evidence-based practice resources to standard of care questions
- Understand the various definitions and criteria for disability due to a mental disorder

**Interpersonal and Communication Skills**
- Communicate effectively with the subject in an informed consent, commitment, or criminal capacity assessment, with special attention to the limits on confidentiality
- Effectively communicate verbally and in written documents the clinical findings relevant to a forensic question

**Systems-based Practice**
- Appreciate the difference between clinical and forensic practice, including the conflicting roles of treating clinician (fact witness) and forensic reviewer (expert witness)

**Practice-based Learning and Improvement**
- Achieve a degree of comfort in dealing with attorneys and the legal system
HOMELESS OPPORTUNITIES AND TREATMENT PROJECT
CLINICAL ROTATION

Director: Dr. Liz Arnold, Project Director

Supervision: Dr. Liz Arnold – General Supervision
Dr. Thomas Brown – Medication Management Supervision

Coordinator: Sharnita Duren, MS

Location: Samaritan Ministries
1243 Paterson Ave.
Winston-Salem, NC 27103
336-748-1962
Report to Dr. Arnold

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.
SECTION FIVE:

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 with 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 effectively communicate these findings to medical peers

7. Demonstrate competence in psychiatric administration, especially the experience of managing an interdisciplinary treatment team

8. 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 read the professional and scientific literature critically

10. Ability to teach basic psychiatry to students in the health professions

C. Attitudes

1. Development of a sense of responsibility for the optimal care of patients

2. Development of 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. Development of an awareness of how physicians' attitudes may influence patient response in the treatment situation
SEMINARS

Interns are required to attend 3 separate PGY-1 seminars while on the inpatient unit that cover a variety of the core topics in general psychiatry. 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, to expose the residents to senior faculty in areas of their expertise, and to build a foundation for later didactic material.

PGY-2 and PGY-3 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.

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 PGY-2 and PGY-3 residents.

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. Attendance of 100% 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. Residents alternate coverage in the ED on Fridays so that this is protected didactic time for the remainder of the residents.
SCHOLARLY ACTIVITY GUIDELINES

Description of Educational Experience:
Another requirement of the ACGME is that General psychiatry residents will become competent consumers of scholarly material. In attaining this competency, residents are encouraged to produce and disseminate scholarly material prior to graduation from the program.

Requirements:
1. Residents will be assigned by chief residents a core psychiatry topic to teach during medical student didactics in either PGY2 or PGY3 training years.

Suggestions:
1. Residents should participate in department and consult liaison journal club presentations and monthly morbidity/mortality case conferences.

2. Residents are encouraged to produce scholarly work suitable for publication, poster presentation, or departmental Grand Rounds.
PSYCHIATRY SEMINARS AND RESIDENT ACTIVITIES

Psychotherapy Case Conference (PGY 2-3)
Psychotherapy Didactic (PGY 2)
Psychotherapy Patient Supervision (PGY-3)
Biological Seminar (PGY 2-3)
PG-1 Seminar (PGY-1)
Psychopharmacology Seminar (PGY 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)
Practical Life Skills (PGY 4 and Fellows)
Miscellaneous/Guest Lectures (All residents)
FIRST YEAR RESIDENT SEMINARS IN GENERAL PSYCHIATRY (PG-1 SEMINARS)

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 SEMINARS 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
ENHANCEMENT SEMINARS

ADVANCED TEST-TAKING SKILLS SEMINAR

The board review seminar series will meet at a minimum of once per month. This seminar covers the approach to taking high-stakes multiple choice examinations. The format alternates between topical reviews and exam item discussion. Residents obtain practice in applying what they know implicitly as well as explicitly to improve test performance. Peer teaching is used extensively.

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 to improve clinical practice.
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 SIX:

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. Resident records will be inspected by attendings, and residents 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 in WakeOne templates for History and Physical.

B. Progress Notes

Daily progress notes should be maintained for each patient. These are done electronically in WakeOne. 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 are completed by filling out all of the appropriate information in the electronic note template for each patient. This includes providing information on the presenting complaint, HPI (including nursing report), pertinent social history and family history, current precautions, mental status examination, labs and imaging, an updated assessment with Axis I-V, and a daily plan.

C. Discharge Summary

Discharge summaries should be completed on the day of discharge and in no event later than 24 hours after discharge. You must complete each summary in WakeOne.
GUIDELINES FOR COMPOSING PSYCHIATRY NOTES

All notes should include the following elements:

1. Identification of the encounter being documented.
   
   **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. Kimball, 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.

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 (90805) and the longer one used for insight-oriented or at times cognitive therapy (90807). 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
ADMISSION POLICIES AND 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 can be 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 or self-care resulting in deterioration of daily functioning.

II. Legal Paperwork

   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:

      i. Examination and Recommendation to Determine Necessity for Involuntary Commitment (1st Opinion) and

      ii. Affidavit

   Both forms need to be notarized by security (6-3305). This same procedure applies to patients who 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 or by phone at 713-5745 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 the 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.

B. If the parent or guardian agrees to hospitalization, regardless of the patient’s wishes, the parent or guardian 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. Both forms should be filled out before the patient leaves the ED to go to the Child-Adolescent Unit.

C. If the parent or guardian refuses to cooperate or is unavailable, and it is deemed necessary to hospitalize the minor, the standard involuntary commitment procedures will be followed.

IV. Some Pointers

1. 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. This is especially true with commitment paperwork. Most magistrates do not have extensive experience in the medical field. Instead of saying "Patient X is suffering from a Major depressive episode and is suicidal," you could say "Patient X is depressed because his wife left him and wants to kill himself by shooting himself in the face."

2. Always send copies of your work-up, along with pertinent laboratory/imaging with the patient when going to an outside hospital. This enables the receiving facility to treat the patient more effectively. Also, remember to include information on any medications that have been given to the patient, most notably sedative medications.

3. Remember that commitment is a legal process. Care should be taken to fill out all the forms completely and correctly. 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.
PROCEDURE FOR ADMISSION OF CURRENT MEDICAL CENTER PATIENTS TO THE ADULT PSYCHIATRY INPATIENT UNIT FROM THE EMERGENCY DEPARTMENT AND IN TRANSFER FROM THE MEDICAL/SURGICAL FLOORS

Background:
With significant changes in the environment regarding the referral and admission of patients to psychiatric facilities, traditional standards for criteria for admission and the process for conducting reviews to deem whether patients are appropriate for admission, are no longer suitable.

Significant environmental factors which have changed include (but are not limited to):

1. Reduced capacity at State Psychiatric Hospitals and the ability of the State Psychiatric Hospitals to refuse admissions.
2. Shortened length of stays in State Psychiatric Hospitals, i.e. minimal “long-term” care.
4. Longer stays in the Emergency Department for patients requiring psychiatric inpatient care and increasing levels of interim treatment being administered.
5. Higher occupancy rates of Medical Center medical/surgical beds.
6. Higher requirements for staffing (nursing and Security) for patients under Involuntary Commitment, in medical/surgical beds.
8. A more “Patient Centered Care” approach within the Medical Center. “Physician-centered” preferences, such as selecting cases on the basis of their educational value, cannot take precedence over what is in the best interest of the patients already in or Emergency Department or already admitted to the Medical and Surgical floors.
9. Now that WFUSM, WFUP, and NCBH are led by a common governance, a greater degree of collaboration and mutual support is expected between all units. Decision making is expected to follow the line that will lead to the best result for the patient and the institution as opposed to the best result for a single business unit.

Purpose:
To provide a clear standard and process for determining whether patients currently in the Medical Center, i.e. in the Emergency Department or in a medical/surgical bed, are appropriate for admission to the Adult Psychiatry Inpatient Unit. To improve the efficiency of the internal admission process during daytime hours and thereby improve the quality of patient care and reduce the burden on the ED, medical/surgical units and staff, and the Psychiatry On-Call physicians.
Procedure:

1. On-Call, “after hours” admission decisions will be handled in the traditional manner, with the on-call attending having the final approval for admissions to the inpatient unit.

2. Patients staffed by a faculty member and deemed suitable for admission to the Adult Psychiatry Unit will be pre-certified by the Admissions Coordinator. The Admissions Coordinator will apprise the physician referring the patient for admission of bed availability and of unit acuity concerns which might affect determination of appropriateness for the admission. The physician will then consult with the accepting inpatient physician, who will ensure that the unit has the capacity (in part, according to the criteria below) and space to admit the patient. Should there be disagreement in regards to the suitability of the admission, or if the inpatient physician is unavailable, the Medical Director of the inpatient unit, or his or her designee, will be asked to consult on the admission, and if necessary, personally examine the patient. Should there still be disagreement, or a decision not be reached within one hour, the Chair of the department, or his or her designee, will arbitrate the discussion. The inpatient attending will discuss with the admissions coordinator specific logistical issues which may affect the timing of the transfer to the unit.

3. The Medical Director of the Inpatient Unit, or his/her designee, in consultation with the Nurse Manager/Assistant Nurse Manager or his/ her designee, will inform the Admissions Coordinator at the start of each day what the “acuity” status of the unit is with regard to Behavioral Management Issues and High Patient Care Requirements. In addition, the Nurse Manager/Assistant Nurse Manager or his/her designee will inform the medical director, or his/her designee, and the admissions coordinator about issues regarding the staffing on the unit. This status can be updated at any time during the day if there is a significant change in the acuity status of the unit. This information will be communicated to the psychiatry care coordinators in the evening to assist with management decisions after hours.

4. Level of Behavioral Management Acuity for the Adult Psychiatry Inpatient Unit will determined by the number of patients who in the last 24 hours have required seclusion or restraint, 1:1 supervision, forced medications or 24 hour security supervision. If 2 or more patients on the Inpatient Unit have required this type of management, with nursing staff at full complement, the Inpatient Unit would be capped for patients with similar, current behavioral management needs. Patients referred for admission who have not required behavioral management in a 24 hour period, with nursing staff at full complement, the unit would be capped for patients with current Behavioral Management needs. The assessment as to whether a patient waiting to be admitted to an adult psychiatry bed has a high degree of behavioral management acuity will be based upon reports of their behavior in the last 24 hours. For patients who have been waiting for >24 hours for an adult psychiatry admission, a daily re-assessment of their clinical status is expected, and the results of the observed behavior in the last 24 hours serves as the basis as assessment of their present behavioral management acuity.

5. Level of High Patient Care Requirements would be determined by the number of patients on the Inpatient Unit who are medically compromised, e.g. requiring “total care” or 1:1 supervision. If 2 or more patients have required total patient care or 1:1 supervision in the past 24 hours, with nursing staff at full complement, the unit would be capped for patients with current High Patient Care requirements.
6. Level of medical stability is determined according to the following criteria:

Serum potassium level should be greater than 2.8 and less than 6. For patients with low potassium level, there should be no active vomiting for at least 4 hrs. For K+ of 2.8-3.1 patient should receive potassium replacement in the ED. No replacement is needed for levels greater than 3.1 if not vomiting and able to eat normally.

Serum sodium level should be 128 or higher. If less than 128, must be documented history of chronic hyponatremia or repeat level demonstrating that sodium is not falling and no evidence that the low sodium is causing mental status changes.

**Acetaminophen overdose:** Patient should have a 4 hour Acetaminophen level of less than 140 (or other appropriate non-toxic level if greater than 4 hours from ingestion) and have no other signs of significant overdose such as significantly elevated liver enzymes or persistent vomiting. INR levels and hepatic transaminases are requested if liver involvement is suspected.

**Diabetics:** Blood sugar level should be between 65-400 and no evidence of DKA. If initial blood sugar is less than 65, hypoglycemia should be treated and patient observed in the ED. Patient can be transferred after blood sugar remains greater than 65 for 2 or more hours and is able to take PO intake.

**Stable Vital Signs:** For elevated blood pressure, patient should have no signs of hypertensive urgency. Patients with blood pressure greater than 200 systolic and/or 110 diastolic and no signs of a hypertensive urgency/emergency, should have blood pressure therapy initiated consistent with ACEP guidelines.

If measured, alcohol level should be less than 300 mg/dl and the patient should have been psychiatrically re-evaluated and still meet commitment criteria. Intoxicated patients with any positive alcohol level should be able to walk safely and take PO.

WBC should be >2000/ Absolute Neutrophil Count> 1000 and less than 20,000.

The unit cannot take patients who have the following medical comorbidities. This list is not meant to be all inclusive:

- Active treatment for Clostridium difficile
- Requiring Jackson-Pratt drains.
- Requiring a wound-vac.
- Are in need of telemetry.
- Medical conditions requiring blood transfusions
- Requiring IV push medications.
- Requiring IV seizure medications.
- Diabetic Ketoacidosis
- Evolving MI
- Evolving CVA
- Uncontrolled hypertensive crisis
- Condition requiring ventilator use.
- Hepatic encephalopathy
- Unexplained elevated WBC
- Acute renal failure
- Unstable vital signs not related to a history of a chronic condition
- Active contagious varicella infection
- Frank GI bleeding
- Sickle cell crisis
- Acute post operative condition
- End stage liver disease
- Requiring peritoneal dialysis
- Requiring central venous access

Medical stability will be determined by the Emergency Department or by the inpatient medical team. Our inpatient unit will plan to accept patients who would otherwise be deemed “medically ready for discharge” and meet the above criteria from the ER or Medical team if not for their psychiatric issues. The inpatient attending can confer with the referring attending should there be specific concerns about the patient’s status. If medical or surgical consults are required during a patient’s inpatient stay, the inpatient psychiatric team can request consults as appropriate. Unresolved questions about medical clearance should be addressed directly with the ER attending or medical inpatient attending rather than through the consult psychiatrist.

7. Elements of an initial consult note should include the patient’s present psychiatric symptoms, past psychiatric history, family psychiatric history, social history, past medical history, medications, and a complete mental status examination. The note should also include a review of tests and procedures. In most cases, obtaining this information in the initial consult note should provide enough information to make the decision to admit the patient, in accordance to North Carolina Baptist Hospitals, Inc. Admission Criteria for Adult Behavioral Health. Part of this policy is listed below:

**Diagnostic Criteria for Admission to the Inpatient Unit**

a) Presence of a mental disorder as defined by the DSM-V-TR.

b) Patients admitted for substance detoxification must also have another DSM diagnosis other than intoxication or withdrawal. Delirium tremens is considered an acute medical emergency and such patients will be treated on a medical unit or higher intensity within the medical center.

c) Patient has failed reasonable outpatient therapeutic options, or is of such diagnostic and treatment complexity that inpatient treatment is the safest, and most expeditious, and least restrictive treatment option. The active psychiatric disorder can either be more effectively treated or treated more rapidly to decrease the individual’s suffering in the inpatient setting.

d) The patient poses an imminent risk for self injury, within an ability to maximize safety, due to the presence of the psychiatric illness.

e) The patient poses an imminent risk for injury to others due to the presence of a psychiatric illness.

f) There is an acute and serious deterioration from the patient’s baseline ability to fulfill age-appropriate responsibilities in a least one area of essential life function to the extent that the behavior is so disordered, disorganized, or bizarre that it would be unsafe for the individual to be treated in a less restricted environment.
g) There is imminent risk for acute medical status deterioration due to the presence and/or treatment of an active psychiatric disorder.

h) Patients with secondary medical diagnoses may be treated on the inpatient behavioral health unit provided that the attending psychiatrist is satisfied, through his or her own review of the assessment of the consultant, that these conditions are stable. Patients with colostomies, ileostomies, tracheotomies must be able to provide substantial self-care for these.

References:


MORNING REPORT / DAILY PATIENT CHECK OUT

Both the ACGME and Joint Commission have requirements in regards to transition of care of patients. With new duty hour regulations for residents, this will become even more important to provide effective care and adequate safety for our patients. This can also provide an excellent teaching opportunity as well.

- Starting July 1, 2011, and each weekday thereafter, a morning report will be instituted. The location of this will be in the conference room by the Sticht Center, where morning report is given. The time will be 7:30 am, and will be led by a faculty member or a senior resident. Attendance is mandatory for all inpatient residents. The resident who is coming off of call will present cases of patients who were admitted to the adult unit, as well as any issues that need to be followed up. This will be a 30 minute discussion. If time allows, the faculty member or senior resident can discuss specific teaching points or recent research in a particular area.

After this meeting, the resident who is coming off of call will then proceed to the child and adolescent unit at 8:00 am, to discuss those patients who were admitted to the child and adolescent unit overnight, and to discuss any issues that need to be followed up. Attendance will be mandatory for child and adolescent fellows and residents rotating on that service. A member of the CL team and Emergency Psychiatry team will also be present for check-out on any patients relevant to their services.

- On weekends and holidays, there will be an abbreviated morning report. The resident who is post call will present cases to the weekend / holiday attending and oncoming resident in a written format at 8:00 am on the adult unit. These will include admissions, consultation, and emergency department patients.

Afternoon checkout

A. At 5:00 pm Monday-Thursday and 4:00 pm on Friday, Inpatient, Consult, and Emergency Psychiatry residents will verbally check-out their patients with the on-call resident for that night. This will include a brief synopsis of pertinent information about each patient as well as issues that may develop during their call shift.
DISCHARGE SUMMARY FORMAT
FOR ADULT PSYCHIATRIC INPATIENT UNIT

Although a majority of the information contained in the discharge summary will be automated from the initial H&P note, this provides a general guide for the information that should be contained within the completed discharge summary.

- Resident’s name
- Unit number
- Location (Adult or Child Inpatient Psychiatry Unit)
- Attending’s name
- Admission date
- Discharge 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 name
- Attending’s name
- cc (who should receive copies for continuity of care)
- Assign to Attending for co-signature
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 a resident leaves the program. Malpractice coverage covers residents for all rotations on site and away from the Medical Center. However, it does not provide coverage for extra-residency practice (i.e. moonlighting). A resident must provide his own coverage if it is not offered by the moonlighting institution.

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 Director of Adult Resident Education 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 SEVEN:
RESIDENT FUNDAMENTALS
AND POLICIES
FACULTY ADVISOR PROGRAM

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 relationship 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:

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

IMPLEMENTATION:

Faculty advisors will be assigned annually as new interns or transfer residents enter the program. 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 PROFESSIONALISM AND TEAM WORK

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

- Compassion
- Integrity
- Respect for others
- Responsiveness to patient needs that supersedes self-interest
- Respect for patient privacy and autonomy
- Accountability to patients, society and the profession
- Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective inter-professional teams that are appropriate to the delivery of care in the specialty.
DUTY HOURS & CALL

NIGHT CALL AND BEEPER 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 8:00 am 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.

As of July 2011, the ACGME has instituted new duty hour policy for interns and residents. Interns will take an average of 6 - 7 week-day primary calls, an average of 7 weekend primary calls, and a variable amount of back-up. These numbers may fluctuate some depending on the number of residents per year. These "call" days are actually shifts and are no longer than 16 hours in duration. Week-day calls are split into two shifts: 5pm until 10pm and 10pm until 8am. The intern that is covering the 10pm until 8am shift will need to leave the hospital by 12pm the day of the shift and by 2pm the next day after the shift is completed.

During the first three months of intern year, the intern will have an upper level resident in house during the duration of call. (In-house back-up). At the end of the three month period in September, interns will have the opportunity to demonstrate their competence to take call without direct upper level supervision by means of an observed patient encounter by a faculty member. The intern will interview a new patient with a faculty member present. After the interview they will present key historical facts, mental status exam findings, and case formulation to the faculty member. If the faculty member agrees that the intern gathered an appropriate history, has the ability to perform an emergent psychiatric assessment, and can present patient findings accurately to a supervisor who would not have been present, and would be willing to ask for help when indicated, he will grant the intern the privilege of taking call without direct supervision. At this time the intern will still have a back-up resident that he can call for help, along with a faculty member who is present via phone to discuss cases and answer questions.

The interns covering the inpatient units are responsible for all on-campus admissions during the week that they are notified of before 5pm on Monday through Thursday and 4pm on Friday. If the patient does not make it to the unit before 6pm on Monday through Thursday or by 5pm on Friday then the new admission goes to the resident on-call. However, the intern(s) on the inpatient unit should make every effort to complete the admission for patients from the WFBH emergency department (ie: go to the ED and see patient if necessary). For admissions coming from outside the hospital, residents on the inpatient unit are responsible for completing these admissions if they make it to the unit by 6pm on weekdays and 5pm on Fridays. Any admissions that come after the times mentioned above are the responsibility of the on-call resident.

Second year residents are expected to take four primary calls, three week-day back-up calls and three weekend back-up calls. During the first three months of the year, one week-day back-up will be in house and all three weekend back-up calls will be in-house. Friday primary calls are covered by second year residents.

Third year residents are expected to take two primary calls and six back-up calls. Depending on the number of residents per year, one to two of the back-up calls will be on the weekend. During the first three months of the year, a variable amount of the week-day back-ups will be in house and the weekend back-ups will be in house during that time.
Fourth and Fifth year residents generally do not take primary call unless there is an emergency. PG-4 residents are assigned to cover emergency room consults in a rotation with all residents on Fridays in order for residents to have protected time for lecture.

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.
**Back-up Call**

The general recommendation is for the primary resident to 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 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. As above, the criteria to call in back-ups are simply a recommendation. If the primary resident feels overwhelmed or fatigued, he is encouraged to call in the back-up at that time.

The backup should also be called if the workload becomes heavy, preventing timely response to patient needs. Patient care is our top priority, and as such, any instance where patient care is compromised by workload should lead to the back-up resident being called in. Residents on 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 Protocol** - *In the event the primary on-call resident is unable to take call due to serious illness, accident, bereavement, or other unforeseen circumstances, then the back-up resident is obligated to take primary call. It is not acceptable for the back-up resident to refuse to cover primary call. It is also not acceptable for the back-up resident to delay coming in when called by the primary resident. The back-up call resident should be able to get to the hospital within 30 minutes of being called. If a back up resident does have to take the primary call, then a 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, his 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 to be removed from the emergency back-up list. PGY-5s do not take primary, back-up or emergency back-up call.*
SUPERVISION OF RESIDENTS DURING CALL

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

• Residents and faculty members should inform patients of their respective roles in each patient’s care.

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

• To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:
  
  o Direct Supervision – the supervising physician is physically present with the resident and patient.
  
  o Indirect Supervision:
    ▪ With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
    ▪ With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

• The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

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

• The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

• Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

• Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

• Residents must communicate major patient events with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life
decisions.

- Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
  - In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.
  - Each PGY-1 resident will perform a core competency exam in order to progress to the next level of supervision.

- Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.
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 24 hours of consecutive clinical responsibility and you may remain in-house up to an additional 4 hours to complete transition of care for patients. In summary, the ACGME standards as of July 2011, now limit a resident work shift to a total of 28hrs.

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 and the chief residents 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.

Reference:
http://www.acgme.org/acWebsite/home/Common_Program_Requirements_07012011.pdf
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 to 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 the resident has been working 24 consecutive hours, he 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 that need to be relayed.

II. Coordination of care:

• All consult notes (ED and inpatient) are to be signed in the electronic system at the end of each shift (before leaving for the day).

• If any department clinicians’ patients are seen on call, that clinician should be electronically routed a copy of the note or notified via email.

III. Weekend call:

• Inpatient residents (adult and child) will leave brief summaries in the attending weekend note file or through email for each patient on the inpatient service. Notes should include labs to check, medical issues to monitor, behavior to monitor, and recommendations for management.

• 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.

• On-call residents will pass the consult list to the next resident on call in a face-to-face checkout. They will check out to each other concerning any pressing issues with inpatients, consults, and/or ED patients.

• Sunday evening on call resident (10pm-8am shift) will have a face-to-face checkout with the primary inpatient team at 7:30 am Monday morning. At 8:00 am the resident will check-out with the primary Child and Adolescent Team, and will then check-out with the consult team. This process will involve a summary of issues with consults (floor or ED) seen, any consults called in but not seen, and updates on current/new patients in the ED or Inpatient Units. Specific information will include labs to check, medical issues to monitor, summary of psychiatric condition over the weekend, behavior to monitor,
medication changes made with rationale, and recommendations for managing behavioral changes.

THE ACGME STANDARDS OF DUTY HOURS AS OF JULY 2011

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

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

- Residents must demonstrate ability for recognition of impairment, including illness and fatigue, in themselves and in their peers; and also show honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

- All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.

- The program must educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation, alertness management and fatigue mitigation processes. The program must adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

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

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

Maximum Hours of Work per Week:

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

- Duty Hour Exceptions: A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.
  
  - In preparing a request for an exception, the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO.

- Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
  
  - PGY-1 residents are not permitted to moonlight.
Residents who are permitted to moonlight must be in good academic standing within the department.

- **Mandatory Time Free of Duty:** Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

- **Maximum Duty Period Length:**
  - Duty periods of PGY-1 residents must not exceed 16 hours in duration.
  - Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.

- Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

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

- Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

- In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
  - Under those circumstances, the resident must: appropriately hand over the care of all other patients to the team responsible for their continuing care; and, document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
  - The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

- **Minimum Time Off between Scheduled Duty Periods:**
  - PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
  - Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
  - Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.
This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

- **Maximum In-House On-Call Frequency:**
  - PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

- **At-Home Call:**
  - Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
  - At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
  - Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
Policies

LEAVE POLICIES

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.

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 the residents, gaining "hands on” experience in history taking, physical examination, neurological examination, talking with patients, and dealing with other staff members. When a resident is on call, he/she should make every effort to get the medical student out to see patients. Where it is possible, the resident should observe the medical student interviewing patients and then give feedback. Residents must read all medical student work-ups and progress notes, review them with the student and critique the efforts. Residents are clearly the role model for the medical students, especially in the process of diagnosis and treatment planning.

PG 2-3 residents will also participate in the delivery of medical student lectures on Thursday afternoons throughout the year. Typically, each PG 2-3 will chose a topic from the following: mental status examination, mood disorders, psychotic disorders, anxiety disorders, substance abuse, personality disorders, factitious/somatoform, 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 via an online student evaluation that is reviewed by the Director of Medical Student Education. Resident input is absolutely necessary for accurate evaluation of student performance.

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://outlook.wakehealth.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.

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 afterhours 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.
PSYCHIATRY RESIDENCY POLICY

AREA: EDUCATIONAL POLICY COMMITTEE

DATE: 6/15/88; revised 4/95; 1/03; 09/05; 9/12

Purpose: The Educational Policy Committee (EPC) is organized to oversee all undergraduate and graduate medical education activities of the Department of Psychiatry. This currently includes medical student education, general psychiatry residency training and child fellowship training.

The EPC will be actively involved in the planning, development, implementation, and evaluation of all significant features of the residency training program and the program for medical student education. The EPC will oversee the activities of the Child and Adolescent Fellowship Faculty Committee, through reports from the Director of Training in Child/Adolescent Psychiatry.

Composition: A committee chairperson and a minimum of 6 (six) additional faculty members are appointed to the EPC by the Chairperson of the Department of Psychiatry. Standing members of the committee include the Director of Residency Training, the Director of Medical Student Education in Psychiatry, and the Director of Training in Child and Adolescent Psychiatry. Additional faculty members may be chosen to represent major areas of clinical teaching and the allied health professions (social work and psychology). Faculty membership of the committee is reviewed annually and suggestions for changes are submitted to the Department Chairperson by the EPC chairperson.

Residents are represented on the EPC by the Chief Resident and a PG-2 resident nominated by the PG-1 and PG-2 residents, and appointed by the Department Chairperson. Such nominations are not binding on final appointment. Resident members participate as voting members of the EPC except in matters involving individual residents, e.g. performance evaluations, in which the PG-2 member does not participate.

The members of the EPC also comprise the Residency Selection Committee, chaired by the Residency Training Director, to oversee the process of resident recruitment and selection.

Process: The EPC meets monthly with additional meetings called by the EPC chairperson as needed to address special issues. All matters involving the creation of or changes in, department policy must be approved by the Department Chairperson.

Any EPC member may raise agenda items for the committee. There should be routine reports from the Residency Training Director, the Director of Medical Student Education, and the Director of the Child and Adolescent Fellowship Program.
PSYCHIATRY RESIDENCY POLICY

AREA: RESIDENT SELECTION COMMITTEE

DATE: 7/10/88; 09/05; 9/12

Description: The members of the Educational Policy Committee are also members of the Resident Selection Committee, which is chaired by the Director of Resident Education.

The committee will meet as convened by the chairperson as required by the residency selection process.

Members of the committee will actively participate in the interviewing process of applicants.

Objectives: The objective of the committee is to provide a broad-based group of faculty and residents to evaluate applicants. The committee will support the Director of Residency Training in recruitment efforts and provide direction and ideas in this area.

Implementation: This policy is effective as of July 1, 1988.

Effectiveness Evaluation: The committee will be largely self-evaluating. It is charged with evaluating the adequacy of the selection process and the accomplishments of accepted applicants.
PSYCHIATRY RESIDENCY POLICY

AREA: RESIDENCY APPLICATION AND SELECTION

DATE: 1/18/89; revised 4/95; 10/00; 1/03; 09/05; 9/12

Description: Application - Prospective applicants requesting information regarding the psychiatric residency training program are routinely referred to the institution’s website for additional materials. An electronic application process for PG-1 applicants was instituted with the 2001 entering class (ERAS). A written application form for house staff positions is available for transfer applicants.

Applications consist of the following documents:

1. The standard application form: hospital or Common Application Form (CAF).
2. A letter of recommendation or Medical Student Performance Evaluation from the applicant's medical school dean.
3. A certified transcript of medical school grades.
5. For transfer applicants, a letter certifying the level of completion of training from the residency director. Personal communication with previous training directors will be pursued.

Completed applications are reviewed by the Director of Resident Education, and potentially acceptable applicants are invited for interviews. Applications are screened to assure that:

1. The applicant is a graduate of a U.S. or Canadian medical school accredited by the Liaison Committee on Medical Education (LCME), or is a graduate of a college of osteopathic medicine in the U.S. accredited by the American Osteopathic Association, or holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG), or has a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction, or has graduated from a medical school outside of the U.S. and has completed a Fifth Pathway Program provided by an LCME accredited school.
2. An international medical graduate must be a U.S. citizen or holder of INS Form 551 or a J-1 visa.
3. The academic record certifies acceptable medical performance during undergraduate medical education.
4. The letters of reference indicate satisfactory performance and ethical character.

For transfer applicants, additional data are required to document satisfactory performance postgraduate education. Personal contact with the training director of the resident's former program should be made by the Director of Resident Education.

Interview: Applicants will be routinely scheduled for interviews with the following persons:

1. The Director of Resident Education
2. The Chief Resident
3. The Department Chairperson
4. Two faculty members, at least one of whom should be a member of the Resident Selection Committee

5. At least one, preferably two residents, one of whom should take the applicant to lunch

The applicant receives a resident-led tour of the department offices, the inpatient unit and the Medical Center facility.

**Rating of Applicants:** The interviewed applicants will be reviewed by the Resident Selection Committee and rank ordered according to acceptability for training on the NRMP form. Transfer applicants will be considered on an individual basis.

**Objectives:** Objectives of the selection process are to achieve adequate numbers of well-qualified first year residents and to fill vacancies in other levels of the training program. We will select residents from among eligible applicants on the basis of preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. We do not discriminate with regard to sex, race, age, religion, national origin, disability, or veteran status.

**Implementation:** The above policies are effective as of July 1, 1988, and revised April 1995, October 2000, January 2003, September 2005, and September 2012.

**Effectiveness Evaluation:** The effectiveness of the resident selection process is formally evaluated by the Resident Selection Committee, which reports to the Department Chairperson.
PSYCHIATRY RESIDENCY POLICY

AREA: SPECIFIED EDUCATIONAL OBJECTIVES

DATE: 7/9/88; revised 4/95; 10/00; 1/03; 09/05; 7/08; 9/12

WAKE FOREST UNIVERSITY SCHOOL OF MEDICINE
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL MEDICINE
STATEMENT OF EXPECTED COMPETENCIES BY GRADUATION

OBJECTIVES: This section outlines the core psychiatry and psychotherapy competencies each resident is expected to achieve by the time of graduation. Methods by which residents may demonstrate achievement of competency may include observation of the care of patients and families, participating in didactics and clinical conferences, case presentations, case logs, portfolios, 360° evaluations, written evaluations, and oral/written examinations.

PSYCHIATRY CORE COMPETENCIES

PATIENT CARE

1. The resident shall demonstrate the ability to perform and document a comprehensive psychiatric history and examination in culturally diverse adult, geriatric and child/adolescent patients to include:
   • complete present and past psychiatric history
   • Social, cultural and educational history
   • Family history, including ethno cultural and generational aspects
   • Substance abuse history
   • Medical history and review of systems
   • Physical and neurological examination
   • Comprehensive mental status examination including the assessment of cognitive functioning
   • Developmental history

2. Based on a comprehensive psychiatric assessment (See #1) the resident shall demonstrate the ability to develop and document
   • A complete DSM multi-axial differential diagnosis
   • An integrative case formulation that includes neurobiological, phenomenological, psychological, and social and cultural issues involved in diagnosis and management
• An evaluation plan including appropriate laboratory, medical and psychological examinations

• A comprehensive treatment plan addressing biological, psychological and social and cultural domains.

3. The resident shall demonstrate the ability to comprehensively assess, discuss, document and intervene concerning the patient’s potential for self-harm or harm to others. This shall include:

• An assessment of risk based on known risk factors

• Knowledge of involuntary treatment standards and procedures

• Effectively intervening to minimize risk

• Implementing prevention methods for self-harm and harm to others

4. The resident shall demonstrate the ability to conduct therapeutic interviews, e.g., enhance the ability to collect and use clinically relevant material through the conduct of supportive interventions, and exploratory interventions and clarifications.

5. The resident shall demonstrate the ability to conduct a range of individual, group, and family therapies using standard, accepted models that are evidence-based, and integrate these psychotherapies in multi-model treatment, including biological and social and cultural interventions.

6. The resident shall demonstrate “competency” in the development and practice of 3 psychotherapies: supportive, cognitive-behavioral and dynamic.

MEDICAL KNOWLEDGE

1. The resident shall demonstrate knowledge of the major psychiatric disorders including age, gender and social and cultural considerations, based on the scientific literature and standards of practice. This knowledge shall include:

• The epidemiology of the disorder

• The etiology of the disorder including (when known) medical, genetic and social/cultural factors

• The phenomenology of the disorder

• The experience, meaning and explanation of the illness for the patient and family including the influence of cultural factors and culture-bound syndromes

• DSM diagnostic criteria

• Effective treatment strategies

• Course and prognosis
2. The resident shall demonstrate knowledge of psychotropic medications including the antidepressants, anti-psychotics, anxiolytics, mood-stabilizers, hypnotics and stimulants. This knowledge shall include the resident shall demonstrate knowledge of substances of abuse. This knowledge shall include:

- Pharmacological action
- Signs and symptoms of toxicity
- Signs and symptoms of tolerance and withdrawal
- Management of toxicity, tolerance and withdrawal
- Epidemiology, including social and cultural factors

3. The resident shall demonstrate knowledge of human growth and development, including normal biological, cognitive, and psychosexual development including social and cultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors.

4. The resident shall demonstrate knowledge of emergency psychiatry. This shall include:

- Suicide
- Crisis intervention
- Differential diagnosis in emergency situations
- Treatment methods in emergency situations
- Homicide, rape, and violent behavior

5. The resident shall demonstrate knowledge of behavioral science and social/cultural psychiatry. This shall include:

- Learning theory
- Theories of normal family organization, dynamics, and communication
- Theories of group dynamic and process
- Theology, anthropology, and sociology as it pertains to clinical psychiatry
- Trans cultural psychiatry
- Community mental health
- Epidemiology
- Research methods and statistics
6. The resident shall demonstrate knowledge of psychosocial therapies. This shall include:
   • All forms of psychotherapies (group, individual, family, behavioral theory and practice)
   • Treatments of psychosexual dysfunctions
   • Hypnosis
   • Doctor-patient relationship

7. The resident shall demonstrate knowledge of somatic treatment methods. This shall include:
   • Pharmacotherapy (as indicated in # 2 above)
   • ECT
   • Biofeedback

8. The resident shall demonstrate knowledge of patient evaluation and treatment selection. This shall include:
   • Psychological testing
   • Laboratory methods used in psychiatry mental status examination
   • Diagnostic interviewing
   • Treatment comparison and selection

9. The resident shall demonstrate knowledge of consultation-liaison psychiatry. This shall include:
   • Specific syndromes, e.g., stress reactions, post-partum disorders, pain syndromes, postsurgical and ICU reactions, etc.
   • Psychiatric aspects of non-psychiatric illness
   • Psychiatric complications non-psychiatric treatment
   • Psychosomatic and somatoform disorders
   • Models of consultation psychiatry

10. The resident shall demonstrate knowledge in child and adolescent psychiatry. This shall include:
    • Assessment and treatment of children and adolescent
    • Disorders usually first diagnosed in infancy, childhood or adolescence
    • Mental retardation and other developmental disabilities
11. The resident shall demonstrate knowledge in forensic psychiatry

12. The resident shall demonstrate knowledge in administrative psychiatry and in systems of health care delivery.

13. The resident shall demonstrate knowledge of ethics.

**INTERPERSONAL AND COMMUNICATION SKILLS**

1. Interpersonal skills refer to the ability of the psychiatrist to develop and maintain therapeutic relationships with culturally diverse patients and work collaboratively with professionals and the public.

2. Interpersonal skills require an underlying attitude of respect for others, including those with differing points of view or from culturally diverse backgrounds, the desire to gain understanding of another's position and reasoning, a belief in the intrinsic worth of all human beings, the wish to build collaboration, the desire to share information in a consultative rather than in a dogmatic fashion, and the willingness to continuously self observe and confront one's own biases and transferences.

3. Interpersonal skills are defined as the specific techniques and methods which facilitate effective and empathic communication between the psychiatrist; patients; families; significant others; colleagues; staff; and health care system. [Whenever families appear below, significant others are to be included].

4. The competent resident is able to demonstrate the following skills:
   - Ability to listen to and understand patients and families.
   - Ability to communicate effectively with patients and families, using verbal, nonverbal, and writing skills as appropriate.
   - Ability to foster a therapeutic alliance with patients, as indicated by instilling feelings of trust, openness, rapport and comfort in the relationship with the physician.
   - Ability to use negotiation to develop an agreed upon health care management plan with patients and families when appropriate.
   - Ability to transmit information to patients and families in a clear, meaningful fashion.
   - Ability to understand the impact of the physician's feelings and behavior on psychiatric treatment.
   - Ability to communicate effectively with allied healthcare professionals and with other professionals involved in the life of patients.
   - Ability to educate patients, families and professionals about medical, psychological and behavioral issues.
   - Ability to work effectively within multidisciplinary, team structures as member, consultant or leader.
• Ability to form relationships with patients, families and professionals in a culturally sensitive and responsive fashion.

• Ability to exhibit professional, ethically sound behavior and attitudes in all patient and professional interactions.

5. The resident shall demonstrate the ability to elicit information. This will include skills in eliciting important diagnostic data and data affecting treatment from individuals from culturally diverse backgrounds. This will include skills in tolerating and managing high levels of affect in the patients.

6. The resident shall demonstrate the ability to obtain, interpret, and evaluate consultations from other medical specialties, other helping professionals and community-based resources. This shall include:

• formulating and clearly communicating the consultation question
• discussing the consultation findings with the consultant
• evaluating the consultation findings

7. The resident shall serve as an effective consultant to other medical specialists, mental health and other helping professionals and community-based resources. The resident should demonstrate the ability to:

• communicate effectively with the requesting party to refine the consultation question
• maintain the role of consultant
• communicate clear and specific recommendations
• respect the knowledge and expertise of the requesting party

8. The resident shall demonstrate the ability to communicate effectively with patients and their families and significant others by:

• providing explanations of psychiatric disorders and treatment (both verbally and in written form) that are jargon free and geared to their educational/intellectual level
• providing preventive education that is understandable and practical respecting the patient and families cultural, ethnic, and economic background and identity and its impact on the illness experience, meaning and explanation.
• demonstrating the ability to develop and enhance rapport and a working alliance with patients, families and significant others.
• The resident shall demonstrate the ability to manage his/her own affects and counter transference. This will include the cross-cultural context, which might involve bias and stereotyping
9. The resident shall maintain psychiatric medical records that are:
   - Legible
   - Timely
   - Capture essential information while simultaneously respecting patient privacy
   - Useful to non-psychiatric health professionals

10. The resident shall demonstrate the ability to effectively lead a multidisciplinary treatment team. This skill includes the ability to:
   - listen effectively
   - elicit needed information from team members
   - integrate information from different disciplines
   - manage conflict
   - Clearly communicate an integrated treatment plan the social/cultural diversity of the team members

11. The resident shall demonstrate the ability to effectively communicate with the patient and their family (while respecting confidentiality)
   - The results of the assessment
   - The risks and benefits of the proposed treatment plan, including
     - Possible side-effects of psychotropic medications
     - Alternative (if any) to the proposed treatment plan
     - Education concerning the disorder, its prognosis and prevention strategies

**PRACTICE BASED LEARNING AND IMPROVEMENT**

1. Psychiatrists must recognize and accept limitations in one’s knowledge base and clinical skills, and understand the need for life-long learning.

2. The resident will have appropriate skills and demonstrate obtaining up to date information from the scientific and practice literature and other sources to assist in the quality care of patients. This shall include but not be limited to:
   - Use of medical libraries
   - Use of information technology including internet based searches and literature databases (e.g., Medline)
   - Use of drug information databases
3. The resident shall evaluate caseload and practice experience in a systematic manner. This may include:

- Maintaining of patient logs
- The review of patient records and outcomes
- Obtaining evaluations from patients and family members (e.g., outcomes and patient/family satisfaction)
- Obtaining appropriate supervision and consultation
- Maintaining a system for examining errors in practice and initiating improvements to eliminate or reduce errors

4. The resident shall demonstrate an ability to critically evaluate the psychiatric literature. This may include:

- Using knowledge of common methodologies employed in psychiatric research to evaluate studies, particularly drug treatment trials
- Conducting and presenting reviews of current research in such formats as journal clubs, grand rounds and/or original publications
- Researching and summarizing a particular problem that derives from the resident's case load

5. The resident shall be able:

- To review and critically assess the scientific literature to determine how quality of care can be improved in relation to one's practice (i.e., reliable and valid assessment techniques, treatment approaches with established effectiveness, practice parameter adherence). Within this aim, the resident should be able to assess the generalizability or applicability of research findings to one's patients, in relation to their demographic, social and cultural and clinical characteristics.
- To develop and pursue effective remediation strategies which are based on critical review of the scientific literature.

**PROFESSIONALISM**

1. The resident shall demonstrate responsibility for their patient's care. This includes:

- Responding to patient's communications (#1)
- Use of the medical record for appropriate documentation of the course of illness and its treatment
- Providing coverage if unavailable, e.g., out of town, on vacation coordinating care with other members of the medical and/or multidisciplinary team providing for appropriate transfer or referral if this is necessary.
2. The resident will respond to communications from patients and health professionals in a timely manner. If unavailable, the resident will establish and communicate backup arrangements. The resident communicates clearly to patients and families about how to seek emergent and urgent care when necessary.

3. The resident shall demonstrate ethical behavior, as defined in the Principles of Medical Ethics with Special Annotations for Psychiatry (APA).

4. The resident shall demonstrate respect for culturally diverse patients and colleagues as persons, including their cultural identity (as influenced by age, gender, race, ethnicity, socioeconomic status, religion/spirituality, sexual orientation, country of origin, acculturation, language, and disabilities, among other factors).

5. The resident insures continuity of care for patients and when it is appropriate to terminate care, does so appropriately and does not abandon patients.

SYSTEMS-BASED PRACTICE

1. The resident shall be able to articulate the basic concepts of systems theory, and how it is used in psychiatry. The resident should have a working knowledge of the diverse systems involved in treating adults, children and adolescents from culturally diverse backgrounds, and understand how to use the systems as part of a comprehensive system of care, in general, and as part of a comprehensive, individualized treatment plan.

2. In the community system the resident shall have:
   • Knowledge of the resources available both publicly and privately for the treatment of psychiatric/behavioral problems, aimed at improving and enhancing the patient's quality of life.
   • Knowledge of the legal aspects of mental health as they impact patients (and their families) with psychiatric problems.

3. The resident should demonstrate knowledge of and interact with managed behavioral health systems. This shall include:
   • participating in utilization review communications and advocating for quality patient care
   • educating patients and families concerning such systems of care

4. Demonstrate knowledge of community systems of care and assist patients to access appropriate psychiatric care and other mental health support services. This requires a knowledge of psychiatric treatment settings in the community that include ambulatory, consulting, inpatient, partial hospital, substance abuse, halfway houses, nursing homes and hospice. The resident should demonstrate knowledge of the organization of care in each relevant delivery setting and the ability to integrate the care of patients across such settings. The entire process should be accomplished in a culturally sensitive and responsive manner.

PSYCHOTHERAPY COMPETENCIES

Training in the basics of psychotherapy begins in the PG 1 year and builds throughout the 4 years of training at Wake Forest. During the first year, interns are taught basic principles of interviewing, communication and supportive psychotherapy in a weekly seminar that runs through the entire year.
During the second year, residents are assigned psychotherapy patients and provide on-going supportive psychotherapy in their outpatient psychiatry clinics. In addition, residents attend 2 psychiatry seminars each week: Psychotherapy Didactic and Psychotherapy Case Conference. Each resident is provided regular supervision of at least two hours per week with experienced psychotherapists from our faculty and clinical faculty. Finally, residents can participate in an experiential process group.

During the third year residents continue in the Psychotherapy Case Conference and Psychotherapy Didactic. While PG2 residents start an intensive "basics of psychotherapy" course in Psychotherapy Didactic Seminar, PG3 residents begin an interactive "hands on" training over 6 months in which they observe and are observed seeing patients for psychotherapy and performing initial evaluations. Residents and faculty give feedback immediately after the patient is seen in an interactive group forum. The 2nd six months of the Psychotherapy Didactic is spent given instruction in core psychotherapy competencies. Psychotherapy Case Conference explores presented topics and patients and applies theories from the various psychotherapy perspectives.

In the fourth year of training, residents are encouraged to continue psychotherapy with patients from the previous year, but many residents elect to do considerably more psychotherapy. It is the expectation of the program that residents perform at least 300 hours of psychotherapy prior to graduation. Residents receive supervision from senior psychotherapy faculty at least 2 hours per week and are encouraged to attend Psychotherapy Case Conference.

In addition to the core activities, interested residents can take advantage of several psychotherapy experiences offered in the department. An intensive outpatient substance abuse group meets four times a week. By the end of training, all residents should be competent in the following 3 psychotherapies: supportive, dynamic and cognitive-behavioral.

Each resident is expected to demonstrate psychotherapy competencies as follows:

**A. Brief (time-limited) psychotherapy**
- Identifies patients and presenting problems appropriate for this treatment modality.
- Negotiate a mutually agreeable area of focus, time frame, and goals for the therapy.
- Develops a working formulation of the patient’s difficulties in the area of focus.
- Chooses and employ a strategy based on and appropriate to the formulation.
- Maintains the focus throughout the course of therapy.

**B. Cognitive-Behavioral Psychotherapy**
- Formulate the patient’s problems in terms of distorted thinking and cognitive schemata.
- Establish a therapeutic relationship with the appropriate balance of supportive, educational, collaborative, and directive elements, including the use of “homework” assignments.
- Help the patient identify automatic thoughts and irrational beliefs using self-observational tools, and understand the connection between such thinking and
problematic feelings and behaviors.

- Help patients modify dysfunctional thoughts by use of appraisal, reality-testing, and thought-stopping.
- Appropriately use behavioral techniques of contingency management and relaxation training.

C. Combined medication and psychotherapy

- Interventions reflect an understanding of how the therapy relationship may influence effectiveness of medication, and how medication use affects the therapy process;
- Evaluates the influence of medication and psychotherapy in the emergence or relief of symptoms.
- Appropriately monitors patient’s patterns of medication use, and the psychotherapeutic implications of these behaviors.

D. Psychodynamic psychotherapy

- Identifies patients and presenting problems appropriate for this treatment modality.
- Listens to the patient for both overt and implicit meanings;
- Monitors and analyzes his/her behavior and psychological experience.
- Recognizes patterns of communication and behavior that derive from patients’ past.
- Uses supportive and interpretative techniques, as appropriate.

E. Supportive psychotherapy

- Identifies patients and presenting problems appropriate for this treatment modality.
- Works toward maintenance or restoration of usual level of function.
- Uses appropriately empathy; reinforcement of strengths and adaptive behaviors; assistance in problem-solving; social skills training; reassurance; fostering autonomy; focus on the “here and now;” appropriately intervening in the environment or support network;
- Maintains proper boundaries in the context of an active, directive treatment strategies
1. Overview

During the PGY1 year, each resident is expected to complete the transformation from student to doctor and to begin to develop the ability to function autonomously as a physician. With the combination of close supervision and extensive educational and clinical opportunities, each PGY1 resident begins to acquire the sense of authority and responsibility necessary to practice medicine; in turn, she begins to develop an identity as a physician. The PGY1 resident is expected to hone interpersonal communication skills and acquire specialized skills for situations unique to psychiatry. Interdisciplinary teams are the norm in inpatient medical and psychiatric settings, and so each resident must behave respectfully and collaboratively with team members.

Finally, the PGY1 resident recognizes that medical practice involves life-long learning. The PGY1 year includes three core clinical experiences: (1) general medical training on outpatient VA medicine service and the outpatient pediatrics service at The Downtown Health Plaza; (2) Outpatient Neurology in the Department of Neurology clinic, as well at the VA in Salisbury; and (3) introductory psychiatric training on the Sticht Center inpatient psychiatry services, as well as an inpatient experience at the VA medical center. This rotation provides the PGY1 resident the opportunity to begin to develop competency in psychopharmacology, electroconvulsive therapy and management of behavioral emergencies.

2. Medical Training: Goals & Objectives (adapted from Psychiatry RRC Essentials)

Each PGY1 resident will develop the ability to gather and organize data, integrate these data into a comprehensive formulation of the problem, develop a well-reasoned differential diagnosis, formulate a treatment plan, and implement treatment care follow-up. The resident will conceptualize medical illnesses in terms of biological, psychological, and socio-cultural factors.

The PGY1 resident will develop a sense and understanding of professionalism and professional principles.

Specifically, each resident will be able to:

**Knowledge**

- Be especially conversant with medical disorders displaying symptoms likely to be regarded as psychiatric and with psychiatric disorders displaying symptoms likely to be regarded as medical
- Be especially cognizant of the nature of the interactions between psychiatric treatments and medical and surgical treatments;

**Skills**

- Perform a complete initial history and physical examination, including ordering appropriate diagnostic studies
Diagnose common medical and surgical disorders and to formulate appropriate initial treatment plans

Provide limited, but appropriate, continuous care of patients with medical illnesses and to make appropriate referrals

**Attitudes**

Relate to patients and their families as well as to other members of the health care team with compassion, respect and professional integrity

**3. Psychiatric Training: Goals & Objectives** (adapted from *Psychiatry RRC*)

Each PGY1 resident will develop competency in inpatient psychiatric practice by having significant responsibility for the assessment, diagnosis, and treatment of a variety of general psychiatric inpatients under the direct clinical supervision of faculty psychiatrists. The resident will develop competency in the bio-psychosocial assessment and management of patients with acute and severe mental illness.

Specifically, each resident will be able to:

**Knowledge and Skills**

Conceptualize severe mental illness in terms of biological, psychological and cultural factors which determine normal and disordered behavior

**Skills**

Conduct a thorough psychiatric evaluation, including a clear and accurate history, a physical examination, a neurological examination and a mental status examination, and a complete and systematic recording of findings;

Gather and organize data, and to integrate these data into a comprehensive formulation, to generate a well-reasoned differential diagnosis, to formulate and implement a treatment plan and to recommend an aftercare plan

**Attitudes**

Behave ethically and professionally when caring for patients and interacting with other health care professionals

Be respectful of cultural, ethnic and spiritual diversity in all interactions with patients, families and other health care providers

Understand and appreciate how their practice affects other health care providers and how that practice occurs in the context of a health care organization and health care system.

**4. Core Competencies** (Adapted from *ACGME General Competencies and Psychiatry RRC*)

These are general descriptions applicable to the entire PGY1 year. Please refer to the goals and objectives for each rotation for more detailed descriptions of the competencies.
**Patient Care**: Residents will provide patient care that is compassionate, appropriate, and effective for the treatment of general medical and psychiatric problems.

**Medical Knowledge**: Residents must demonstrate knowledge about established and evolving biomedical, neurobiological, clinical, epidemiological and behavioral psychological sciences relevant to general medicine and pediatrics.

**Practice-Based Learning and Improvement**: Residents will investigate and evaluate their patient care practices, appraise scientific evidence, and improve patient care practices.

**Interpersonal and Communication Skills**: Residents will demonstrate interpersonal and communication skills which result in effective information exchange and teaming with patients, patient’s families and other health care providers.

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

**Systems-Based Practice**: Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively access system resources to provide care that is of optimal value.

5. Psychiatry-Specific Objectives

Each resident will be able to:

− Develop and implement an appropriate psychopharmacological treatment plan;

− Assess for electroconvulsive therapy;

− Assess behavioral emergencies and perform crisis interventions.

6. Evaluation of Competencies

**Performance Evaluations**:

Psychiatry: Faculty supervisors complete performance evaluations for each resident on each rotation. On Psychiatry, faculty completes a standardized evaluation that assesses the six core competencies using a web-based evaluation system. Evaluations are completed at the end of each rotation and at the midway point for rotations lasting more than one month. Faculty is encouraged to review results directly with residents; residents can also review completed evaluations online.

Internal Medicine, Pediatrics, and Neurology: The medicine, pediatrics, and neurology services use the e-value evaluation tools; these results are typically directly reviewed with each resident. The Program Director also reviews the evaluations. Residents have online access to these evaluations.

**Patient Logs**: While on the Psychiatry service, residents use a web-based tracking system to collect information about each patient contact, including demographics, diagnoses and treatment modalities employed. Residents can monitor their own clinical experiences in
this way. During each semiannual evaluation, the Program Director reviews a summary of patient logs for each resident. In addition, each resident keeps a log of psychotherapy hours and turns that log in to the program coordinator semi-annually.

360-Degree Evaluations: Inpatient social workers, nurses and other staff at WFUBMC will evaluate the performance of residents with regard to the core competencies of patient care, interpersonal and communication skills and professionalism. These evaluations are kept anonymous and are reviewed during the Semiannual Evaluation.

Standardized Examination of Knowledge: The Psychiatry Resident In-Training Exam (PRITE) is administered to each resident in October. The program distributes results in December and the Program Director reviews the results with each resident during the semiannual evaluation.

Semiannual Evaluations: The Program Director meets with each PGY1 resident after approximately six months of the first year and then again after the completion of the PG1 year. The Program Director reviews each of the above evaluations, monitors each resident’s progress in the achievement of the core competencies and the psychiatry-specific competencies and modifies the educational plan if necessary.

Residents will interview two patients while observed by faculty. The resident will perform a clinical interview and a mental status evaluation. The resident will present patient to faculty member with an adequate assessment and plan and formulation.

Finally, residents will turn in to program director/ coordinator five discharge summaries as evidence of ability to appropriately and accurately document inpatient treatment.
1. Overview

Having accomplished basic competency in practicing inpatient medicine and psychiatry, the PGY2 resident moves on to more advanced tasks; these include managing an outpatient psychiatric practice, learning to perform psychotherapy, assessing and managing children and adolescents with mental illness and serving severely and persistently mentally ill adults in the community. The PGY2 resident begins to develop competency in the various psychotherapeutic modalities. Through the community psychiatry rotation, the PGY2 resident starts to gain a broader appreciation of the mental health system and their role in it. Seminars greatly expand their medical knowledge base by offering more in-depth treatments of topics covered in the PGY1 seminar series. The PGY2 resident analyzes and modifies practice by means of individual general supervision and psychotherapy supervision, group supervision in child & adolescent psychiatry and community psychiatry and participation in departmental case conferences. The PGY2 year consists of the following clinical experiences: (1) psychotherapy (2) outpatient child & adolescent psychiatry, (3) addiction psychiatry, (4) consult-liaison and emergency psychiatry, (5) ECT, as well as (6) geriatric, suboxone, and neurobehavioral experiences.

2. General Goals & Objectives (adapted from Psychiatry RRC Essentials)

Each PGY2 resident will develop competence in consult-liaison and emergency psychiatric practice by having significant responsibility for the assessment, diagnosis and treatment of psychiatric patients in a variety of practice settings under the clinical supervision of faculty psychiatrists. The resident will develop competence in the bio-psychosocial assessment and management of adult outpatients, children and adolescents, community-dwelling patients with severe mental illness and patients experiencing psychiatric crises. In addition, the resident will learn how to perform ECT. Specifically, each resident will be able to:

Knowledge and Skills

- Conceptualize mental illness in terms of biological, psychological and social and cultural factors that determine normal and disordered behavior
- Formulate a differential diagnosis and treatment plan for all psychiatric disorders;

Skills

- Conduct a thorough psychiatric evaluation, including a clear and accurate history, physical examination, neurological examination and mental status examination, and complete and systematic recording of findings
- perform ECT
- Gather and organize data, to integrate these data into a comprehensive formulation, to generate well-reasoned differential diagnosis, to formulate and implement a treatment plan that includes monitoring of outcomes and adjustment of the plan as needed
• Perform at least two types of psychotherapy, cognitive-behavioral psychotherapy and interpersonal psychotherapy

• Provide care for chronically mentally ill patients with appropriate psychopharmacological, psychotherapeutic and psychosocial rehabilitative interventions

• Provide psychiatric care to patients who are receiving treatment from other mental health professions and coordinating such treatment

• Assess urgent/emergent situations and perform crisis interventions

• Critically appraise the psychiatric literature and apply it to patient care

**Attitudes**

• Behave ethically and professionally when caring for patients and interacting with other health care professionals;

• Be respectful of cultural, ethnic and spiritual diversity in all interactions with patients, their families and other health care providers;

• Understand and appreciate how their practice affects other health care providers and occurs in the context of a health care organization and health care system.

3. **Core Competencies: Adapted from ACGME General Competencies and Psychiatry (RRC)**

These are general descriptions applicable to the entire PGY2 year. Please refer to the goals and objectives for each rotation for more detailed descriptions of the competencies.

• **Patient Care.** Residents will provide patient care that is compassionate, appropriate, and effective for the treatment of general psychiatric problems.

• **Medical Knowledge.** Residents must demonstrate knowledge about established and evolving biomedical, neurobiological, clinical, epidemiological and behavioral psychological sciences relevant to general medicine and pediatrics.

• **Practice-Based Learning and Improvement.** Residents will investigate and evaluate their patient care practices, appraise scientific evidence, and improve their patient care practices.

• **Interpersonal and Communication Skills.** Residents will demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient’s families and other health care providers.

• **Professionalism.** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population.

• **Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.
4. Psychiatry-Specific Objectives and Competencies: Adapted from Psychiatry RRC

Each resident will be able to:

• develop and implement an appropriate psychopharmacological plan;

• perform the following psychotherapeutic interventions: cognitive- behavioral psychotherapy brief psychotherapy (interpersonal psychotherapy)

• assess behavioral emergencies and perform crisis interventions;

• provide psychiatric care to patients who are receiving treatment from other mental health professionals and coordinating such treatment;

• perform psychosocial rehabilitative interventions for patients with severe and persistent mental illness.

5. Evaluation of Competencies

• Performance Evaluations. Faculty supervisors complete a web-based performance evaluation that assesses the six core competencies for each resident on each rotation. Evaluations are completed at the end of each rotation and at the midway point for rotations lasting more than one month. Faculty is encouraged to review results directly with residents; residents can also review completed evaluations on-line.

• Patient Logs. Residents use a web-based tracking system to collect information about each patient contact, including demographics, diagnoses and treatment modalities employed. Residents can monitor their own clinical experiences in this way. During each semiannual evaluation, the Program Director reviews a summary of patient logs for each resident.

• Standardized Examination of Knowledge. The Psychiatry Resident In-Training Exam (PRITE) is administered to each resident in October. The program distributes results in December and the Program Director reviews the results with each resident during the semiannual evaluation.

• Psychotherapy Evaluations. Residents will be evaluated on the basis of (1) clinical logs tracking actual psychotherapy experience, (2) clinical performance evaluations by psychotherapy supervisors, (3) direct evaluation of psychotherapy by in-session supervisors, (4) measurement of patient outcomes, (5) participation in psychotherapy seminars and (6) presentation at psychotherapy case conferences.

• Presentations at conferences. Residents have the opportunity to present cases at psychotherapy case conference, at Morbidity and Mortality Conference and with individual psychotherapy supervisors. After 2nd year, residents will interview therapy patients in psychotherapy didactic conference while being observed via one way mirror.

• Semiannual Evaluations. The Program Director meets with each PGY2 resident in February for a midway evaluation and in August (of the PGY3 year) for a final evaluation of the PGY2 year. The Program Director reviews each of the above evaluations, monitors each resident’s progress in the achievement of the core competencies and the psychiatry-specific competencies and modifies the educational plan, if necessary.
Overview

The PGY 3-4 resident develops more advanced psychiatric skills, with a focus on the transition from being a trainee to an independent practitioner. During the PGY3 year, each resident continues to work toward achieving competency in psychotherapy, and expands into new clinical areas, specifically consultation-liaison psychiatry and addiction psychiatry. Each resident also returns to the inpatient setting for additional training in managing an inpatient treatment team, in administrative psychiatry and in performing electroconvulsive therapy.

The PGY 3 year consists of the following clinical experiences: (1) adult outpatient psychiatry with at least 12 months of continuous experience, and (2) participation in scholarly activities.

The PGY 4 year consists of:
(1) Adult outpatient psychiatry (2) Advanced Inpatient Psychiatry (3) Electives (4) Chief residency (for two residents), (5) participation in scholarly activities, (6) community psychiatry experiences, and (7) forensic psychiatry

2. Psychiatric Training: Goals & Objectives (adapted from Psychiatry RRC Essentials)

Each PGY3-4 resident will develop competence in inpatient and outpatient psychiatric practice by having significant responsibility for the assessment, diagnosis and treatment of psychiatric patients in a variety of practice settings under the clinical supervision of faculty psychiatrists. The resident will develop competence in the bio-psychosocial assessment and management of psychiatric inpatients, psychiatric outpatients and medical-surgical inpatients with psychiatric disorders.

Specifically, each resident will be able to:

Knowledge and Skills

− Conceptualize mental illness in terms of biological, psychological and social and cultural factors that determine normal and disordered behavior;

− Formulate a differential diagnosis and treatment plan for all psychiatric disorders, with a particular emphasis on the interface between psychiatric and medical-neurological disorders

Skills

− Conduct a thorough psychiatric evaluation, including a clear and accurate history, physical examination, neurological examination and mental status examination, and complete and systematic recording of findings

− Gather and organize data, to integrate these data into a comprehensive formulation, to generate well-reasoned differential diagnosis, to formulate and implement a treatment plan that includes monitoring of outcomes and adjustment of the plan as needed;
Perform five different types of psychotherapy, including cognitive-behavioral, brief, psychodynamic, supportive, as well as combined medical management and psychotherapy.

Provide combined psychotherapeutic and psychopharmacological treatment to psychiatric inpatients and outpatients

Provide psychiatric care to patients who are receiving treatment from other mental health professions and coordinating such treatment

Assess urgent/emergent situations and perform crisis interventions

Critically appraise the psychiatric literature and apply to it patient care

**Attitudes**

- Behave ethically and professionally when caring for patients and interacting with other health care professionals
- Be respectful of cultural, ethnic and spiritual diversity in all interactions with patients, their families and other health care providers
- Understand and appreciate how their practice affects other health care providers and occurs in the context of a health care organization and health care system

**3. Core Competencies** (Adapted from ACMGE General Competencies and Psychiatry RRC)

*These are general descriptions applicable to the entire PGY3-4 years. Please refer to the goals and objectives for each rotation for more detailed descriptions of the competencies.*

**Patient Care:** Residents will provide patient care that is compassionate, appropriate, and effective for the treatment of general psychiatric problems.

**Medical Knowledge:** residents must demonstrate knowledge about established and evolving biomedical, neurobiological, clinical, epidemiological and behavioral psychological sciences relevant to general medicine and pediatrics.

**Practice-Based Learning and Improvement:** residents will investigate and evaluate their patient care practices, appraise scientific evidence, and improve their patient care practices.

**Interpersonal and Communication Skills:** residents will demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient’s families and other health care providers.

**Professionalism:** residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population

**Systems-Based Practice:** residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.
4. Psychiatry-Specific Objectives & Competencies (Adapted from Psychiatry RRC)

Each resident will be able to:

- Develop and implement an appropriate psychopharmacological plan;
- Perform the following psychotherapeutic interventions:
  - Cognitive-behavioral psychotherapy
  - Brief psychotherapy
  - Psychodynamic psychotherapy
  - Supportive psychotherapy
  - Integrated psychopharmacology and psychotherapy
- Provide psychiatric care to patients who are receiving treatment from other mental health professionals and coordinating such treatment;

5. Evaluation of Competencies

Performance Evaluations: Faculty supervisors complete a web-based performance evaluation that assesses the six core competencies for each resident on each rotation. Evaluations are completed at the end of each rotation and at the midway point for rotations lasting more than one month. Faculty is encouraged to review results directly with residents; residents can also review completed evaluations on-line.

Patient Logs: Residents use a web-based tracking system to collect information about each patient contact, including demographics, diagnoses and treatment modalities employed. Residents can monitor their own clinical experiences in this way. During each semiannual evaluation, the Program Director reviews a summary of patient logs for each resident.

360-Degree Evaluations: Inpatient social workers, nurses and other staff at WFUBMC will evaluate the performance of residents with regard to the core competencies of patient care, interpersonal and communication skills and professionalism. The evaluations are kept anonymous and are reviewed during the Semiannual Evaluation.

Standardized Examination of Knowledge: The Psychiatry Resident In-Training Exam (PRITE) is administered to each resident in October. The program distributes results in December and the Program Director reviews the results with each resident during the February semi-annual evaluation.

Presentations at conference: Residents have the opportunity to present at biweekly departmental case conferences and EBM conferences and receive feedback on their presentations.

Semiannual Evaluations: The Program Director meets with each PGY3-4 resident twice yearly for a review of their progress. The Program Director reviews each of the above evaluations,
monitors each resident's progress in the achievement of the core competencies and the psychiatry-specific competencies and modifies the educational plan if necessary.

**Final Summative Evaluation:** The Program Director meets with each PGY4 resident at the end of her training (or at the end of the PGY3 year for residents entering child and adolescent psychiatry training) to complete a final evaluation of the six core competencies and five psychotherapy competencies, based on performance throughout the entire residency.
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; 10/12

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 RESIDENT POLICY

AREA: SUPERVISION

DATE: 6/10/88; revised 4/95; 10/00; 1/03; 09/05; 3/07, 10/12

DESCRIPTION

Supervision is provided in 4 basic formats:

1. Faculty Advisors (described in separate section).
2. Psychotherapy supervision.
3. Direct supervision during clinical rotations.

1. Faculty advisors: are assigned at the beginning of residency training and continue throughout training at a frequency determined jointly by the advisor and resident.

2. Supervision of Psychotherapy: Each resident is 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-pharmacotherapy. Supervision with individual supervisors is expected to be 1 hour weekly with a minimum term of three months. Group supervision will also be performed as well. Some cancellation may be necessary on the part of both the supervisor and the resident, but excessive cancellation of supervision on the part of the resident will be subject to disciplinary action. Use of audio and video tapes or one-way-window on occasion during supervision are 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 prior to graduation.

3. Direct Supervision during Clinical Rotations: Each clinical rotation will provide direct supervision within the subspecialty area that it serves. This supervision must include observation of resident performance, feedback as to performance, observation and participation in different techniques of patient management, and face-to-face supervision. Evaluation of supervision is discussed under Evaluation Procedures.

Objectives:

1. Faculty Advisors: See separate section on faculty advisors

2. Supervision of Psychotherapy: To teach techniques of a variety of schools of psychiatry, to teach techniques of interpretation in the context of individual psychotherapy, to recognize and deal with problems of transference and countertransference, to teach techniques of handling difficult and resistant patients, to provide a long-term psychotherapy experience in the context of close supervision by a knowledgeable therapist, and to participate in practice-based learning and improvement.

3. Supervision during Clinical Rotations: To provide direct "hands on" supervision in the context of the clinical rotation to provide exposure to specific techniques used during the clinical rotation (e.g., amytal interview, ECT, group therapy,
commitment procedures), to provide a background of selected readings in the literature pertinent to the clinical rotation, to develop specific skills related to the rotation (including interpersonal and communication skills), and to provide an experienced resource person to assist the resident in dealing with systems-based practice.

Implementation: Faculty advisors are assigned for each new entering resident at the beginning of training. Residents are assigned two psychotherapy supervisors from the pool of full-time faculty and clinical faculty in the community by the Training Director during the PG 2-4 years. The minimum period of supervision with an individual supervisor is three months, though a six month experience is encouraged. Inpatient attendings at all training sites directly supervise the residents assigned to their teams. The Director of the Adult Outpatient Clinic supervises residents on that service, along with the subspecialty clinic attendings.

Effectiveness Evaluation: The Educational Policy Committee is responsible for evaluation of the supervisory process. Mutual evaluation forms are utilized to assess faculty and resident use of the supervision. Educational seminars in supervisory performance and in use of the electronic evaluation system will be offered to the Department's clinical supervisors periodically according to need and with all new faculty.
Description: Hours for being "on call" are as follows:

Monday - Thursday nights: 5:00 p.m. - 8:00 a.m. (split intern shifts: 5p-10a / 10p-8a)
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/fifth 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 firsthand 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 as well as the ACGME policies effective July 1, 2011.

**Effectiveness Evaluation:** Adequacy of resident coverage will be judged by the attending on call and direct feedback given to the resident on call. As stated previously, in the case of interns, they will be required to pass an observed patient interview and provide a verbal synopsis to the attending who monitors them in order to take call without direct in-house supervision by an upper level resident. 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.
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 and later revised in July, 2011.

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: Residents are expected to log their duty hours daily through the logging system. 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 + 4 hours for PGY 2-4 and 16 hours for PGY 1
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. Revised duty hour restrictions per ACGME requirements went into effect on July 1, 2011.
**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.
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 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-1 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; reviewed 10/12

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. Sick time is not to be used as additional vacation days.

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 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)

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.

**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.
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; 07/11; 10/12

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. As of July, 2011, moonlighting hours must be recorded as part of a residents weekly work hours.

**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.
MOONLIGHTING PRIVILEGE REQUEST FORM

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_____________________

APPROVED BY PROGRAM DIRECTOR:_________________________
Date_____________________

1/19/10
PSYCHIATRY RESIDENCY POLICY
AREA: DRESS CODE
DATE: 1/30/89: revised 10/00; 1/03; 09/05; 3/07; 10/07; 06/12

POLICY

The dress and appearance of staff/faculty contributes to the Medical Center’s environment of caring and clinical excellence. Staff/faculty members are expected to dress in a manner that is neat, clean, and appropriate for the work being performed.

SCOPE

Applies to Staff, Faculty

GUIDELINES

Dress code guidelines have been established to meet the following goals:

• Ensure workplace safety

• Present a professional image for patients, families and the public

• Promote a positive work environment with limited distractions caused by inappropriate dress

Staff/faculty should consider these goals when choosing clothing for the workplace and should dress in a manner that is appropriate for the role and work environment. Individuals who work in clinical or public areas represent the Medical Center and should maintain a professional appearance that inspires the confidence of its customers.

GENERAL GUIDELINES

The following guidelines apply to all staff/faculty, regardless of role:

Clothing

• Clothing must not be dirty, faded, torn or frayed.

• Tight, sheer or revealing clothing is not permitted.

• Clothing must meet all applicable safety standards, including the standards of infection control, OSHA, Joint Commission and other accrediting or regulatory bodies.

Scented Products

Fragrant products, other than minimally scented personal care products, are not permitted.

Identification

• Medical Center identification badges must be worn so that the picture and name are clearly visible. Badges should be worn above the waist; collar and shirt-pocket heights are preferred. For safety precautions, lanyards must be breakaway or detachable.
APPEARANCE STANDARDS FOR CLINICAL/PUBLIC AREAS

The following appearance standards apply to staff/faculty members who have contact with patients, families or the public. These standards are in addition to the general guidelines outlined above.

Clothing

In accordance with OSHA guidelines, individuals working in clinical areas must wear shoes with enclosed toes and that are appropriate to job function. To maintain a professional appearance, shoes should be a standard color.

The following are not permitted:

- Denim garments
- Shorts or sports attire
- Hats, caps, bandanas, unless worn for medical or safety purposes or part of a uniform

Hair/Facial Hair

- Hair should be professional, clean, neatly styled and of appropriate color.
- Beards, mustaches and sideburns must be neatly trimmed.

Fingernails

- Hands and fingernails should be clean and neatly manicured. Nails should be less than ¼ inch in length. Artificial fingernails or extenders may not be worn by staff providing direct patient care. Fingernail polish, when worn, should not be chipped or cracked.

Tattoos

- Tattoos deemed offensive or unprofessional must be covered by clothing.

Jewelry/Piercings

- Jewelry and accessories should be small in size, worn in moderation, and must not be offensive to patients or pose a hazard. No more than two earrings may be worn per ear. Visible body piercing (e.g., tongue piercing, nose piercing, or eyebrow rings/bars) is not permitted.

ACCOMMODATION FOR RELIGIOUS BELIEFS

The Medical Center will make reasonable accommodations for sincerely held religious beliefs that contradict dress code guidelines as long as they pose no undue hardship.
PSYCHIATRY RESIDENCY POLICY

AREA: GRIEVANCE POLICY

DATE: IMPLEMENTED NOVEMBER 1, 2006; revised 10/12

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 adviser 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 adviser 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 polices take effect.
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 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: May 19, 2009

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

AREA: DISMISSAL OR DISCIPLINE OF RESIDENT AND APPEAL PROCESS

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

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:

ATTENDANCE - TEACHING SEMINARS, FIRST THROUGH FOURTH YEARS

DATE: April 16, 1998; revised 10/00; 1/03; 09/05; 3/07; 10/12

DESCRIPTION: Attendance and participation in all required seminars (PG-1, Psychotherapy and Biological Psychiatry Seminars) is essential for residency training. Residents must attend seminars at least 100% of the time (when not on vacation or educational leave) in order to receive credit for the semester's clinical rotations. The only excused absence is for attendance at a conference or meeting previously approved by the training director. If resident attendance drops below 70%, (including vacation or educational leave), the resident will be required to meet with the program director in order to devise an appropriate remediation plan for the missed seminars. Failure to complete the remediation program will result in disciplinary action as determined by the Educational Policy Committee.

OBJECTIVES: To assure adequate didactic experiences for residents and maintain an adequate educational experience for resident education.

IMPLEMENTATION: The revised policy took effect July 1, 2012

EFFECTIVENESS: Residents not meeting the minimum attendance requirements will receive an update of their attendance every quarter and will be reviewed with them during semi-annual reviews. The faculty will continuously review resident attendance and participation at seminars and complete attendance forms. The training director will review with each resident during semi-annual reviews. Resident feedback will be solicited through individual and group processes.

PSYCHIATRY RESIDENCY POLICY

AREA: Journal Club

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

Description: The Journal Club meets each month on a Friday. Attendance is open to all faculty members and residents. Articles are presented by residents and by faculty. Resident presenters are selected by the Chief Resident or a PG-3 or PG-4 Journal Club resident coordinator.

Objectives: The Journal club provides an opportunity for residents to meet with other residents and faculty members and to hear recent articles reviewed and discussed by peers and faculty. Resident reviewers have the opportunity to summarize journal articles in the context of evidence-based medicine, national guidelines for research conduct and reporting, the ethics of experimentation with human subjects, and the individual resident’s clinical and research interests.

Implementation: The Journal Club has evolved through many different formats. The present format is generally a combination of several previous formats, i.e. resident vs faculty presentations.

Effectiveness Evaluation: The success of the Journal Club is generally assessed
by the level of resident and faculty participation and the degree of preparation required for the presentations.
PSYCHIATRY RESIDENCY POLICY

AREA: OVERALL EVALUATION OF RESIDENT PERFORMANCE

DATE: 6/19/88; revised 4/95; 1/03; 09/05; 3/07; 10/12

Description: Evaluation of each resident’s performance is based on the written evaluation of all supervisors, service chiefs or their designee faculty, performance examinations (written and oral), contents of the showcase portfolio, semiannual evaluation of the Director of Residency Training, and other observations by the faculty (including Internal Medicine, Emergency Medicine, Pediatrics, and Neurology). All written material will be maintained in a confidential file accessible only through the Director of Residency Training. Beginning with the incoming residents on July 1988, the evaluation files have been open to the resident for review in the presence of the Director of Residency Training or his designee to insure integrity of the files.

At the end of each academic year, each resident’s performance will be reviewed by the Educational Policy Committee. Written evaluations and a summary by the Director of Residency Training form the basis for the review, although additional material may be sought if necessary. Actions of the Educational Policy Committee of a serious nature, 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. The results of the Committee evaluation will be communicated to the resident by the Director of Residency Training along with a written summary, which will be signed by the resident and entered into the training file. At this time, recommendations for more intensive study in certain areas will be made, if necessary. It is expected that positive feedback for achievement is an integral part of this process.

There will be a final written evaluation for each resident who completes training or leaves the program early, reviewing the resident’s performance during the final period of training and verifying that the graduate has demonstrated sufficient professional ability to practice competently, independently, and ethically.

The PRITE will be performed annually as one standard assessment procedure. Results of this test will be placed in the resident’s training file, and will be analyzed by the Director of Residency Training with the resident for implementation of future study. Results of the PRITE are not available to other faculty members, except in a general manner which may be used to improve the overall teaching program. A clinical skills verification exam is completed annually by PG-3 and PG-4 trainees, and two (2) core competency exams are required in the PG-1 year. Additional performance assessments will be developed for other rotations.

Objectives: To provide a structured and equitable means of assessing resident performance to evaluate mastery of necessary knowledge and skills for certification of adequacy of psychiatric training (core competence). To provide the resident objective feedback on his or her performance and identify deficient areas of knowledge and skill.

Implementation: This policy was implemented during the 1988-89 academic year and revised to meet to changing requirements of the appropriate Residency Review Committees of the ACGME.

Effectiveness Evaluation: It is the responsibility of the Educational Policy Committee to review formally the effectiveness of resident evaluation using both faculty and resident input. Such a critical review should examine consistency, equality of application, potential sexual or racial bias, and relation to final outcome (positions obtained, certification status, self-satisfaction, and success in the field).
PSYCHIATRY RESIDENCY POLICY

AREA: MUTUAL EVALUATION OF RESIDENT PERFORMANCE AND TEACHING QUALITY

DATE: 5/29/88; revised 4/95; 1/03; 09/05; 3/07; 10/12

Description: Evaluation of resident performance is an integral part of the learning experience. Direct feedback from supervisors is essential for the resident to be able to better evaluate and improve performance. This feedback should be both on a daily basis in supervision or the performance of daily tasks and during the final evaluation done of the resident's performance. An open and honest evaluation, whether positive or negative, is a valid and essential part of teaching responsibility. Evaluation of resident performance should be a mutual process, during which both the quality of both the resident's activity and the quality of the teaching program are discussed in an atmosphere of mutual respect. To facilitate this open and mutual evaluation process, formal written evaluations will be done after each clinical rotation and periodically during supervision by both the supervisor and the resident. **There will also be the opportunity for formal mid rotation feedback beginning in 2012.** Checklists for both aspects of the evaluation process will be distributed. After mutual discussion of the evaluation, the evaluations will be signed by both the resident and the supervisor before submission to the Director of Residency Training.

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

Content of the evaluation is outlined in the E*Value evaluation forms. Negative comments as well as positive comments are necessary for growth and learning during residency training as well as for the experience of teaching. The evaluation by the resident of supervision and clinical rotations should be used by faculty, to improve the quality of the teaching experience.

Objectives:

1. To promote effective evaluation of resident and faculty performance in an atmosphere of mutual respect in a face-to-face process.
2. To integrate the process of evaluation into the learning experience for both resident and faculty.
3. To provide a spectrum of many evaluations for the resident throughout training.
4. To provide a confidential means of providing feedback when direct discussion is not preferred.

Implementation: Beginning with the 1988-89 academic year, all written evaluations of resident performance have been discussed mutually along with the resident's evaluation of the teaching rotation or supervision. When special problems exist, it is expected that verbal or written contact will be made to the Director of Residency Training in addition to the formal evaluation. The Department Chair and the Training Director also meet monthly with the residents as a group for open discussion of program concerns and rotation site-specific issues.

Effectiveness Evaluation: The mutual evaluation process will be evaluated by the Educational Policy Committee. Feedback will be continuously solicited from both residents and faculty as to the effectiveness of the evaluation process.
PSYCHIATRY RESIDENCY POLICY

AREA: DISMISSAL OR DISCIPLINE OF RESIDENT AND APPEAL PROCESS

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

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: RELEASE OF RESIDENTS' NAMES TO COMMERCIAL AGENCIES

DATE: 9/28/88; 09/05; 10/12

AIM: To protect the privacy of the resident or recent graduate and at the same time make employment or educational options available to all residents who might wish to take advantage of them.

Description: Names and addresses of residents (present or past) will not be released to any inquiring commercial agency. However, all requests received will be posted on the residents’ bulletin board. Individual residents may contact the agency if desired.

Effectiveness Evaluation: Not anticipated.
SECTION EIGHT:

READING LIST
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


Comprehensive Texts


Board Preparation/General Study


Review Books

- Psychiatry Pearls. Alex Kolevzon, Daniel Stewart. Hanley & Belfus (2004) *(Full disclosure: A. Garakani is an author of this textbook)*

Forensic Psychiatry

### Psychopharmacology


### Neuroscience/Neuropsychiatry

- **Windows to the Brain.** Hurley and Taber American Psychiatric Publishing 2008
- **Neuropsychiatric Assessment, Review of Psychiatry Volume 23.** Yudofsky & Kim American Psychiatric Publishing 2004

### Emergency/On Call Psychiatry

- **Assessment and Treatment of Suicidal Patients, Chiles & Strosahl APPI 2005**

### Child Psychiatry

- **Clinical Manual of Child and Adolescent Psychopharmacology Finding.** 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
Addiction Psychiatry


General Interest


Psychopathology

- *Dementia Praecox or the Group of Schizophrenias*. Eugene Bleuler. International Universities Press (1950)

Psychological Therapies

• Motivational Interviewing; Miller Rollnick Guilford Press. 2nd Edition (2002)
• Thoughts Without a Thinker: Psychotherapy From a Buddhist Perspective. Mark Epstein 1995
• Psychotherapy and Existentialism: Victor Frankl, 1967

Memoirs/Personal Accounts


Novels/Books Relevant to Psychiatry

• The Bell Jar. Sylvia Plath. Perennial (1999)
• Spectacular Happiness. Peter Kramer
• The Moviegoer. Walker Percy
• Love In the Ruins. Walker Percy
• Better Than Well American Medicine Meets the American Dream. Carl Elliott, MD, PhD WW Norton and Company 2003
• Listening to Prozac. Peter Kramer, MD
• Learning Outside The Lines. Mooney/Cole 2000
• Driven To Distraction. Edward Hallowell, MD
• A Fans Notes. Frederick Exley