

# PSYCHIATRY RESIDENCY PROGRAM



**2011 - 2012**

**UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES  
COLLEGE OF MEDICINE**

**DEPARTMENT OF PSYCHIATRY**

**PSYCHIATRY RESIDENCY PROGRAM**

**MANUAL**

**2011-2012**

**Ben Guise, M.D.**

**Associate Professor**

**Director of Psychiatry Residency Education**

Please report corrections and changes to  
La Tanya Poole

Fax: (501) 526-8198  
Telephone: (501) 526-8161  
E-mail: [poolelatanyam@uams.edu](mailto:poolelatanyam@uams.edu)  
UAMS Department of Psychiatry  
4301 W. Markham # 589  
Little Rock, AR 72205

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### **EDUCATIONAL PROGRAM**

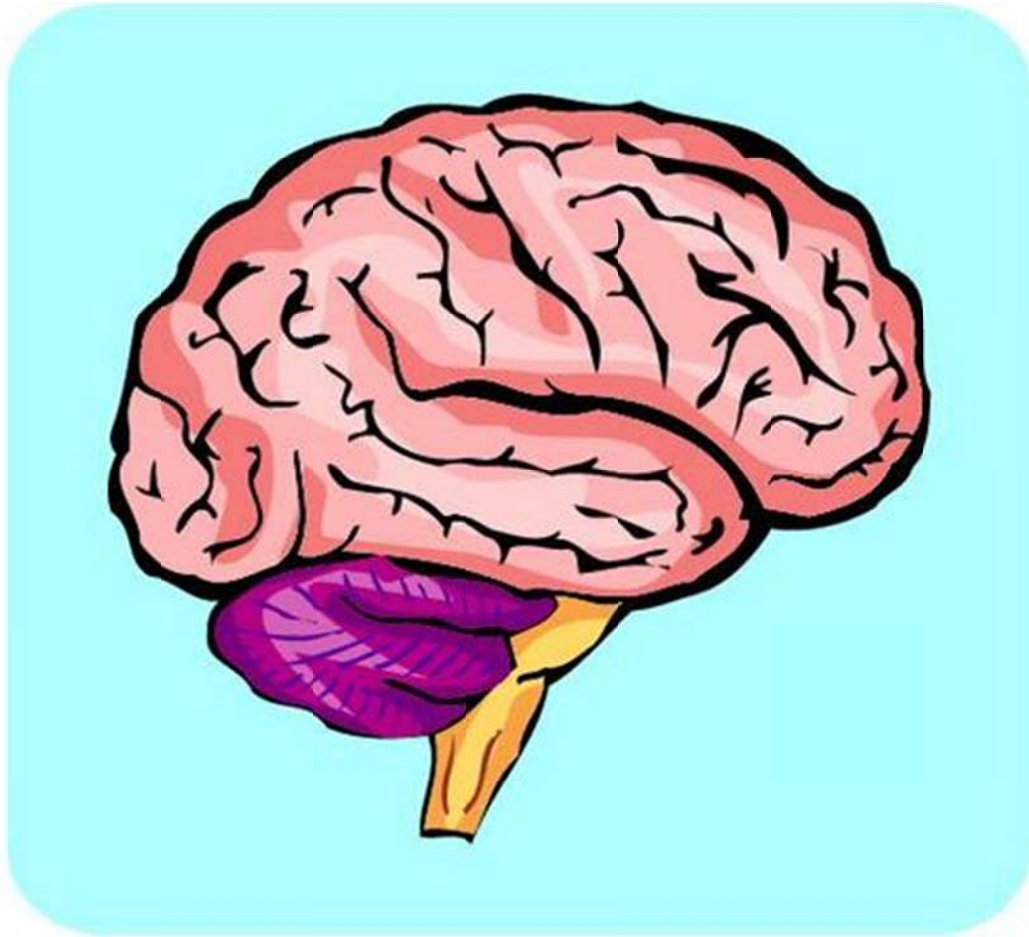
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# INTRODUCTION

## PROGRAM GOALS AND PHILOSOPHY

The primary goal of the Psychiatry Residency Education Program of the University of Arkansas for Medical Sciences (UAMS) is to educate physicians to become specialists in psychiatry who will meet the varying needs of the citizens of the State of Arkansas. Encompassed within this goal is the strongly held belief that psychiatry is a medical specialty; psychiatrists are physicians first and, second, experts in mental and emotional disorders.

This philosophical principle is implemented by the selection of residents who have exhibited competence in general medicine and who remain enthusiastic about their primary identity as physicians. All aspects of the educational program maintain the orientation that, as a physician/psychiatrist, one accepts the responsibility (with appropriate referral and consultation) of the diagnosis and treatment of patients from the bioscientific perspective as well as in regard to their psychosocial needs.

Consistent with the overall goal and philosophical orientation of the program is the need to provide specific educational experiences to residents who will have varying roles in the field of psychiatry. Among these roles are academic psychiatrist, public sector psychiatrist, and private practice psychiatrist.

## OBJECTIVES AND CRITERIA FOR GRADUATION

Criteria for graduation include successful completion of objectives set forth in all essential teaching rotations in the Psychiatry Residency Manual. Residents must successfully complete all residency assignments for the prescribed 48 months of education as dictated by the Residency Review Committee for Psychiatry. A scholarly paper or research paper must be completed and approved by the Residency Research Committee as well. Residents must satisfactorily demonstrate competency as defined by the ACGME and measured by the residency. This includes any mechanism for measuring competencies, such as portfolios, 360° evaluations or any other means that the residency uses for evaluation purposes.

The training objectives for graduation are reached when a resident is viewed as a solid clinician, able to use current literature, and able to negotiate a general psychiatric practice. This includes demonstrated competency in the ACGME competency areas. The faculty on the Residency Education Committee (REC), the residency director, and the Chairman determine resident promotions.

## SUMMARY OF THE CLINICAL TRAINING PROGRAM

The clinical training program progresses in a stepwise fashion. Each year's clinical experience demands mastery of the previous year. The various clinics and hospitals are complementary in nature, allowing a broad range of treatment modalities and diverse patient problems.

**FIRST YEAR** (Internship) Clinical experiences consist of four months of primary care, two months of neurology, and six months of inpatient psychiatry.

**SECOND YEAR** Clinical Experiences for one semester of this year consist of two months (50% time) on a Geriatric Psychiatry unit, two months (50% time) on the Alcohol Drug Treatment Unit, two months (50% time) on a psychiatry in-patient unit, longitudinal child psychiatry outpatient work equal to two full-time months. In the other semester there are six weeks of night float call rotation (in two, separated three-week blocks), six weeks of Psychiatry inpatient unit (in two, separated three-week blocks), six weeks of Psychiatry Consultation/Liaison service, and six weeks of Psychiatry Consultation/Liaison/ER service.

PGY 2, 3, and 4 residents are assigned their own outpatients whom they follow in clinic on an ongoing basis one half day each week. PGY 2 residents see patients at the North Little Rock VA Hospital. PGY 3 and 4 residents see patients in the PRI Walker Family Clinic over the course of two years.

**THIRD YEAR** Clinical experiences consist of 12 months of outpatient care in three distinctly different settings. The residents spend 1½ days each in a community mental health outpatient clinic, a family outpatient clinic, and a veteran's outpatient clinic

**FOURTH YEAR** Regarded as a "track" year. The individual resident, with the approval of a faculty advisor and the Residency Education Committee, plans a fourth-year experience that will be consistent with long-term career goals. The REC evaluates each resident's ECT experience individually and may require the resident to participate in more ECT training this year. The following are to be regarded as examples and not exclusive of other elective possibilities:

Academic Psychiatry - Administrative and teaching responsibilities as well as research in education. Opportunities for chief of service (ASH/VA) residents.

Administrative Psychiatry – Opportunities exist at various sites to gain experience in administrative issues.

Public Sector Psychiatry - Supervision and teaching of junior residents in a public hospital inpatient service, consultation to public agencies such as the police department, consultation to a community mental health clinic, and JCAHO compliance and policies.

Child Psychiatry - Entry into the Child Psychiatry Fellowship program at UAMS.

Private Practice Psychiatry - Primary assignment to the adult outpatient clinic; work in the Student Mental Health Service at UAMS.

Chief Resident - Serves as a faculty/resident liaison assuming some administrative and teaching duties.

Research – Opportunities are available for mentored projects in outcomes, basic, and clinical studies. See description of resident research track

**DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES  
FACULTY ROSTER**

**CHAIR**

Marie Wilson Howells Professor

G. Richard Smith, M.D.

**UNIVERSITY HOSPITAL DIVISION**

Professor & Chair Emeritus:

Frederick G. Guggenheim, M.D.

Professor Emeritus:

Roscoe A. Dykman, Ph.D.

Professor:

James Clardy, M.D.

Lawrence Labbate, M.D.

Linda Worley, M.D.

Associate Professor:

Jeff Clothier, M.D.

Gail Eisenhauer, M.D.

Ben Guise, M.D.

Eugene Kuc, M.D.

Erick Messias, M.D.

J. Scott Stanley, M.D.

Assistant Professor:

Lou Ann Eads, M.D.

Betty L. Everett, Ph.D.

Jennifer Fausett, Ph.D.

Michael Hollomon, MD

Lewis Krain, M. D.

Irving Kuo, M.D.

Terri Miller, Ph.D.

Gary Schroeder, Ph.D.

Laura H. Tyler, Ph.D., LPC

Adjunct Professor:

Richard C. Lippincott, M.D.

Instructor:

Barbara Lynn Mason, RNP

## **PRI NORTHWEST ARKANSAS**

Associate Professor: Michael Hollomon, M.D.  
Jon Rubenow, D.O.  
Gerald Stein, M.D.

Assistant Professor: Keith Berner, M.D.  
Kyle Johnson, M.D.

## **DIVISION OF HEALTHCARE SERVICES RESEARCH**

Professor: Brenda Booth, Ph.D.  
John Fortney, Ph.D.  
JoAnn Kirchner, Ph.D.  
Teresa Kramer, Ph.D.  
Richard R. Owen, M.D.  
Jeffrey Pyne, M.D.  
Greer Sullivan, M.D.

Associate Professor: Geoffrey Curran, Ph.D.  
Ellen Fischer, Ph.D.

Assistant Professor: Dean Blevins, Ph.D.  
Patti Bokony, Ph.D.  
Teresa Hudson, Pharm.D.

Instructor: Terri Davis, Ph. D.  
Jeff Smith, ABD  
Angie Waliski, Ph.D.

## **DIVISION OF PEDIATRIC PSYCHIATRY**

Professor Emeritus: Patricia Youngdahl, Ph.D.

Interim Director : Jody Brown, M.D.

Professor: Patrick Casey, M.D.  
Catherine Stanger, Ph.D.

Assistant Professor: Mark Andersen, M.D.

Instructor:

Jody Brown, M.D.  
Juan Castro, M.D.  
Steven Domon, M.D.  
Molly Gathright, M. D.  
Jennifer Gess, Ph.D.  
Zaid Malik, M.D.  
Terri Miller, Ph.D.  
Angie Shy, M.D.  
John Webber, M.D.  
Veronica Williams, M.D.  
Bruce Cohen, M.S.

#### **VA MENTAL HEALTH DIVISION**

ACOS for Mental Health, VAMC  
and Assistant Professor:  
Professor:

Tina McClain, M.D.  
John Fortney, Ph.D.  
Lawrence Labbate, M.D.  
Richard Owen, M.D.  
Greer Sullivan, Ph.D.

Associate Professor:

Kathy Henderson, M.D.  
Tim A. Kimbrell, M.D.  
Eugene Kuc, M.D.  
Dinesh Mittal, M.D.  
Annette Slater, M.D.  
John Spollen, M.D.

Assistant Professor:

Grace Aikman, Ph.D.  
Patricia Allred, M.D.  
Sandra Ellis, M.D.  
Erica Hiett, M.D.  
Irving Kuo, M.D.  
Mark Hinterthuer, Ph.D.  
Monica Shotwell, M.D.

Instructor:

Glen White, Ph.D.  
Mark Worley, M.D., Ph.D.  
Greg Wooten, M.D.  
Kelley Burrow, M.D.  
Jeremy Hinton, M.D.  
Shanna Palmer, M.D.  
Lisa Snow, M.D.  
Marcus Wellen, M.D.

### **Division of Behavioral Health**

Professor and Medical Director:

Larry Miller, M.D.

### **ARKANSAS STATE HOSPITAL**

Assistant Professor and Medical Director:

Steve Domon, M.D.

Professor:

Ann Guthrie, M.D.  
O. Wendall Hall, M.D.

Puru Thapa, M.D.

Assistant Professor:

Joe Alford, Ph.D.

Kara D. Belue, M.D.

Natalie Brush-Strode, M.D.

April Coe-Hout, Ph.D.

Megan Edwards, Psy.D.

Lisa Evans, Ph.D.

Robert Forrest, M.D.

Stacy McBain, M.D.

Raymond Molden, M.D.

Carl Reddig, Ed.D.

James Shea, M.D.

Rush Simpson, M.D.

Michelle Vanlandingham, M.D.

Brandon Wall, M.D.

Adjunct Professor:

Jennifer Whitmere, Ph.D.  
Veronica Williams, M.D.  
J. Thomas Sullivan, J.D.

### **CENTER FOR ADDICTION RESEARCH**

Professor:

Alan Budney, Ph.D.  
Alison Oliveto, Ph.D.  
Catherine Stanger, Ph.D.

Assistant Professor:

Michael Mancino, M.D.  
Maxine Stitzer, Ph.D.

### **BRAIN IMAGING RESEARCH CENTER**

Professor:

Clint Kilts, Ph.D.

Assistant Professor:

Andy James, Ph.D.

### **VOLUNTARY ADULT FACULTY DIVISION**

Associate Clinical Professor:

Philip Mizell, M.D.

Assistant Clinical Professor:

Gregory Krulin, M.D.

Clinical Instructor:

Ali M. Hashmi, M.D.

**RESIDENT ROSTER**

Address all residents' mail to Slot 589.  
Residency program telephone: 526-8120

PGY Year (effective 7/1/11)

Ivanjo Aldea	4
Alan Bagley	(2 ACH)
John Burnett	4
Lyndsey Burnett	2
Adria Carney	(1 ACH)
Ginger Clifton	2
Laura Conley	3
Deepmala Deepmala	(1 ACH)
Crystal DeWeese	(1 ACH)
Romika Dhar	1
Justin Dyniewski	(2 ACH)
Margaret Ege	2
Dianna Esmaeilpour	1
Rachel Fiori	4
Robin Forward-Wise	4
Brandi Hankins	(2 ACH)
Tracy Haselow	4
Ryan Helm	3
Samuel House	1
Natalie Jordan	3
Sean Kaley	3
Kristi Kindrick	3
W. Clint Kindrick	3
Matt Krupp	2/3
Nihit Kumar	2
Jacquelyn Lange	1
Brent Lawlis	4
Jacquelyn Martin	4
Tiffany Mattingly	1
Kelsey McClellan	2
Dot Mecum	2
Melissa Poole	Forensic
Justin Powell	2
Veronica Raney	1
Shona Ray	3
Abeer Washington	4
Lindsey Wilbanks	1
Brandi Yarberry	1



# **EDUCATIONAL PROGRAM**

# **RESIDENT POLICIES**

## **Criteria and Processes for Academic Actions of Reappointment, Evaluation, Promotion, and other Disciplinary Actions**

In compliance with the UAMS COM GME Committee policy on Evaluation and Promotion, the following guidelines apply:

### **Reappointment**

Educational appointments to the Psychiatry Residency program are for a term not exceeding one year. The resident agreement of appointment, which outlines the general responsibilities for the College of Medicine and for the resident, is signed at the beginning of each term of appointment. Renewal of the resident agreement of appointment for an additional term of education is the decision of the Program Director and the Department Chair. Promotion to the next level of training is dependent upon the resident performing at an acceptable level and meeting the requirements for clinical competence for that post graduate year (PGY). Please see the document, Goals and Objectives for Each Post Graduate Year, which follows this policy statement.

It is the intent of the Program to develop physicians clinically competent in the field of Psychiatry. Physicians completing the program will be eligible for certification by the American Board of Psychiatry and Neurology with an ultimate goal of a 100% pass rate on this examination.

Clinical competence requires:

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
3. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
4. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals.
5. **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
6. **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

## **Evaluation and Promotion**

During the residency period, the above elements of clinical competence will be assessed in writing frequently by direct faculty supervisors with subsequent review by the Program Director. Evaluations by peer resident physicians, patients, nursing staff and other paramedical personnel may be included at less frequent intervals. A resident will meet with the Program Director or other designee twice a year to review results of evaluations, in-service scores, and clinical exercises. A summary of the evaluations will be reviewed and signed by the resident. The evaluations will be maintained in confidential files and only available to authorized personnel. Upon request, the resident may review his/her evaluation file at any time during the year.

Reappointment and promotion to a subsequent year of training require satisfactory ratings on these evaluations and on the recommendation of the Competency/Promotions Subcommittee of the Residency Education Committee.

A resident receiving any unsatisfactory evaluation during the year may be immediately reviewed by the Program Director and any written recommendations made to him/her may include:

1. specific corrective actions
2. repeating a rotation
3. psychological counseling
4. academic warning status or probation
5. suspension or dismissal, if prior corrective action, academic warning and/or probation has been unsuccessful.

The resident may appeal an unsatisfactory evaluation by submitting a written request to appear before the department's Competency/Promotions Subcommittee of the Residency Education Committee in a meeting called by the Program Director. The Committee will review a summary of the deficiencies of the resident, and the resident will have the opportunity to explain or refute the unsatisfactory evaluation. After review, the decision of this Committee is final.

At the completion of the residency program, the Program Director will prepare a final evaluation of the clinical competence of the resident. This evaluation will stipulate the degree to which the resident has mastered each component of clinical competence – patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. In this evaluation the Program Director will verify that the resident “has demonstrated sufficient professional ability in Psychiatry to practice competently and independently”. This evaluation will remain in the resident's permanent file to substantiate future judgments in hospital credentialing, board certification, agency licensing, and in the actions of other bodies.

## **Academic and Other Disciplinary Actions (in accordance with UAMS COM GME Policy on Disciplinary Actions)**

### Probation/Suspension/Dismissal

Actions of Probation/Suspension/Dismissal will follow the guidelines in the GME Committee Policy on Academic and Other Disciplinary Actions policy as follows.

1. A resident may be placed on probation by the Program Director for reasons including, but not limited to any of the following:
  - a. failure to meet the performance standards of an individual rotation;
  - b. failure to meet the performance standards of the program;
  - c. failure to comply with the policies and procedures of the GME Committee, the UAMS Medical Center, or the participating institutions
  - d. misconduct that infringes on the principles and guidelines set forth by the training program;
  - e. documented and recurrent failure to complete medical records in a timely and appropriate manner;
  - f. when reasonably documented professional misconduct or ethical charges are brought against a resident which bear on his/her fitness to participate in the training program.
2. When a resident is placed on probation, the Program Director shall notify the resident in writing in a timely manner, usually within a week of the notification of probation. The written statement of probation will include a length of time in which the resident must correct the deficiency or problem, the specific remedial steps and the consequences of non-compliance with the remediation.
3. Based upon a resident's compliance with the remedial steps and other performance during probation, a resident may be:
  - a. continued on probation;
  - b. removed from probation;
  - c. placed on suspension; or
  - d. dismissed from the residency program.

### Suspension

1. A resident may be suspended from a residency program for reasons including, but not limited, to any of the following:
  - a. failure to meet the requirements of probation;
  - b. failure to meet the performance standards of the program;
  - c. failure to comply with the policies and procedures of the GME Committee, the UAMS Medical Center, or the participating institutions;
  - d. misconduct that infringes on the principles and guidelines set forth by the training program;
  - e. documented and recurrent failure to complete medical records in a timely and appropriate manner;
  - f. when reasonably documented professional misconduct or ethical charges are brought against a resident which bear on his/her fitness to participate in the training program;

- g. when reasonably documented legal charges have been brought against a resident which bear on his/her fitness to participate in the training program;
  - h. if a resident is deemed an immediate danger to patients, himself or herself or to others;
  - i. if a resident fails to comply with the medical licensure laws of the State of Arkansas.
2. When a resident is suspended, the Program Director shall notify the resident with a written statement of suspension to include:
- a. reasons for the action;
  - b. appropriate measures to assure satisfactory resolution of the problem(s);
  - c. activities of the program in which the resident may and may not participate;
  - d. the date the suspension becomes effective;
  - e. consequences of non-compliance with the terms of the suspension;
  - f. whether or not the resident is required to spend additional time in training to compensate for the period of suspension and be eligible for certification for a full training year.

A copy of the statement of suspension shall be forwarded to the Associate Dean for Graduate Medical Education and the Director of Housestaff Records.

3. During the suspension, the resident will be placed on “administrative leave”, with or without pay as appropriate depending on the circumstances.
4. At any time during or after the suspension, the resident may be:
- a. reinstated with no qualifications;
  - b. reinstated on probation;
  - c. continued on suspension; or
  - d. dismissed from the program.

### Dismissal

1. Dismissal from a residency program may occur for reasons including, but not limited to, any of the following:
- a. failure to meet the performance standards of the program;
  - b. failure to comply with the policies and procedures of the GME Committee, the UAMS Medical Center, or the participating institutions;
  - c. illegal conduct;
  - d. unethical conduct;
  - e. performance and behavior which compromise the welfare of patients, self, or others;
  - f. failure to comply with the medical licensure laws of the State of Arkansas;
  - g. inability of the resident to pass the requisite examinations for licensure to practice medicine in the United States, if required by the individual residency program.

2. The Program Director shall contact the Associate Dean for GME and provide written documentation which led to the proposed action.
3. When performance or conduct is considered sufficiently unsatisfactory that dismissal is being considered, the Program Director shall notify the resident with a written statement to include:
  - a. reasons for the proposed action,
  - b. the appropriate measures and timeframe for satisfactory resolution of the problem(s).
4. If the situation is not improved within the timeframe, the resident will be dismissed.
5. Immediate dismissal can occur at any time without prior notification in instances of gross misconduct including, but not limited to theft of money or property; physical violence directed at an employee, visitor or patient; use of, or being under the influence of alcohol or controlled substances while on duty, patient endangerment, illegal conduct.
6. When a resident is dismissed, the Program Director shall provide the resident with a written letter of dismissal stating the reason for the action and the date the dismissal becomes effective. A copy of this letter shall be forwarded to the Associate Dean for GME and the Director of Housestaff Records.

A resident involved in the disciplinary actions of probation, suspension and dismissal has the right to appeal according to the GME Committee policy Adjudication of Resident Grievances.

## **Psychiatry Residency Program GOALS AND OBJECTIVES FOR EACH POST GRADUATE YEAR**

### **At the completion of PGY-1 the resident must have:**

#### *Patient Care*

- demonstrated the ability to perform an initial psychiatric evaluation
- demonstrated the ability to perform a mental status examination
- demonstrated the ability to diagnose and treat basic medical problems
- demonstrated the ability to diagnose and treat basic neurological problems

#### *Medical Knowledge*

- shown basic understanding of the major psychiatric diagnoses
- shown basic understanding of psychotropic medications

#### *Practice-based Learning and Improvement*

- demonstrated ability to present cases in conference review and support the clinical decisions made

#### *Interpersonal and Communication Skills*

- demonstrated ability to function in an interdisciplinary team
- demonstrated the ability to communicate effectively with patients and families

#### *Professionalism*

- demonstrated an appropriate level of professional behavior
- demonstrated a high level of ethical behavior

#### *Systems-based Practice*

- successfully completed 12 months of PGY-1 rotations

#### **As demonstrated by:**

- Supervisor evaluation
- Patient log
- PRITE
- Core didactic attendance
- Portfolio entries
- Semi-annual review
- Scored Clinical Interviewing

### **At the completion of PGY-2 the resident must have:**

#### *Patient Care*

- demonstrated the ability to perform emergency, admission, and consultation psychiatric examinations
- demonstrated the ability to perform a mental status examination, including:

- assessment of suicide risk
- assessment of homicide risk
- cognitive evaluation
- demonstrated the ability to diagnose and treat acute psychotic agitation
- demonstrated the ability to diagnose and treat acute alcohol withdrawal
- demonstrated competence in biopsychosocial case formulation
- demonstrated the ability to perform an initial geriatric psychiatric evaluation
- demonstrated the ability to manage common psychiatric diagnoses in the geriatric population
- demonstrated the ability to perform an initial child psychiatric evaluation
- demonstrated the ability to manage common psychiatric diagnoses in the pediatric population

#### *Medical Knowledge*

- demonstrated the ability to make major psychiatric diagnoses by DSM-IV criteria
- demonstrated the appropriate use of common psychotropic medications

#### *Practice-based Learning and Improvement*

- participated in all scheduled didactics, conferences and case presentations
- demonstrated ability to utilize medical literature to inform diagnostic and treatment decisions
- demonstrated ability to present cases in a team setting, develop and support a treatment plan incorporating input and feedback from the team

#### *Interpersonal and Communication Skills*

- demonstrated the ability to function as a member of a clinical treatment team
- demonstrated the ability to communicate effectively with patients and families

#### *Professionalism*

- completed all required medical records
- demonstrated an appropriate level of professional behavior
- demonstrated a high level of ethical behavior

#### *Systems-based Practice*

- successfully completed 12 months of PGY-2 rotations
- made appropriate referrals for outpatient care
- made appropriate referrals for psychotherapy

#### **As demonstrated by:**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>● Supervisor evaluation</li> <li>● Portfolio entries</li> <li>● Core didactic attendance</li> <li>● Semi-annual review</li> </ul> | <ul style="list-style-type: none"> <li>● Patient log</li> <li>● PRITE</li> <li>● Psychotherapy supervisor evaluation</li> <li>● Scored Clinical Interviewing</li> </ul> |
|--|---|

## **At the completion of PGY-3 the resident must have:**

### *Patient Care*

- demonstrated the ability to perform outpatient psychiatric evaluations
- demonstrated the ability to use psychotropic medications appropriately for the management of common psychiatric disorders
- demonstrated the ability to appropriately use short and long-term psychotherapies in the management of common psychiatric disorders

### *Medical Knowledge*

- demonstrated competence in psychodynamic case formulation

### *Practice-based Learning and Improvement*

- participated in all scheduled didactics and conferences
- demonstrated ability to review cases with supervisor and incorporate feedback and evidence from medical literature to improve treatment planning

### *Interpersonal and Communication Skills*

- demonstrated the ability to lead a clinical treatment team
- demonstrated the ability to communicate effectively with patients and families

### *Professionalism*

- completed all required medical records
- demonstrated an appropriate level of professional behavior
- demonstrated a high level of ethical behavior

### *Systems-based Practice*

- successfully completed 12 months of PGY-3 rotations
- made appropriate referrals for group psychotherapy
- demonstrated the ability to manage severe mental illness in the community mental health setting and assertive community treatment setting

### **As demonstrated by:**

- Supervisor evaluation
- Psychotherapy supervisor evaluation
- Patient log
- Portfolio entries
- Core didactic attendance
- PRITE
- Semi-annual review
- Mock board exam

## **At graduation from the program the resident must have:**

### *Patient Care*

- demonstrated the ability to perform a comprehensive psychiatric evaluation
- demonstrated the ability to diagnose and manage psychiatric symptoms in the setting of medical illness
- demonstrated the ability to diagnose and treat common substance abuse and dependence
- demonstrated competence in medication management of common psychiatric disorders

- demonstrated development of competence in the use of supportive psychotherapy
- demonstrated development of competence in the use of cognitive psychotherapy
- demonstrated development of competence in the use of behavioral psychotherapy
- demonstrated development of competence in the use of dynamic psychotherapy
- Demonstrated development of competence in concurrent use of medications and psychotherapy

*Medical Knowledge*

- demonstrated competence in the use of DSM-IV diagnostic criteria

*Practice-based Learning and Improvement*

- participated in all scheduled didactics and conferences
- demonstrated ability to review cases with supervisor and incorporate feedback and evidence from medical literature to improve treatment planning
- demonstrated the ability to function as an independent clinician

*Interpersonal and Communication Skills*

- demonstrated the ability to lead a clinical treatment team
- demonstrated the ability to communicate effectively with patients and families

*Professionalism*

- completed all required medical records
- demonstrated an appropriate level of professional behavior
- demonstrated a high level of ethical behavior
- satisfy scholarly requirement per policy

*Systems-based Practice*

- successfully completed 12 months of PGY-4 rotations

**As demonstrated by:**

- |                            |                                       |               |
|----------------------------|---------------------------------------|---------------|
| • Supervisor evaluation    | • Mock board exam                     | • Patient log |
| • Portfolio entries        | • Psychotherapy supervisor evaluation | • PRITE       |
| • Semi-annual review       |                                       |               |
| • Core didactic attendance |                                       |               |

Revised 5/21/09

## **Addressing Resident Concerns**

At times various issues resulting from miscommunication, stress, or inappropriate behavior may arise. In compliance with the UAMS COM GME Committee Policy on Addressing Concerns in a Confidential and Protected Manner, the resident should follow these guidelines to raise and resolve issues of concern in a confidential manner:

1. A resident should discuss the concern with the supervising, senior level resident or attending physician or the resident's assigned faculty advisor.
2. If the above discussion does not resolve the concern, the resident should meet with the Program Director or his/her designee.
3. If the issue cannot be resolved by the Program Director, the resident should contact a member of the Resident Council or the Associate Dean for Graduate Medical Education. Members of the Resident Council can meet with the resident and offer advice on how to resolve or handle the problem and if further steps are necessary. Based on the discussion and advice at this meeting, the resident may resolve the problem, and no further action is necessary.
4. For serious issues for which confidentiality is of the utmost importance, the resident may seek assistance directly from the Program Director, the Department Chair and/or the Associate Dean for GME.

## **Supervision**

Residents are required to receive at least two hours of direct supervision per week on all rotations, one hour of which is one to one with attendings. Most rotations have much more supervision than this.

In addition to the clinical supervision provided at the assigned clinical sites, each resident (2nd through 4th year) is assigned a psychotherapy supervisor. These supervisors are full-time faculty members or respected clinicians in the community who are on the clinical faculty. They provide a weekly opportunity for residents to discuss psychotherapy cases in detail and to discuss other professional issues.

All supervisory assignments are for the entire year. All residents on outpatient rotations will have additional supervision with the medical director of the clinic. If a resident has some difficulty with the supervisory assignment, this should be discussed with the Director of the Residency Program before changes are made. Residents who wish additional supervision -- especially PGY 3s who are seeing more than four patients in the Outpatient Clinic -- should see the Director of Residency Education. Supervisors should be contacted in early July. Residents are expected to meet with their supervisors weekly.

All supervisory assignments are evaluated by both supervisors and residents. (See forms in the Appendix.)

The Department of Psychiatry Residency Education Program is committed to promoting patient safety and resident well-being and to providing a supportive educational

environment. Didactic and clinical education activities have priority in the allotment of residents' time and energy. The learning objectives of the program will not be compromised by excessive reliance on residents to fulfill service obligations. Duty hour assignments are made with the recognition that faculty and residents collectively have responsibility for the safety and welfare of patients. In compliance with the UAMS COM GME Committee policy on Resident Supervision, the following guidelines are followed for supervision of the care of patients and backup support:

1. Qualified faculty physicians supervise all patient care and their schedules are structured so that adequate supervision is available at all times.
2. Attending faculty physician supervision is provided appropriate to the skill level of the residents on the service/rotations.
3. Specific responsibilities for patient care are included in the written description of each service/rotation; this information is reviewed with the resident at the beginning of the service/rotation. In general, the chief or senior level resident oversees the lower level resident and intern. The faculty physician oversees the entire team and is available at all times in person, by telephone or beeper.
4. Rapid, reliable systems for communication with supervisory physicians are available.
5. On-call responsibilities and supervision are documented by the call schedules and are reviewed with the resident at the beginning of each service/rotation or if/when there is a change in the schedule.
6. The following procedure is followed to address fatigue of the resident:
  - a. Any faculty or resident who notices fatigue sufficient to negatively affect the performance of a resident via their training will notify the chief resident who will then contact and arrange for a backup person to relieve the resident in consultation with the Program Director.
  - b. The Program Director determines when the resident should return to the education program.
  - c. The Program Director notifies the attending faculty physician about these arrangements.
  - d. Residents are required to take the "Sleep, Alertness and Fatigue Education in Residency" (SAFER) educational module in WebCT at the beginning of residency.
  - e. Faculty are given instruction in fatigue via educational materials which are distributed by the Office of Education.

## Duty Hours and Work Environment

In compliance with the UAMS COM GME Committee policies on duty hours/work environment and moonlighting and, considering that the care of the patient and educational clinical duties are of the highest priority, the following guidelines apply:

### Duty Hours

1. Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.
2. Residents are provided one day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
3. Duty periods of PGY I residents will not exceed 16 hours in duration.
4. Duty periods of PGY 2 and above will not exceed 24 hours of continuous duty in the hospital. If needed, a resident may stay up to an additional 4 hours to effect transitions in care. No new clinical duties will be assigned during these 4 hours.
5. In order to ensure adequate time for rest and personal activities, a 10-hour time period is provided between daily duty periods and a 14 hour time period is provided after any 24 hour duty period.
6. Residents will not be scheduled for more than 5 consecutive nights of night float.

### On-Call Activities

The goal of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period.

1. **In-house call:**
  - a. Occurs no more frequently than every third night, averaged over a four-week period.
  - b. On psychiatry rotations, in-house call will occur no more frequently than every fourth night, averaged over a four week period.
2. **At-home call (pager call):**
  - a. The frequency of at-home call is not subject to the every third night limitation.
  - b. Residents taking at-home call are provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period.
  - c. When residents are called into the hospital from home, the hours spent in-house are counted toward the 80-hour limit.
  - d. The Program Director and the teaching faculty will monitor the demands of at-home call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

The resident is expected to be on duty during normal working hours, as established by each rotation, Monday through Friday. Additional duty hours include on-call duties. Night, weekend and holiday call schedules are formulated by the chief resident and depend on the specific educational rotation. Residents must be available by telephone or pager while on-call. Specific call schedules and responsibilities are delineated in the written goals/objectives of each rotation, which are reviewed with the resident at the

beginning of the rotation.

## Work Environment

1. **Meals:** food is available for those residents who provide 12 consecutive hours of in-house call.
2. **Call rooms:** call rooms are provided for all residents who take in-house call.
3. **Ancillary support:** adequate ancillary support for patient care is provided. Except in unusual circumstances, providing ancillary support is not the resident's responsibility except for specific educational objectives or as necessary for patient care. This is defined as, but not limited to, the following: drawing blood, obtaining EKGs, transporting patients, securing medical records, securing test results, completing forms to order tests and studies, monitoring patients after procedures.

## **Education Policy Committee/Residency Education Committee**

The Residency Education Committee shall meet once monthly to consider business relating to the Residency Education Program. The members of this committee shall include the Residency Education Director and Program Coordinator, Faculty Representatives from each of the major training sites, a resident from each respective PGY class, the Chief Resident, and the Directors of all of the subspecialty Residency Education Programs to include Child and Adolescent, Forensics, Addictions, and Geriatrics. This committee shall be responsible for planning, developing, implementing, and evaluating all significant features of the residency program including curricular goals and objectives and the selection of residents. This committee will also specifically evaluate the residents, the teaching faculty, and the program (see below). This committee shall act as an advisory body to the Director of the Program and the Department Chair. The activities of the committee will also include, but not be limited to the following:

### **YEARLY RESIDENCY EDUCATION COMMITTEE CALENDAR**

#### **July**

#### **August**

Report from PGY-1 representative regarding performance and problems for the new class  
Discuss call issues or problems  
Evaluate Teaching Staff

#### **September**

Discuss recruitment efforts  
Promotion Committee meets

#### **October**

#### **November**

Selection Committee meets

#### **December**

Selection Committee meets  
Promotion Committee meets

#### **January**

Selection Committee meets

#### **February**

Discussion of PRITE results and program implications  
Selection Committee meets

**March**

Program Evaluation

(Resident anonymous evals, Recorded Faculty Comments, Board pass rate, PRITE, GME Survey, ACGME Resident Survey)

Promotion Committee meets

**April**

PGY IV Residents present proposed schedules for 4<sup>th</sup> year

**May**

Discuss psychotherapy supervision for coming year

Didactic schedules for the new year

Finalize PGY-4 schedules for new year

Rotation schedules for the new

PGY 1-3s

Reminder of important upcoming dates

**June**

Finalize the psychotherapy supervisor assignments

Select resident class REC representation

Discuss any new changes in rotations

Promotion Committee meets

REC meetings are generally held on the first Wednesday of every month from noon until 1:30.

**Note:**

The Promotion Committee meets quarterly of each academic year (September, December, March, and June) to discuss residents' performance, competency, and professional growth. All REC faculty members are invited to attend.

The Selection Committee meets in November, December, January, and February to evaluate and select candidates for the residency program. All REC faculty members and the Chief Resident are invited to attend these meetings.

# **RESIDENT ROTATIONS**

- **Goals**
- **Resident Duties**
- **Recommended Reading Assignments**

All program requirements for residency training in psychiatry can be found at [www.acgme.org](http://www.acgme.org).

### RESIDENT PATIENT LOGS

The Accreditation Council for Graduate Medical Education (ACGME) requires a record maintained of specific cases treated by residents in a manner which does not identify patients, but which illustrates each resident's clinical experience in the program. This record must demonstrate that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. This record will be reviewed periodically with the program director or a designee, and be made available to the ACGME Site Visitor of the program. Logs will be provided by the Residency Program Office. You may also devise your own plan. See the Appendix for an example of a patient log.

### DOCUMENTATION OF PROCEDURES

While on inpatient units, the opportunity will arise for residents to perform procedures upon their assigned patients. Many hospitals and educational institutions require documentation of procedures performed during training to grant the privilege to perform or teach these procedures. This includes procedures such as ECT and lumbar punctures.

A permanent record of each resident's training is kept in the residency office. It is the responsibility of each resident to document procedures he or she performs for inclusion in this file.

### BLOCK DIAGRAM OF ROTATION SCHEDULES

<b>Year 1</b>	4 Months	2 Months	6 Months
	Primary Care	Neurology	In-Patient Psychiatry

<b>Year 2</b>	6 Months			6 Months		
	2 Months	2 Months	2 Months	3 Months	6 Weeks	6 Weeks
	Ger. Psych 50 %	Addictions 50%	In-pt. Psych 50%	Consult/Liaison	Night Float	In-Pt. Psych
	Child Psychiatry 40%					
	½ day per week Psychotherapy (long-term)					

<b>Year 3</b>	12 Months
	Full-time Outpatient
	½ day per week Psychotherapy (long-term)

<b>Year 4</b>	12 Months
	Electives
	½ day per week Psychotherapy (long-term)

**ROTATION: EVALUATION AND TREATMENT OF ACUTE PSYCHIATRIC INPATIENTS**

**ATTENDINGS: William Meeks, MD & Jennifer Middleton, MD**

**TELEPHONE: 257-2847**

**MAIL SLOT: 116/NLR OR 3K/NLR**

**LOCATION: UNIT 3K NLR VA**

### **COURSE DESCRIPTION**

Unit 3K is an acute psychiatric unit with an average of 90 admissions per month and an average length of stay of 5 days. Residents on the unit will be the primary physicians for approximately 6-8 new patients per week, thus averaging a patient census of 5-7 patients. With the rapid turn around time, residents will learn effective time management skills, rapidly stabilize acutely ill patients, and make appropriate referrals for further treatment. Working closely with a multidisciplinary treatment team is an essential component of this rotation in order to insure that patients receive appropriate and timely care in this fast paced environment. PGY-2 Residents will spend six weeks on this service. Each resident is expected to complete at least one portfolio entry during their rotation on 3K, is expected to attend all didactics and grand rounds, and is expected to participate in visiting professor rounds weekly. A schedule for the typical week is included below.

### **GOALS**

1. To manifest **medical knowledge and interpersonal and communication skills (patient interviewing)** sufficient to competently evaluate common acute presentations seen in acute psychiatry.
2. To gain facility with treatment modalities for the illnesses commonly diagnosed on acute adult inpatient units, and develop **medical knowledge** with respect to the same especially psychopharmacology.
3. To develop competence in **interpersonal communication skills, professionalism, and systems-based practice** by working through an interdisciplinary approach to patient evaluation, treatment and follow up.
4. To demonstrate **professionalism** by presenting patients in a orderly, comprehensive, and timely manner and develop competence in formulating the biopsychosocial aspects of the patient's condition.
5. To develop time management skills necessary for a high volume, rapid turnover inpatient unit similar to the private practice world.
6. To learn to interact with patients and staff in a **professional** manner. (**Interpersonal and communication skills**)

**ROTATION: EVALUATION AND TREATMENT OF ACUTE PSYCHIATRIC INPATIENTS (CONT'D)**

7. To develop safe intervention tactics (**patient care, interpersonal and communication, professionalism**) for crisis situations of a psychotic and/or behavioral nature.
8. To gain experience within the legal system (**systems-based practice**) in initiating commitment procedures and with testifying competently in court.

**OBJECTIVES**

1. The resident will perform a diagnostic psychiatric interview (**patient care, communication**) on all assigned patients and will develop a differential diagnosis (**medical knowledge**) based on the interview for each patient.
2. The resident will document rationale (**patient care, medical knowledge**) for all treatments prescribed.
3. The resident will be the team leader (**communication, professionalism**) in weekly multidisciplinary staff meetings on all assigned patients and will interact informally with multidisciplinary staff on a daily basis.
4. The resident will present each patient, including a biopsychosocial formulation, to the attending, and will complete an integrated summary of assessments by all treatment disciplines within 72 hours of admission on each patient (**medical knowledge, professionalism, communication**).
5. The resident will prepare a court treatment plan, file a petition and testify in all civil commitment cases assigned. If no legal proceedings are required for any assigned patient during the 3-month rotation, the resident will review documents prepared and attend the court hearing of another physician on the unit. The resident will also participate in "mock court" with the attending.

**SPECIFIC DUTIES OF ALL RESIDENTS**

1. Become familiar with the electronic medical record to decrease duplication of work and to increase information gathering ability (**systems-based practice**).
2. Evaluate approximately 6 new patients per week and within 24 hours of presentation, formulate a differential diagnosis and treatment plan, and present the case in a professional manner. (**patient care, communication, professionalism, medical knowledge**)
3. Complete required documentation in a timely, thorough and **professional** manner.
4. Attend daily morning rounds. (Rounds begin at 8:30, but arrival on the unit no later than 8:00 is encouraged.)
5. Attend weekly case conference (**practice-based learning**) or other educational activity and present patient or other information as assigned.
6. Have 7 hours of weekly supervision with attending.
7. Attend weekly multidisciplinary staff meetings (**communication, professionalism**) and take over increasing duties each week in this meeting.
8. Attend didactics, grand rounds, and for PGY-IIs outpatient clinic weekly (**professionalism, practice-based learning**). (New patients will not be assigned during didactic and clinic times.)

**ROTATION: EVALUATION AND TREATMENT OF ACUTE PSYCHIATRIC INPATIENTS (CONT'D)**

9. Actively participate in the education of junior medical students (**practice-based learning**) assigned to the service.
10. Contact families with the patient's consent for information and aid in follow up (**communication**).
11. Appear in court when patients are on holds and present information in a **professional** manner (**communication, systems-based practice**).
12. Attend all ECT treatments on assigned patients. (All residents will be expected to attend at least 2 treatments even if they are not assigned an ECT patient during their rotation.)
13. Complete at least one portfolio entry during this rotation (**practice-based learning**).

**RECOMMENDED READING MATERIAL**

*Psychiatry and Law for Clinicians (Concise Guide)*—Robert Simon, M.D.

*The Practitioner's Guide to Psychoactive Drugs*---Editors: Bassuk, Schoonover, & Gelenberg

*Molecular Basis of Psychiatry*---Editors: S. Hyman, M.D. and E. Nester, M.D.

*Electroconvulsive Therapy: A Programmed Text*---J. Beyer, M.D., R. Weiner, M.D. and M. Glenn, M.D.

**ROTATION: EVALUATION AND TREATMENT OF ACUTE PSYCHIATRIC INPATIENTS (CONT'D)**

**HOURS PER WEEK**

Direct Patient Care and Ward Work: 25 hours  
 Educational Conference and Staffing: 3 hours  
 Supervision: 7 hours  
 Approximate Total Hours on Ward: 32-35 hours

**Please Note the following Schedule is flexible and subject to change**

	Monday	Tuesday	Wed	Thursday	Friday	
<b>800</b>	Report to Unit 3K and perform any pre-round duties					
<b>830</b>	Morning Report and Exit Interviews					
<b>900</b>	Brief Daily Run-through of patient lists					
<b>930</b>	Patient care/supv	Patient care/supv	Staffing	Patient care/supv	Patient care/supv	
<b>1000</b>			Patient care/supv			
<b>1030</b>			CaseConf for PG-2			travel
<b>1100</b>						
<b>1130</b>						
<b>1200</b>	Lunch		travel/lunch	Res. Mtg	Lunch	
<b>1230</b>	Patient care/supv	Patient care/supv	PG-2 UAMS Clinic PG-1 Patient Care/Supv	Didac 1&2	Patient care/supv	
<b>100</b>				Didac 2	Resident Lecture	
<b>130</b>						
<b>200</b>				Didac 2	Patient care/supv	
<b>230</b>						
<b>300</b>						
<b>330</b>				Grand Rounds		
<b>400</b>						
<b>430</b>						

**ROTATION: EMERGENCY PSYCHIATRY**  
**ATTENDING: SHANNA PALMER, MD**  
**TELEPHONE: 257-5719**  
**MAIL SLOT: VA SLOT 704, 116T/LR**  
**LOCATION: LITTLE ROCK VA EVALUATION CLINIC/EMERGENCY ROOM**

## GOALS AND OBJECTIVES

The evaluation clinic/emergency room at the VAMC in Little Rock is responsible for the emergency and urgent psychiatry care of eligible veterans on a 24-hour basis. This service is responsible for the evaluation and triage of most psychiatric patients who present for admission.

The goals and objectives of this rotation are as follows:

1. The resident will develop **knowledge** and experience (**patient care, professionalism, communication**) in emergency evaluations, triage, and management of urgent and emergent psychiatric illness.
2. The resident will develop experience in crisis management including the management of suicidal and assaultive patients. (**patient care, systems-based practice**)
3. The resident will develop experience with the effectiveness of particular crisis management techniques including various pharmacological (**medial knowledge**), psychological (**medical knowledge, communication**), and social interventions (**systems-based practice**).
4. The resident will develop experience in management skills, supervising and collaborating with multiple health professionals, including medical students, APNs, RNs, RNP, social workers and ER staff (**communication, professionalism, systems-based practice**).

## SPECIFIC DUTIES OF THE RESIDENT

1. The resident will be expected to work in the environment of the general emergency medicine services within the VAMC (**systems-based practice, communication**). Supervision will be available on a case-by-case basis and immediately available during regular daytime hours (**practice-based learning**).
2. The resident will be expected to attend the clinic from 8 to 4:30 on a 5-days-a-week basis (**professionalism**). Evening hours will be covered by the on-call resident
3. Didactics will be seminar based. As such, the Evaluation Clinic resident will be expected to prepare topics and lead many of the discussions (**professionalism, practice-based learning, medical knowledge**).

**ROTATION:           EMERGENCY PSYCHIATRY (CONT'D)**

RECOMMENDED READING MATERIALS

Handbook of Emergency Psychiatry -- Andrew Slaby

The Clinical Psychiatric Interview -- MacKinnon and Michels  
(especially chapters 1, 9, 14, and 15)

Comprehensive Textbook of Psychiatry -- Kaplan and Sadock (various chapters)

HOURS PER WEEK (obviously depends on the other commitments of the resident)

Direct Patient Care:     hours

Case Conference/Staffing:

At least 3.25 hours per week, but varies according to clinical needs.

Supervision:

Ongoing on a case-by-case basis. I would describe the supervision as intense.

Administrative (Record Keeping): Less than 1 hour per week.

Total Number of Hours Per Week:   40

**ROTATION:** MENTAL HEALTH CLINIC NLRVA (PGY 3)  
**ATTENDING:** ERICA HIETT, MD, IRVING KUO, MD, & ANNETTE SLATER, MD  
**TELEPHONE:** 257-3166 or 257-3131  
**MAIL SLOT:** 116/F2  
**LOCATION:** 1L170, NLR, VA HOSPITAL

#### GOALS AND OBJECTIVES

1. To gain experience in the evaluation and management of psychiatric patients (**patient care, medical knowledge, communication**) in an outpatient setting (**systems-based practice**)
2. To gain experience in the management of psychotropic medications (**medical knowledge**) -- their side effects, mechanisms of action, drug interactions, and routine lab work required
3. To further residency education and provide experience in public speaking through preparing and presenting daily lectures (**practice-based learning, medical knowledge, professionalism, communication**)

#### SPECIFIC DUTIES OF THE RESIDENT

1. Evaluate patient's need for psychotropic medication (**communication, medical knowledge**).
2. Monitor patient for progress, side effects, and toxicity, making medication adjustments as necessary. (**patient care**)
3. Evaluate need for referral to other care providers, such as psychology and social work services, substance abuse treatment, or inpatient care. (**systems-based practice, communication**)
4. Participate in resident and medical student education through preparing daily lectures based on recommended reading and review of current literature. (**practice-based learning, medical knowledge, professionalism, communication**)

#### RECOMMENDED READING MATERIALS

Principles and Practice of Psychopharmacology – Philip G. Janicak et al  
Textbook of Psychopharmacology -- American Psychiatric Association Press  
Neurology for Psychiatrists -- Kaufman  
Textbook of Psychiatry -- APP  
Textbook of Psychiatry -- Kaplan and Sadock  
Essentials of Psychopharmacology -- Stahl

**ROTATION: MENTAL HEALTH CLINIC NLRVA (PGY 2) (CONT'D)**

HOURS PER WEEK

Direct Patient Care: 30 hours; 100% return appointments

Didactic: 2.5 hours

Administrative (Record Keeping): NA

Total Number of Hours Per Week: 32.5 approximately

Record keeping time will be part of direct patient care.

**ROTATION:** ARKANSAS STATE HOSPITAL (ASH) -- INPATIENT -- UNIT A  
**ATTENDING:** PURU THAPA, MD & MICHELLE VANLANDINGHAM, MD  
**TELEPHONE:** 686-9423  
**MAIL SLOT:** ASH 703  
**LOCATION:** ASH - UNIT A

#### GOALS AND OBJECTIVES

1. Develop expertise in interviewing psychiatric patients. **(communication)**
2. Enhance ability in case formulation and the differential diagnosis process. **(medical knowledge)**
3. Expand knowledge base and gain practical experience in using pharmacologic agents as well as other treatment modalities in an inpatient public hospital setting. **(patient care, medical knowledge)**
4. Develop ability to lead a multidisciplinary treatment team. **(communication, professionalism, systems-based practice)**
5. Foster an empathetic approach in the treatment of the seriously mentally ill. **(professionalism)**
6. Understand patients' legal rights and commitment laws and proceedings in Arkansas and participate in the process. **(systems-based practice, patient care)**
7. Get experience in electroconvulsive therapy. **(patient care, medical knowledge)**

#### SPECIFIC DUTIES OF THE RESIDENT

1. Work up and implement treatment process from admission to discharge. **(patient care, medical knowledge)**
2. Run a multidisciplinary treatment team. **(communication, professionalism, systems-based practice)**
3. Supervise, monitor and teach assigned junior medical students on the unit, and deliver selected didactic lectures in the early AM didactics. **(practice-based learning, medical knowledge, professionalism, communication)**
4. Follow the treatment of any patients in the Unit who are receiving ECT per ECT Protocol (see following page). **(medical knowledge, patient care)**

**ROTATION:            ARKANSAS STATE HOSPITAL -- INPATIENT -- UNIT A  
(CONT'D)**

RECOMMENDED READING MATERIAL

APA Textbook of Psychiatry

Essential Psychopharmacology, by Stephen M. Stahl

Electroconvulsive Therapy: A Programmed Text, by Glenn and Weiner;  
American Psychiatric Press

HOURS PER WEEK

Direct Patient Care: 15 hours

Case Conference/Staffing: 8 hours

Supervision: 5 hours

Administrative (Record Keeping): 5 hours

Total No. of hours per week: 33 hours

**PURU THAPA, MD & MICHELLE VANLANDINGHAM, MD – INPATIENT – UNIT A  
A Typical Week on Unit A, ASH**

<b>MONDAY</b>  <b>AM</b>	7:45 - 8:15	AM Didactics - Unit A Bullpen
	8:15 - 8:45 8:45 - 12:00	AM Report - Unit A Report Room Master Treatment Plan/Treatment Update Ward Work
<b>PM</b>	1:30 – 2:30 2:30 – 4:15	Professor Rounds – Unit A Bullpen Ward Work
<b>TUESDAY</b>  <b>AM</b>	7:45 - 8:15 8:15 - 8:45 8:45 - 11:30	AM Didactics - Unit A Bullpen AM Report - Unit A Report Room Master Treatment Plan/Treatment Update Ward Work
	<b>11:30 – 12:30</b>	<b>Psychopharmacology Conference - ASH Large Conference Room</b>
<b>PM</b>	1:00 – 4:15	Ward Work
<b>WEDNESDAY</b>  <b>AM</b>	7:45 - 8:15 8:15 - 8:45 <b>8:45 - 10:30</b>	AM Didactics - Unit A Bullpen AM Report – Unit A Report Room <b>Court Commitment Proceedings (Go to court only for your patient)</b>
	10:00-11:30 8:45 - 12:00 1:30 – 2:30	Utilization Review (2 <sup>nd</sup> and 4 <sup>th</sup> Wed of month) Ward Work Didactics (schedule flexible)
<b>PM</b>	1:00 – 4:15	Ward Work /Didactics
<b>THURSDAY</b>  <b>AM</b>	7:45 - 8:15 8:15 - 8:45 8:45 - 12:00	AM Didactics - Unit A Bullpen AM Report – Unit A Report Room Treatment Plan/Treatment Update Ward Work
	<b>12:00 – 4:00</b> <b>4:00 - 5:00</b>	<b>Resident Didactics/Lunch</b> <b>Departmental Grand Rounds</b>
<b>FRIDAY</b>  <b>AM</b>	7:45 - 8:15 8:15 - 8:45 <b>8:45 - 10:30</b>	AM Didactics - Unit A Bullpen AM Report – Unit A Report Room <b>Court Commitment Proceedings (Go to court only for your patient)</b>
	8:45 - 12:00	Ward Work
<b>PM</b>	1:30 – 2:30 2:30 – 4:15	Ward Work Ward Work

**ROTATION:**           **INPATIENT PSYCHIATRY UNITS  
PSYCHIATRIC RESEARCH INSTITUTE (PRI) - UAMS**

**ATTENDING:**       **JEFF CLOTHIER, MD**

**TELEPHONE:**      **526-8603**

**MAIL SLOT:**       **554**

**LOCATION:**         **PRI**

**Description of the Course:**

The adult inpatient program at the Psychiatric Research Institute includes 20-24 adult beds on two separate units. These units are functionally distinct. The 6S unit houses a medically involved unit where patients can receive significant medical and psychiatric care concurrently with the assistance of the appropriate consultation services. Section 5N houses a general adult unit that manages higher functioning patients. The average number of admissions to these units is approximately 40-50 admissions per month and an average length of stay of 9-10 days. Residents on the unit will assist the primary physicians for approximately 6-8 new patients per week; the average patient census per inpatient team is 8-10 patients. Working closely with a multidisciplinary treatment team is an essential component of this rotation in order to insure that patients receive appropriate and timely care. PGY-1 Residents will spend 12 weeks on this service. Each resident is expected to complete at least one portfolio entry during their rotation on PRI, is expected to attend all didactics and grand rounds, and is expected to participate in visiting professor rounds.

**GOALS**

1. To manifest **medical knowledge and interpersonal and communication skills (patient interviewing)** sufficient to competently evaluate common acute presentations seen in acute psychiatry.
2. To gain facility with treatment modalities for the illnesses commonly diagnosed on acute adult inpatient units, and develop **medical knowledge** with respect to the same especially psychopharmacology.
3. To develop competence in **interpersonal communication skills, professionalism, and systems-based practice** by working through an interdisciplinary approach to patient evaluation, treatment and follow up.
4. To demonstrate **professionalism** by presenting patients in a orderly, comprehensive, and timely manner and develop competence in formulating the biopsychosocial aspects of the patient's condition.
5. To develop time management skills necessary for a high volume, rapid turnover inpatient unit similar to the private practice world.
6. To learn to interact with patients and staff in a **professional** manner. (**Interpersonal and communication skills**)
7. To develop safe intervention tactics (**patient care, interpersonal and communication, professionalism**) for crisis situations of a psychotic and/or behavioral nature.

## ROTATION: PRI (CONT'D)

8. To gain experience within the legal system (**systems-based practice**) in initiating commitment procedures and with testifying competently in court.

### OBJECTIVES

1. The resident will perform a diagnostic psychiatric interview (**patient care, communication**) on all assigned patients and will develop a differential diagnosis (**medical knowledge**) based on the interview for each patient.
2. The resident will document rationale (**patient care, medical knowledge**) for all treatments prescribed.
3. The resident will be the team leader (**communication, professionalism**) in weekly multidisciplinary staff meetings on all assigned patients and will interact informally with multidisciplinary staff on a daily basis.
4. The resident will present each patient, including a biopsychosocial formulation, to the attending, and will complete an integrated summary of assessments by all treatment disciplines within 72 hours of admission on each patient (**medical knowledge, professionalism, communication**).

### SPECIFIC DUTIES OF ALL RESIDENTS

1. Become familiar with the electronic medical record to decrease duplication of work and to increase information gathering ability (**systems-based practice**).
2. Evaluate approximately 6 new patients per week and within 24 hours of presentation, formulate a differential diagnosis and treatment plan, and present the case in a professional manner. (**patient care, communication, professionalism, medical knowledge**)
3. Complete required documentation in a timely, thorough and **professional** manner.
4. Attend daily rounds.
5. Attend case conference (**practice-based learning**) or other educational activity and present patient or other information as assigned.
6. Have 7 hours of weekly supervision with attending.
7. Attend weekly multidisciplinary staff meetings (**communication, professionalism**) and take over increasing duties each week in this meeting.
8. Attend didactics, grand rounds (**professionalism, practice-based learning**). (New patients will not be assigned during didactic and clinic times.)
9. Actively participate in the education of junior medical students (**practice-based learning**) assigned to the service.
10. Contact families with the patient's consent for information and aid in follow up (**communication**).
11. Appear in court when patients are on holds and present information in a **professional** manner (**communication, systems-based practice**).
12. Attend all ECT treatments on assigned patients.
13. Complete at least one portfolio entry during this rotation (**practice-based learning**).

**ROTATION:           PRI (CONT'D)**

**RECOMMENDED READING MATERIAL**

The residents are encouraged to read contemporary sources in respected Journals as they related to specific patients. Desktop access to UAMS library facilitates this.

*Organic Psychiatry—W.A. Lishman*

*Neuropsychiatry—Fogel, Schiffer, and Rao*

*Molecular Basis of Psychiatry--*Editors: S. Hyman, M.D. and E. Nester, M.D.

*Electroconvulsive Therapy: A Programmed Text---*J. Beyer, M.D., R. Weiner, M.D. and M. Glenn, M.D.

**HOURS PER WEEK**

Direct Patient Care and Ward Work: 25 hours  
Educational Conference and Staffing: 3 hours  
Supervision: 7 hours  
Approximate Total Hours on Ward: 32-35 hours

**ROTATION:** CHILD AND ADOLESCENT PSYCHIATRY

**ATTENDING:** GAIL EISENHAUER, MD

**TELEPHONE:** 364-4670

**MAIL SLOT:** ACH 654

**LOCATION:** ARKANSAS CHILDREN'S HOSPITAL,  
SOUTH CAMPUS, CHILD STUDY CENTER, 5<sup>TH</sup> FLOOR

#### GOALS AND OBJECTIVES

To gain knowledge and experience about the evaluation and treatment of psychiatric disorders in children and adolescents within the family/relationship context.

#### ROTATION DESCRIPTION

This is a required 6-month rotation occurring in the second year. Faculty/Staff consists of seven full-time child psychiatrists, four psychologists, five full-time social workers, and one case manager. Residents participate in the assessment and treatment of children and adolescents in an outpatient clinic setting two half days per week and on the pediatric consultation liaison service one half day per week. During this rotation, residents will obtain adequate **knowledge** and skill to diagnose children, adolescents and families, determine psychiatric services necessary (**systems-based practice**), and provide, when indicated, comprehensive care. Residents will conduct thorough psychiatric evaluations (**communication**), medication management (**medical knowledge**), individual therapy (**medical knowledge, communication**), family therapy, and be introduced to aspects of play therapy while in the outpatient clinic. Residents will also develop the skills to evaluate and manage children in a general medical/surgical hospital with emotional and behavioral disorders (**systems-based practice**). They will work collaboratively with physicians, nurses, and other mental health professions while providing assessment and treatment for patients in the emergency room and medical/surgical inpatient services (**communication, professionalism**). It is required that each case be discussed with and supervised by a faculty member (**practice-based learning**). A faculty child and adolescent psychiatrist is always available for supervision. Residents will also attend a one hour lecture each week that is specific for topics related to child and adolescent development and psychopathology (**practice-based learning**).

## ROTATION: CHILD AND ADOLESCENT PSYCHIATRY (CONT'D)

1. Perform new evaluations of children and adolescents and their families. **(patient care, medical knowledge, communication)**
2. Participate in ongoing medication management of children and adolescents. **(patient care, medical knowledge)**
3. Begin developing an area of psychotherapeutic expertise, and initiate treatment in this area. **(medical knowledge, communication)**
4. Develop skills in working with experts in other disciplines. **(systems-based practice, communication)**

The maximum caseload for each resident in the outpatient clinic is to perform one new patient assessment (two hours) each day and follow-up care for two outpatients in 30 minute visits. For the one-half day of hospital based consultation the average number of consults per day is 2.

Individual Supervision is provided for on a case by case basis as it is a requirement that all outpatient and consultation assessments and follow-up visits be discussed with faculty.

Residents will also select a topic pertaining to child and adolescent psychiatry and present a one hour lecture to their peers and a faculty member during their six month rotation.

### RECOMMENDED READING MATERIALS

Child and Adolescent Psychiatry--A Comprehensive Textbook by Melvin Lewis, MD

Pediatric Neuropsychiatry – by C. Edward Coffey, Roger A. Brumback

Concise Guide to Child and Adolescent Psychiatry- Third Edition, by Mina K Dulcan, MD, D. Richard Martini, MD and MaryBeth Lake, MD. American Psychiatric Publishing, Inc.

### HOURS PER WEEK

Direct Patient Care: 9 hours

Consultation Liaison Teaching Rounds: 1 hour

Didactics: 1 hour

Administrative (Record Keeping): 2 hours

Total Number of Hours Per Week: 13 hours approximately

**ROTATION: PSYCHIATRIC CONSULTATION SERVICE -- UNIVERSITY HOSPITAL**

**ATTENDING: SCOTT STANLEY, MD**

**TELEPHONE: 526-8521**

**MAIL SLOT: 554**

**LOCATION: UNIVERSITY HOSPITAL**

## **GOALS AND OBJECTIVES**

### **GOALS**

1. To understand the manner in which psychiatric illness can present in med/surg services. **(medical knowledge)**
2. To understand the psychological impact of illness on patients and be able to identify their coping skills and resources. **(medical knowledge)** It is essential to assess the degree to which a patient is adapting to the severe stress of hospitalization and medical illness.
3. To increase understanding of neuropsychiatric illnesses. **(medical knowledge)**
4. To be familiar with treatment modalities appropriate for medically ill patients. **(medical knowledge, patient care)**
5. To understand the consultation process and the techniques, responsibilities, and limitations of the consultant role. **(systems-based practice, communication, professionalism)**
6. To promote liaison relationships with medical, surgical, and emergency medicine services. **(communication, professionalism, systems-based practice)**
7. To demonstrate a variety of interventions and therapies relevant to medically ill patients, including time-effective psychotherapy, somatic therapies, behavioral techniques, liaison methods, and multidisciplinary team approaches.

### **OBJECTIVES**

#### **Skills:**

1. Interview patients in a variety of settings within the general hospital. **(patient care, communication)**
2. Evaluate for psychopathology in patients with concomitant medical conditions. **(medical knowledge, communication)**
3. Learn to present a case in a concise and efficient manner. This involves describing the reason for the consult, the current medical issues requiring inpatient medical care, and the psychiatric symptoms that generated the consult questions. It is also critical to provide past psychiatric, medical, family, social and substance abuse history, current vitals and meds, relevant labs and diagnostic imaging as well as a complete mental status exam including a mmse.
4. Perform a neuropsychiatric examination. **(medical knowledge, communication)** This may include a MMSE, neurological exam, an HIV dementia scale and tests designed to assess particular domains of CNS functioning such as the go, no go test, Trails A and B, tests for apraxia, agnosia etc.

**ROTATION: PSYCHIATRY CONSULTATION SERVICE -- UNIVERSITY HOSPITAL  
(CONT'D)**

5. Gather data from appropriate collateral sources. On CL it is often necessary to talk to family members, friends, AA sponsors, roommates, parole officers and o/p physicians caring for the patient. **(communication, professionalism)** If a patient is in psychiatric treatment it is **mandatory** to make every effort to contact the patient's therapist and/or psychiatrist.
6. Understand the role of medical illness and its treatments in the patient's psychiatric symptoms. **(medical knowledge, patient care)**
7. Understand the role of the patient's psychiatric symptoms on his/her medical illness and its treatments. **(medical knowledge, patient care)**
8. Recognize emotional responses from the patient, staff, and consultant. **(communication, professionalism, systems-based practice)**
9. Make recommendations about somatic treatments and appreciate concerns about physiologic effects, contraindications, drug interactions, and dosing in the medically ill. **(medical knowledge, patient care)**
10. Make recommendations about and provide psychoeducation, brief psychotherapy, and behavioral management techniques. **(communication, professionalism)**
11. Write a useful consultation note. **(communication, professionalism, patient care)**
12. Maintain communication with the consultees and define ongoing needs. **(professionalism, communication)**
13. Monitor the patient's course during hospitalization and provide continuing input as indicated.
14. Participate as a member of a multidisciplinary team to optimize patient care. **(systems-based practice, communication)**
15. Understand local resources for follow-up and be able to make appropriate referrals. **(systems-based practice, communication)**
16. Efficiently triage cases to manage clinical urgency and time pressure.
17. Proactively seek supervision when facing emergent issues.
18. Recognize when attending to attending discussion is needed to resolve consultant/consultee conflict.

**KNOWLEDGE**

1. Resident will become knowledgeable about the following essential topics in consultation psychiatry **(medical knowledge)**:

Adjustment Disorders  
Aggression/Impulsivity  
AIDS/HIV Disease  
Alcohol and Drug Abuse in the General Medical Setting (including withdrawal states)  
Anxiety in the General Medical Setting  
Determination of Capacity and other Forensic Issues in C-L Psychiatry  
Coping with Illness  
Death, Dying, and Bereavement  
Delirium/Agitation  
Dementia in the General Medical Setting  
Depression in the General Medical Setting  
Factitious Disorders and Malingering

Pain  
**ROTATION: PSYCHIATRY CONSULTATION SERVICE -- UNIVERSITY HOSPITAL  
(CONT'D)**

Personality Disorders in the General Medical Setting  
Psychiatric Issues Related to Pregnancy  
Psychiatric Manifestations of Medical and Neurologic Illness  
Psychological Factors Affecting Medical Conditions  
Psycho-Oncology  
Psychopharmacology of the Medically Ill (including drug interactions)  
Psychotherapy of the Medically Ill  
Somatoform Disorders  
Suicide  
Transplantation Psychiatry  
Traumatic Brain Injury

2. Resident will be expected to explore several areas of interest in depth. **(practice-based learning)**

#### SPECIFIC DUTIES OF THE RESIDENT

1. Resident is responsible for overseeing the management of the University Hospital Psychiatric Consultation team, which may include of 3<sup>rd</sup> and 4<sup>th</sup> year medical students, Neurology interns, and/or Family Medicine residents. **(patient care, medical knowledge, professionalism, communication, system-based practice)**
2. Respond to consultation requests and complete the pertinent paperwork in a timely manner, communicating directly with the consultees as indicated. **(professionalism, communication)**
3. Follow up patients remaining in the hospital. **(patient care)**
4. Attend daily rounds.
5. Participate actively in weekly supervision. **(practice-based learning)**
6. Participate in weekly combined psychiatric consultation services conference. **(practice-based learning)**
7. Teach medical students and rotating residents. **(professionalism, communication, practice-based learning)**
8. Complete resident section of billing form the day the patient is staffed and give billing form to attending for his/her signature.

#### RECOMMENDED READING MATERIAL

Readings maintained on Electronic Reserves at the UAMS library.

Levenson, James L (Ed) (2005) Textbook of Psychosomatic Medicine

Wise MG and Rundell JR (Eds). (2002). The American Psychiatric Press Textbook of Consultation-Liaison Psychiatry: Psychiatry in the Medically Ill, 2<sup>nd</sup> Edition.

Yudofsky SC and Hales RE (Eds). (2002). The American Psychiatric Publishing Textbook of Neuropsychiatry and Clinical Neurosciences, 4<sup>th</sup> Edition.

**ROTATION:           PSYCHIATRY CONSULTATION SERVICE -- UNIVERSITY HOSPITAL  
(CONT'D)**

Teaching Consultation-Liaison Psychotherapy: Assessment of Adaptation to Medical and Surgical Illness, Jonathan J. Hunter, M.D., F.R.C.P.(C.) Robert G. Maunder, M.D., F.R.C.P. (C.), Mona Gupta, M.D., F.R.C.P. (C.) Academic Psychiatry, 31:5, September-October 2007

**HOURS PER WEEK**

Direct patient care: 25-30 hours

Case Conference/staffing: 5-10 hours

Didactics: 1 hour

Individual Supervision: 1 hour

Administrative: 5 hours

Total Hours: 45 (excludes clinic, other supervision, other didactics)

**ROTATION: SUBSTANCE ABUSE**

**ATTENDING: SHANE SPARKS, MD**

**TELEPHONE: 257-3100**

**MAIL SLOT: VA SLOT 704, 116E/NLR**

**LOCATION: SPECIAL TREATMENT SECTION, BUILDING 170, NLR VA**

#### GOALS AND OBJECTIVES

1. Learning to work within an interdisciplinary team. **(professionalism, communication, system-based practice)**
2. Managing comorbid psychiatric and medical conditions. **(medical knowledge)**
3. Working with families (as available). **(professionalism, communication)**
4. Addressing the unique issues and problems of substance-abusing patients and their families. **(medical knowledge, systems-based practice)**
5. Exploring issues of specific sub-populations (e.g., minorities, geriatric populations, etc.). **(medical knowledge)**
6. Using neuropsychological testing, laboratory testing, and diagnostic procedures when appropriate. **(medical knowledge, communication)**
7. Training in the use of various psychotherapies and pharmacotherapies in this population. **(patient care, medical knowledge)**
8. Training in the use of buprenorphine, acamprosate, naltrexone and nicotine replacement therapies. **(medical knowledge)**
9. Studying unique issues involved in cocaine addiction, phencyclidine dependence, volatile hydrocarbon inhalant abuse, etc. **(medical knowledge)**
10. Developing an understanding and familiarity with rational criteria for different levels of care and patient transfer across levels of care. **(patient care, systems-based practice, communication, professionalism)**

#### SPECIFIC DUTIES OF THE RESIDENT

The rotation was patterned after the "Model Curriculum for Alcohol and Drug Abuse Training and Experience During the Adult Psychiatry Residency," by J.A. Halikas (The American Journal on Addictions, 1(3):222-229, 1992). Halikas suggested that the required resident rotation should last a minimum of 2 months and occur some time in PGY-2.

## ROTATION:           SUBSTANCE ABUSE (CONT'D)

Clinical elements on the rotation include:

1. Comprehensive psychiatric assessments of substance-abusing patients. **(medical knowledge, communication)**
2. Direct patient management responsibility of psychiatric issues. **(patient care, professionalism)**
3. Functioning as part of a multidisciplinary treatment team. **(communication, professionalism, systems-based practice)**
4. Participation in group therapy. **(medical knowledge, communication)**
5. Participation in Alcoholics Anonymous groups. **(medical knowledge, professionalism, communication)**
6. Contact with community resources (including a halfway house and a methadone clinic). **(systems-based practice, communication)**

Interactive teaching techniques for this rotation include having the residents evaluate the strengths and weaknesses of various group leaders when they observe group therapy because this "actualizes" their understanding of group therapy techniques and tenets. In addition, the residents are asked to evaluate the impact of pending or recent organizational changes because this may increase their appreciation of organizational issues and how these relate to patient care and the interdisciplinary team.

### RECOMMENDED READING MATERIALS

As particular patient issues arise, related sentinel articles will be distributed for discussion.

### HOURS PER WEEK

Direct Patient Care: 12

Groups: 1

Case Conference/Staffing: 1

Supervision: 1

Administrative (Record Keeping): 2.5

Total No. of hours per week: 17.5

**ROTATION: WALKER FAMILY CLINIC**

**ATTENDING: ERICK MESSIAS, M.D.**

**TELEPHONE: 526-8200**

**MAIL SLOT: 568**

**LOCATION: PSYCHIATRIC RESEARCH INSTITUTE**

#### GOALS AND OBJECTIVES

1. To participate in a multidisciplinary, group practice managing the evaluation and treatment of a wide variety of mental illnesses and conditions in a late adolescent, adult, and geriatric population. **(patient care, medical knowledge, systems-based practice)**
2. To experience the management of serious and acute mental illnesses and emotional crises in an outpatient setting. **(patient care, medical knowledge)**
3. To design treatment plans using the appropriate combinations of psychopharmacology, psychotherapies, behavioral techniques, social services, and medical consultation. **(systems-based practice, medical knowledge, communication)**
4. To orchestrate patient care in the context of institutional structures and economic constraints imposed by various insurance structures. **(systems-based practice)**
5. To concentrate on "time conscious" psychotherapies during the rotation. **(professionalism, patient care)**
6. To participate in continuous clinical improvements using disease-specific outcomes assessment tools. **(practice-based learning)**

#### SPECIFIC DUTIES OF THE RESIDENT

1. The clinic is best viewed as a practice opportunity for the rotating resident **(patient care)**. Managing confidentiality, flexibly meeting the needs of different patients, proactively seeking supervision, coordinating care, and record keeping and billing, are critical skills to be mastered. **(professionalism)**.
2. New patients evaluated by the resident will remain in the resident's care throughout the rotation. Treatment plans will address the individual patient's needs and may involve the participation of non-psychiatrist, mental health providers). Residents will be expected to provide a comprehensive and integrated assessment of patients' needs with respect to diagnostic/biological, psychological and social issues. Creating and conducting groups; experiencing couples and family therapy; and exposure to behavioral techniques will be encouraged. A thorough diagnostic assessment and attention to target symptoms will guide the prudent use of psychopharmacology. **(systems-based practice, medical knowledge, patient care)**

**ROTATION: WALKER FAMILY CLINIC (CONT'D)**

3. The clinic practice will be guided by evidence based medicine and an enduring commitment to understand and respect patients as unique human beings.  
**(systems-based practice, medical knowledge, patient care).**

RECOMMENDED READING MATERIAL

Textbook of Psychopharmacology, American Psychiatric Association Press

Dynamic Psychotherapy, Marc H. Hollender, M.D., and Charles B. Ford, M.D.

The Theory and Practice of Group Therapy (4th edition), Irving Yalom, M.D.

Psychotherapy in a New Key: A Guide to Time Limited Dynamic Psychotherapy, Hans Strupp, Ph.D., and Jeffery Binder, Ph.D.

Handbook of Short-Term Dynamic Psychotherapy, Paul Crits-Christoph, Ph.D., and Jacque P. Barber, Ph.D.

A more comprehensive reading list will be presented at the time of the rotation.

HOURS PER WEEK

Direct Patient Care: 10 hours

Group Supervision: 1 hour

Individual Supervision: 1 hour

**ROTATION:** CONSULTATION-LIAISON SERVICE / LR VAMC  
**ATTENDING:** MARCUS WELLEN, MD  
**TELEPHONE:** 257-6604  
**MAIL SLOT:** 116T/LR  
**LOCATION:** LRVA Emergency Room

#### GOALS AND OBJECTIVES

1. To learn about the various psychiatric syndromes that most commonly present in a medical setting. **(medical knowledge)**
2. To learn about the various psychiatric treatment modalities utilized in a medical setting. **(patient care, medical knowledge)**
3. To gain knowledge of the consultation process and learn ways to communicate effectively with other professional staff. **(communication, systems-based practice)**
4. To become familiar with psychological and social factors that contribute to somatic illness. **(medical knowledge)**

#### SPECIFIC DUTIES OF THE RESIDENT

Evaluate new consultations daily on medical/surgical wards (approximately 40/month).

Attend rounds daily.

Follow up consultations and confer with staff and family members daily.

Assist with transfers to acute psychiatry/STS as needed.

Assist with follow-up MHC appointments as appropriate.

Attend conferences as scheduled.

Supervision weekly.

**ROTATION:           CONSULTATION-LIAISON SERVICE / LR VAMC (CONT'D)**

RECOMMENDED READING MATERIAL

Manual of Psychiatric Medicine (2005) -- Editors: Wyszynski and Wyszynski

Clinical Neurology for Psychiatrists (2007) – Editor: Kaufman

Textbook of Consultation/Liaison Psychiatry (2002) -- Editors: Rundell and Wise

Massachusetts General Hospital Handbook of General Psychiatry (2004) -- Editor: Cassem

Patients' Competence to Consent to Treatment: Appelbaum P. S. N Engl J Med. 2007 Nov 1;357(18):1834-40.

Additional selected readings from attendings:

HOURS PER WEEK

Direct Patient Care: 15-20 hours

Case Conference/Staffing: 7 hours

Supervision: 1 hour

Administrative (Record Keeping): 5 hours

Total Number of Hours Per Week: 32 hours

(excluding didactic, clinic, other supervision)

**ROTATION: GERIATRIC PSYCHIATRY**

**ATTENDING: LEWIS KRAIN, MD**

**TELEPHONE: 257-3146**

**MAIL SLOT: 116A/NLR**

**LOCATION: NLRVA**

#### GOALS AND OBJECTIVES

1. Develop competency in the assessment and management of common psychiatric diagnoses associated with geriatric patients, especially depression, dementia, and delirium (**medical knowledge, patient care**).
2. Develop competency in the management of chronic mental illnesses (e.g. schizophrenia, bipolar disorder) in older patients, and understand how care of these illnesses changes through the lifespan (**medical knowledge, patient care**).
3. Understand the importance of using a multi-disciplinary approach to managing mental health issues in older patients, both on the regular treatment team (e.g. social work, nursing, occupational therapy) and in interactions with consulting services (e.g. geriatric medicine, neurology, PM&R, etc) (**systems-based practice, communication, professionalism**).
4. Develop competency in communicating with families in order to obtain collateral information and coordinate care. This includes the ability to use family meetings to obtain information, convey medical recommendations, and steer treatment planning (**systems-based practice, communication, professionalism**).
5. Residents will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses, and should be able to serve as an effective leader of the multi-disciplinary team by the end of the rotation (**practice-based learning, systems-based practice, professionalism, patient care**).
6. Understand the etiology and neurobiology of dementia and delirium, using required readings as well as self-guided study based on cases admitted to the inpatient unit (**medical knowledge, practice-based learning**).

#### SPECIFIC DUTIES OF THE RESIDENT:

1. This is a half-time rotation. Residents are expected to be available for patient care and supervision between 8AM and noon every weekday. Residents are expected to respond promptly to calls and pages from unit staff (professionalism).
2. Residents are responsible for initial assessment of new patients admitted to the unit. This includes physical exam, review of systems, and patient history, as well as admitting orders.
3. Residents are responsible for ongoing daily care of inpatients on the geriatric psychiatry unit, including daily interviews and assessments. Residents are responsible for entering appropriate orders into CPRS and charting progress notes as needed.

**ROTATION:            GERIATRIC PSYCHIATRY (CONT'D)**

4. Residents are expected to be present for rounds/ treatment team meetings. These meetings occur daily at 8:30 AM.
5. Residents are expected to be present for all family meetings, provided these meetings are scheduled before noon.
6. Residents who have patients treated with ECT are expected to be present to assist the attending with this procedure (which may begin before 8AM).

**RECOMMENDED READING MATERIALS:**

Reading materials will be provided based upon the clinical cases present on the unit at any given time.

**HOURS PER WEEK:**

Direct Patient Care: 10 hours

Groups: 0

Case Conference/Staffing: 3 hours

Supervision: 2 hours

Record Keeping: 5 hours

Total hours per week: 20

**ROTATION: INPATIENT PSYCHIATRY UNITS-UAMS  
PSYCHIATRIC RESEARCH INSTITUTE  
NORTHWEST ARKANSAS (PRI-NWA)**

**ATTENDING: MICHAEL HOLLOMON, MD**

**TELEPHONE: 479-757-1400**

**MAIL SLOT: Behavioral Health Unit, 609 West Maple Street, Springdale, Arkansas  
72764**

**LOCATION: NORTHWEST MEDICAL CENTER OF WASHINGTON COUNTY  
SPRINGDALE, ARKANSAS**

**Description of the Course:**

The adult inpatient program at the Psychiatric Research Institute-NWA includes 29 adult beds. It is a general adult unit that manages higher functioning patients with a variety of psychiatric diagnoses. The average number of admissions to these units is approximately 40-50 admissions per month with an average length of stay of 6 days. Residents on the unit will assist the primary physicians for approximately 6-8 new patients per week; the average patient census per inpatient team is 4 patients. Working closely with a multidisciplinary treatment team is an essential component of this rotation in order to insure that patients receive appropriate and timely care. PGY-1 Residents will spend 5 weeks on this service. Each resident is expected to complete at least one portfolio entry during their rotation on PRI, is expected to attend all didactics and grand rounds, and is expected to participate in visiting professor rounds.

**GOALS:** The residency program requires its residents to obtain **competencies** in the 7 areas below sufficient to evaluate and treat presentations commonly seen in acute psychiatry. Toward this end, programs must define the specific knowledge, skills and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

**OBJECTIVES**

1. The resident will be able to perform a diagnostic psychiatric interview (**patient care, communication**) on all assigned patients and will develop a differential diagnosis (**medical knowledge**) based on the interview for each patient.
2. The resident will be able to discuss and document rationale (**patient care, medical knowledge**) for all treatments prescribed.
3. The resident will serve as the team leader (**communication, professionalism**) in weekly multidisciplinary staff meetings on all assigned patients and will interact informally with multidisciplinary staff on a daily basis.

## ROTATION: PRI-NORTHWEST INPATIENT (CONT'D)

4. The resident will present each patient, including a biopsychosocial formulation, to the attending, and will complete an integrated summary of assessments by all treatment disciplines within 72 hours of admission on each patient (**medical knowledge, professionalism, communication**).

## SPECIFIC DUTIES OF ALL RESIDENTS

1. Become familiar with the electronic medical record to decrease duplication of work and to increase information gathering ability (**systems-based practice**).
2. Evaluate approximately 6 new patients per week and within 24 hours of presentation, formulate a differential diagnosis and treatment plan, and present the case in a professional manner. (**patient care, communication, professionalism, medical knowledge**)
3. Complete required documentation in a timely, thorough & **professional** manner and in keeping with the requirements and policies of the hospital. (**system-based practices**)
4. Attend daily rounds.
5. Attend case conference (**practice-based learning**) and other educational activities and present patient or other information as assigned.
6. Have 2 hours of direct supervision with attending per week.
7. Attend weekly multidisciplinary staff meetings (**communication, professionalism**) and take over increasing duties each week in this meeting.
8. Attend didactics, grand rounds (**professionalism, practice-based learning**). (New patients will not be assigned during didactic and clinic times.)
9. Actively participate in the education of junior medical students (**practice-based learning**) assigned to the service.
10. Contact families with the patient's consent for information and aid in follow up (**communication**).
11. Appear in court when patients are on holds and present information in a **professional** manner (**communication, systems-based practice**).
12. Attend all ECT treatments on assigned patients.
13. Complete at least one portfolio entry during this rotation (**practice-based learning**).

## RECOMMENDED READING MATERIAL

The residents are encouraged to read contemporary sources in respected Journals as they related to specific patients. Desktop access to UAMS library facilitates this.

*Organic Psychiatry*—W.A. Lishman

*Neuropsychiatry*—Fogel, Schiffer, and Rao

*Molecular Basis of Psychiatry*---Editors: S. Hyman, M.D. and E. Nester, M.D.

*Electroconvulsive Therapy: A Programmed Text*---J. Beyer, M.D., R. Weiner, M.D. and M. Glenn, M.D.

**ROTATION: PRI-NORTHWEST INPATIENT (CONT'D)**

**HOURS PER WEEK**

Direct Patient Care and Ward Work: 15 hours  
Educational Conference and Staffing: 1.5 hours  
Supervision: 2 hours  
Approximate Total Hours on Ward: 18-20 hours

**ROTATION:** PSYCHIATRIC CONSULTATION SERVICE – PRI-NWA  
**ATTENDING:** MICHAEL HOLLOMON, MD

**TELEPHONE:** 479-757-1400

**MAIL SLOT:** Behavioral Health Unit, 609 West Maple Street, Springdale, Arkansas  
72764

**LOCATION:** NORTHWEST MEDICAL CENTER OF WASHINGTON COUNTY

## **GOALS AND OBJECTIVES**

### **GOALS**

1. To understand the manner in which psychiatric illness can present in medical and surgical services. **(medical knowledge)**
2. To understand the psychological impact of medical illness on patients and be able to identify their coping skills and resources. **(medical knowledge)**
3. To increase understanding of neuropsychiatric illnesses and their treatment. **(medical knowledge and patient care)**
4. To become familiar with treatment modalities appropriate for medically ill patients. **(medical knowledge, patient care)**
5. To understand the consultation process and the techniques, responsibilities, and limitations of the consultant role. **(systems-based practice, communication, professionalism)**
6. To promote and manage liaison relationships with medical, surgical, and emergency medicine services. **(communication, professionalism, systems-based practice)**
7. To demonstrate a variety of interventions and therapies relevant to medically ill patients, including time-effective psychotherapy, somatic therapies, behavioral techniques, liaison methods, and multidisciplinary team approaches.

### **OBJECTIVES**

#### **Skills:**

1. Interview patients in a variety of settings within the general hospital. **(patient care, communication)**
2. Evaluate for psychopathology in patients with concomitant medical conditions. **(medical knowledge, communication)**
3. Learn to present a case in a concise and efficient manner. This involves describing the reason for the consult, the current medical issues requiring inpatient medical care, and the psychiatric symptoms that generated the consult questions. It is also critical to provide past psychiatric, medical, family, social and substance abuse history, current vitals and meds, relevant labs and diagnostic imaging as well as a complete mental status exam including a mmse.

## ROTATION: PRI-NWA PSYCHIATRIC CONSULTATION (CONT'D)

4. Perform a neuropsychiatric examination. **(medical knowledge, communication)** This may include a MMSE, neurological exam, an HIV dementia scale and tests designed to assess particular domains of CNS functioning such as the go, no go test, Trails A and B, tests for apraxia, agnosia etc.
5. Gather data from appropriate collateral sources. On CL it is often necessary to talk to family members, friends, AA sponsors, roommates, parole officers and o/p physicians caring for the patient. **(communication, professionalism)** If a patient is in psychiatric treatment it is **mandatory** to make every effort to contact the patient's therapist and/or psychiatrist.
6. Understand the role of medical illness and its treatments in the patient's psychiatric symptoms. **(medical knowledge, patient care)**
7. Understand the role of the patient's psychiatric symptoms on his/her medical illness and its treatments. **(medical knowledge, patient care)**
8. Recognize emotional responses from the patient, staff, and consultant. **(communication, professionalism, systems-based practice)**
9. Make recommendations about somatic treatments and appreciate concerns about physiologic effects, contraindications, drug interactions, and dosing in the medically ill. **(medical knowledge, patient care)**
10. Make recommendations about and provide psychoeducation, brief psychotherapy, and behavioral management techniques. **(communication, professionalism)**
11. Write a useful consultation note. **(communication, professionalism, patient care)**
12. Maintain communication with the consultees and define ongoing needs. **(professionalism, communication)**
13. Monitor the patient's course during hospitalization and provide continuing input as indicated.
14. Participate as a member of a multidisciplinary team to optimize patient care. **(systems-based practice, communication)**
15. Understand local resources for follow-up and be able to make appropriate referrals. **(systems-based practice, communication)**
16. Efficiently triage cases to manage clinical urgency and time pressure.
17. Proactively seek supervision when facing emergent issues.
18. Recognize when attending to attending discussion is needed to resolve consultant/consultee conflict.

## KNOWLEDGE

1. Resident will become knowledgeable about the following essential topics in consultation psychiatry **(medical knowledge)**:

Adjustment Disorders

Aggression/Impulsivity

AIDS/HIV Disease

Alcohol and Drug Abuse in the General Medical Setting (including withdrawal states)

Anxiety in the General Medical Setting

Determination of Capacity and other Forensic Issues in C-L Psychiatry

Coping with Illness

## ROTATION: PSYCHIATRY CONSULTATION SERVICE, PRI-NWA (CONT'D)

Death, Dying, and Bereavement  
Delirium/Agitation  
Dementia in the General Medical Setting  
Depression in the General Medical Setting  
Factitious Disorders and Malingering  
Pain  
Personality Disorders in the General Medical Setting  
Psychiatric Issues Related to Pregnancy  
Psychiatric Manifestations of Medical and Neurologic Illness  
Psychological Factors Affecting Medical Conditions  
Psycho-Oncology  
Psychopharmacology of the Medically Ill (including drug interactions)  
Psychotherapy of the Medically Ill  
Somatoform Disorders  
Suicide  
Transplantation Psychiatry  
Traumatic Brain Injury

2. Resident will be expected to explore several areas of interest in depth. **(practice-based learning)**

### SPECIFIC DUTIES OF THE RESIDENT

1. Resident is responsible for overseeing the management of the Consultation/Liaison team, which may include 3<sup>rd</sup> and 4<sup>th</sup> year medical students, Neurology interns, and/or Family Medicine residents. **(patient care, medical knowledge, professionalism, communication, system-based practice)**
2. Respond to consultation requests and complete the pertinent paperwork in a timely manner, communicating directly with the consultees as indicated. **(professionalism, communication)**
3. Follow up patients as needed throughout their hospital course. **(patient care)**
4. Attend daily rounds.
5. Participate actively in weekly supervision. **(practice-based learning)**
6. Participate in weekly combined psychiatric consultation services conference. **(practice-based learning)**
7. Complete resident section of billing form the day the patient is staffed and give billing form to attending for his/her signature. **(systems-based practice)**

**ROTATION: PSYCHIATRY CONSULTATION SERVICE – PRI-NWA, (CONT'D)**

RECOMMENDED READING MATERIAL

Readings maintained on Electronic Reserves at the UAMS library.

Levenson, James L (Ed) (2005) Textbook of Psychosomatic Medicine

Wise MG and Rundell JR (Eds). (2002). The American Psychiatric Press Textbook of Consultation-Liaison Psychiatry: Psychiatry in the Medically Ill, 2<sup>nd</sup> Edition.

Yudofsky SC and Hales RE (Eds). (2002). The American Psychiatric Publishing Textbook of Neuropsychiatry and Clinical Neurosciences, 4<sup>th</sup> Edition.

Teaching Consultation-Liaison Psychotherapy: Assessment of Adaptation to Medical and Surgical Illness, Jonathan J. Hunter, M.D., F.R.C.P.(C.)Robert G. Maunder, M.D., F.R.C.P. (C.), Mona Gupta, M.D., F.R.C.P. (C.) Academic Psychiatry, 31:5, September-October 2007

HOURS PER WEEK

Direct patient care: 18 hours

Case Conference/staffing: 1.5 hours

Individual Supervision: 1 hour

Total Hours: 20-22 (excludes clinic, other supervision, other didactics)

**ROTATION: PRI-NWA OUTPATIENT CLINIC**

**ATTENDING: MICHAEL HOLLOMON, MD**

**TELEPHONE: 479-750-2742**

**MAIL SLOT: JONES MEDICAL BUILDING, 609 MAPLE STREET, SUITE 403,  
SPRINGDALE, ARKANSAS 72764**

**LOCATION: JONES MEDICAL BUILDING**

#### GOALS AND OBJECTIVES

1. To participate in a multidisciplinary, group practice managing the evaluation and treatment of a wide variety of mental illnesses and conditions in a late adolescent, adult, and geriatric population. **(patient care, medical knowledge, systems-based practice)**
2. To experience the management of serious and acute mental illnesses and emotional crises in an outpatient setting. **(patient care, medical knowledge)**
3. To design treatment plans using the appropriate combinations of psychopharmacology, psychotherapies, behavioral techniques, social services, and medical consultation. **(systems-based practice, medical knowledge, communication)**
4. To orchestrate patient care in the context of institutional structures and economic constraints imposed by various insurance structures. **(systems-based practice)**
5. To gain experience in "time conscious" psychotherapies during the rotation. **(professionalism, patient care)**
6. To participate in continuous clinical improvements using disease-specific outcomes assessment tools. **(practice-based learning)**

#### SPECIFIC DUTIES OF THE RESIDENT

1. The clinic is best viewed as a practice opportunity for the rotating resident **(patient care)**. Managing confidentiality, flexibly meeting the needs of different patients, proactively seeking supervision, coordinating care, and record keeping and billing, are critical skills to be mastered. **(professionalism)**.
2. New patients evaluated by the resident will remain in the resident's care throughout the rotation. Treatment plans will address the individual patient's needs and may involve the participation of non-psychiatrist, mental health providers). Residents will be expected to provide a comprehensive and integrated assessment of patients' needs with respect to diagnostic/biological, psychological and social issues.
3. Creating and conducting groups, experiencing couples and family therapy; and exposure to behavioral techniques will be encouraged. A thorough diagnostic assessment and attention to target symptoms will guide the prudent use of psychopharmacology. **(systems-based practice, medical knowledge, patient care)**

## ROTATION: PRI-NWA OUTPATIENT (CONT'D)

4. The clinic practice will be guided by evidence based medicine and an enduring commitment to understand and respect patients as unique human beings. (**systems-based practice, medical knowledge, patient care**).

### RECOMMENDED READING MATERIAL

Textbook of Psychopharmacology, American Psychiatric Association Press

Dynamic Psychotherapy, Marc H. Hollender, M.D., and Charles B. Ford, M.D.

The Theory and Practice of Group Therapy (4th edition), Irving Yalom, M.D.

Psychotherapy in a New Key: A Guide to Time Limited Dynamic Psychotherapy, Hans Strupp, Ph.D., and Jeffery Binder, Ph.D.

Handbook of Short-Term Dynamic Psychotherapy, Paul Crits-Christoph, Ph.D., and Jacques P. Barber, Ph.D.

A more comprehensive reading list will be presented at the time of the rotation.

### HOURS PER WEEK

Direct Patient Care: 10 hours

Individual Supervision: 1 hour

## Fourth-Year Electives

The Fourth Year is regarded as a "track" year. The individual resident, with the approval of the Residency Education Committee, plans a fourth-year experience that will be consistent with long-term career goals. The following are to be regarded as examples and not exclusive of other possibilities:

Chief Resident – Serves as a faculty/resident liaison assuming some administrative and teaching duties.

Academic Psychiatry - Administrative and teaching responsibilities as chief resident, a research project, and outpatient clinical responsibilities associated with a subspecialty clinic (e.g., neurobehavioral).

Public Sector Psychiatry - Supervision and teaching junior residents in a public hospital inpatient service, consultation to public agencies such as the police department, and consultation to a community mental health clinic.

Child Psychiatry - Entry into the Child Psychiatry Fellowship program at UAMS/ACH.

Private Practice Psychiatry - Primary assignment to the adult outpatient clinic. Private practice activities such as billing and managing an office can be emphasized.

Each resident has the opportunity to select a PGY-4-year faculty advisor/mentor. The year's program can then be prepared with the advisor's input and approval.

Senior electives schedules and the names of senior advisors for the PGY 4 year should be submitted to the Residency Office for approval by a date to be announced in the Spring semester of the PGY 3 year. The schedules will be presented to the Residency Education Committee for subsequent acceptance.

If residents want to make changes in their electives during the course of the year, written approval from all parties involved needs to be obtained. The Director of Residency Education will give final approval with input from the REC if needed. No change is to be made until the request is approved.

Any resident planning to work in non-UAMS-affiliated facilities must have their plans approved by the Residency Director.

## PGY IV Elective Descriptions

Please use the form that follows and describe the elective(s) that you are proposing. Consult with the supervisor of the elective for his/her input. You must submit these descriptions to the Residency Education Committee when finalizing your PGY IV schedule. You must include the following competency discussion in the proposal.

Please include in your description of goals and objectives which of the following competencies will be included in the curriculum and how. It is not necessary to include all of these.

- a. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
- b. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
- c. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
- d. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals
- e. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
- f. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

## PGY IV ELECTIVE DESCRIPTION

**ELECTIVE:**

**ATTENDING:**

**TELEPHONE:**

**MAIL SLOT:**

**LOCATION:**

GOALS AND OBJECTIVES (including competency language; see list above)

SPECIFIC DUTIES OF THE RESIDENT

SUPERVISOR'S RECOMMENDED READING MATERIALS

Electives, P.2

HOURS PER WEEK:

Direct Patient Care: \_\_\_\_\_ hours

Case Conference/Staffing: \_\_\_\_\_ hours

Supervision: \_\_\_\_\_hours

Administrative (Record Keeping): \_\_\_\_\_hours

Total Number of Hours Per Week: \_\_\_\_\_hours

## Resident Research

There are presently two specified ways that a resident may become involved in research during their residency. The first is to become involved in the "Resident Research Track". The other is to apply for an NIMH or similarly sponsored research fellowship.

### Resident Research Track:

If a resident becomes interested in research and would like to focus more time in research, he/she may apply to be involved in the resident research track. A meeting will be held in the second year during the regularly scheduled didactics. This meeting will be directed by the Vice-Chair for Research and the Resident Research Track Director. This meeting will include a discussion of research as a career, different research activities within the department, and a description of the Resident Research Track. Interested residents are then encouraged to contact either the Vice-Chair of Research or the Director for an appointment. There will be an application process that includes approval of the Residency Program Director. Application materials will be available at the PGY II meeting and/or from the Research Track Director.

There will be an identified and approved list of mentors for this track. A resident will choose a mentor based on their area of interest. By March of the PGY II year, the resident will have identified a mentor, an area of interest and created goals and objectives for their research proposal. This proposal will be submitted to the Residency Research Committee for approval. Ongoing documentation of progress will be submitted quarterly.

By the beginning of the third year of training, a resident will have identified a specific project. In order to create ample research time during the third year, one of the outpatient rotations will be moved from the PGY III year into the PGY IV year. This will enable a resident to spend 1.5 days per week in research activities throughout the PGY III year including a 1:1 weekly meeting with the mentor. The Resident Research Committee will monitor the resident's progress to ensure progress toward stated goals. Work on the research project can then continue via elective time in research in the PGY IV year.

During the fourth year, a research track resident may schedule as much elective time as needed to work on the project. It is expected that the resident will have regularly scheduled weekly meetings with their mentor. The mentor along with the Resident Research Committee will evaluate the resident with respect to their performance on a quarterly basis. There will be regular meetings of all of the residents involved with a research faculty who will present educational activities and discuss the research experiences and activities of the members.

The intended product of a resident's involvement in the Research Track is manifest competency in all of the following areas (these are good ideas for goals on the resident research track goals sheet):

- Human subjects protection and H.I.P.P.A. research training (both mandatory)
- A written protocol regarding intended research
- IRB approval of the project or completion of the course if IRB approval already received
- Presentation at the departmental poster session
- Presentation of Departmental Grand Rounds
- Presentation at a national meeting (poster or presentation)

- A manuscript submission to a peer reviewed journal

**Table 1: Time line of application and evaluation activities.**

<b><u>Event</u></b>	<b><u>yr</u></b>	<b><u>time</u></b>
Intro to Resident Research	2	Fall PGY II Didactics
Obtain approval from Residency Training Director	2	February
Submit agreement with mentor	2	March
Begin Research Track	3	July

## Scholarly Paper/Formal Presentation

Every resident is required to complete a scholarly paper (or equivalent – see below) prior to graduating. The purpose of this requirement is to educate residents in critically reviewing the current psychiatric literature, as well as to offer residents the opportunity to submit papers for publication. We ask for scholarly literature reviews, reports of ongoing or completed research, or similar documents.

The three important deadlines for scholarly papers are:

**January 15 of the PGY-IV year:**

Submit abstract of scholarly paper.

**March 1 of your PGY-IV year:**

Submit scholarly paper for initial review by the resident's mentor.

**May 15 of your PGY-IV year:**

Submit final version of scholarly paper.

NOTE: The March 1 initial review deadline is recommended, but not mandatory.

We suggest the following steps in preparing and writing a scholarly paper:

1. Select a topic of interest.
2. Recruit a faculty advisor -- preferably someone who has an interest or expertise in your topic, and who will be able to spend time with you discussing and reviewing your paper.
3. Review the literature and conduct any research needed for your paper.
4. Write your paper.
5. Have your faculty advisor, and as many other people as you would like, review the paper far enough in advance of the deadline so that time remains to revise it if necessary.

Residents may substitute for the scholarly paper a publication which is accepted and presented at a national meeting. This may include a poster, paper, presentation or workshop. If there is question as to the nature or quality of a "national" meeting, this must be approved by the Residency Education Director beforehand. Some examples of national meetings include, but are not limited to:

APA – American Psychiatric Association

AADPRT – American Association for Directors of Psychiatry Residency Training Programs

AAP – Association for Academic Psychiatry

AACAP – American Association for Child and Adolescent Psychiatry

AAPL – American Academy of Psychiatry and the Law

AAGP – American Association for Geriatric Psychiatry

# GENERAL PSYCHIATRY DIDACTICS

## **General Psychiatry Seminars**

### **Essentials Series**

Designed to cover the basics of psychiatry with an emphasis on psychopathology and therapeutics. The essentials series contains a series of lectures on psychopharmacology and a series of Patient Interviewing and Communication skills where PGY I residents are observed interviewing patients on videotape with fundamental interviewing skills discussed. This series is required of all PGY I residents.

**Patient Interviewing and Communication Skills** -- Thursdays, 2:00-3:00 pm, required of PGY 1 residents. Serves as a course on interviewing, case presentation, and performing a psychiatric examination. It is taught in six sessions in the second half of the year during the Essentials Series using taped patient interviews.

### **Intermediate Series**

Designed to cover areas not addressed in the Essentials Series. Includes a year-long introductory course to psychotherapy. The biopsychosocial treatment plan begins to be more emphasized this year. This series is required of all PGY 2 residents.

### **Advanced Series**

Designed to cover the major areas of general psychiatry in greater depth and to introduce residents to areas not included in the Essentials and Intermediate series. Readings may be announced or distributed by instructors. Contains several sessions on interviewing for the Boards. Case conferences are used to teach and ensure proficiency in the five ACGME psychotherapy competencies. This series is required of all PGY 3 and 4 residents.

## **Psychotherapy Seminars**

**Psychotherapy Series** -- Thursdays, 2:00-3:00 pm, required of PGY 2 residents. Introduces residents to psychotherapy. This is an inclusive series that covers the spectrum from technical methods to theories. It uses textbook and other required reading.

**Advanced Psychotherapy Series** -- Thursdays (variable times from 2:00-4:00), required of PGY 3 and 4 residents. Designed to further develop residents' psycho-therapeutic skills and knowledge. Includes interactive case conferences concentrating on the ACGME mandated psychotherapies. This is done by faculty selection of a case that illustrates specific principles and allows residents to interact in order to gain and demonstrate competency.

## **ESSENTIALS LECTURE SERIES TOPICS -- PGY 1s**

Assessment and Treatment of the Agitated Patient  
Understanding UAMS Call  
Overview of Psychiatry Services at ASH  
Emergency Psychiatry: VA  
Violence Risk Assessment  
Acute Management of Substance Use Disorders  
Borderline Patients in the ER  
Overview of Neuropsychiatry  
Suicide  
AIDS  
Dementia  
Delirium  
PTSD  
ECT  
Anxiety Disorders  
Mood Disorders  
Overview of Personality Disorders  
Neurology for Psychiatrists: Neurological Exam  
Psychiatry Ethics  
Portfolio/Competencies  
Forensic Case Study  
Schizophrenia Overview  
Psychopharmacology: Schizophrenia and Schizoaffective Disorder  
Psychopharmacology: Unipolar Depression  
Psychopharmacology: Bipolar Depression  
Psychopharmacology: General Anxiety & Panic Disorders  
Psychopharmacology: PTSD  
Psychopharmacology: OCD  
Psychopharmacology: Dementia  
Psychopharmacology: Agitated and Aggressive Behavior  
Patient Interviewing & Communication Skills  
Psychological Testing  
Bio/Psycho/Social/Spiritual Formulation  
Psychiatrist in the Courtroom  
Overview of Psychotic Disorders  
Sexual & Gender Identity Disorders  
Teaching to Teach  
Introduction to Forensic Psychiatry  
Confidentiality and Tarasoff  
Neuroimaging  
Basic Cortical Exam

## INTERMEDIATE LECTURE SERIES TOPICS-- PGY 2s

Long-Term Treatment and Management of CMI  
Ethics  
Survey of Major Therapists  
Portfolio Project  
Psychotherapy Seminar  
Interpersonal Psychotherapy  
Psychotherapy Series  
Introduction to Consults  
Sleep Disorders  
Personality Disorders: Clusters A, B, and C  
Neurology Case Conference  
Adjustment Disorders  
Schizophrenia; Epidemiology & Phenomenology  
Right to Treatment/Right to Refuse Treatment  
Overview of Research Opportunities  
Research Seminar  
Behavioral Change Secondary to Neurological Trauma  
Non-Alzheimer's Dementias  
Substance Abuse  
Illicit Drug Intoxication and Withdrawal  
Medical Evaluation of Psychiatric Patients  
Dissociative Disorders  
Cultural Competence  
Cultural Influences in Mental Health  
Critical Updates in Antenatal Medicine  
Geriatric Psychiatry  
Affective Disorders  
Religion & Psychiatry  
Unipolar Depression  
Bipolar Disorder  
Non-Verbal Communication  
Factitious and Malingering Disorders in a Medical Setting  
Cognitive Behavior Therapy: Practical Application  
Long-Term Care  
Introduction to Consults  
Somatoform Disorders  
Delirium and Capacity  
Special Considerations in the Medically Ill Patient

## **ADVANCED LECTURE SERIES TOPICS -- PGY 3s and 4s**

Teaching Seminars  
ABCs of Managed Care  
PTSD  
Substance Abuse  
History of Psychiatry  
Basic Law and Malpractice for Psychiatrists  
Civil Competence  
Confidentiality and Tarasoff  
Portfolio/Competences  
Family Therapy: Theoretical Approaches  
Family Therapy: Who's in the Therapist's Chair?  
Psychiatric Malpractice  
Paraphilias  
Group Dynamics  
Case Conferences: Supportive Therapy; Cognitive Behavioral Therapy;  
Psychopharmacology and Psychotherapy; Neurology; Psychodynamic  
Psychotherapy; Forensic  
Advocacy Groups  
Future of Medicine and Health Care  
Finance and Regulation of a Psychiatry Practice  
Advanced Interviewing for Boards  
Understanding Psychiatric Literature  
Opiate Use: Withdrawal and Treatment  
Psychiatric Rehabilitation  
Public Systems Psychiatry  
Civil Commitment  
Capacity to Stand Trial and Insanity Defense  
Advanced Cortical Exam  
Interpreting EEG's  
Assessment of Malingering  
Motivational Interviewing  
Bio/Psycho/Social Formulation  
Non-Verbal Communication

## **ATTENDANCE REQUIREMENT FOR DIDACTICS**

Attendance at Thursday afternoon didactics and grand rounds is required. Absences must be documented on leave forms, taken as either vacation or sick leave. It is understandable that there may be rare emergent clinical issues that prevent attendance, but these should be very uncommon and must be reported to the office of education.

### **Sample Weekly Didactic Schedule**

#### **Thursday**

2:00 - 3:00 P.M.	<b>PGY 1 RESIDENTS</b> Essentials Lecture Series and Patient Interview Series
12:00 -1:00 P.M.	<b>PGY 2 RESIDENTS</b> Child & Adolescent Lectures
2:00 - 4:00 P.M.	Intermediate Lecture Series and Introduction to Psychotherapy Series
2:00 - 4:00 P.M.	<b>PGY 3 &amp; 4 RESIDENTS</b> Advanced Lecture Series (Interviewing for Boards, Case Conferences, etc.)
4:00 – 5:00 P.M.	<b>ALL RESIDENTS</b> Weekly Grand Rounds (except during July and August)

**LEARNING OBJECTIVES**  
**FOR**  
**DIDACTICS**

## PSYCHOPHARMACOLOGY: BIPOLAR DISORDER

### Objectives

The resident will be able to:

1. Name the medications useful in the treatment of bipolar disorder. Include agents used for both acute episodes of mania and for maintenance therapy.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes seen in patients with bipolar disorder, and how each of the pharmacological agents referred to above affect these processes.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe how treatment with the above agents affects the course, prognosis and outcome of bipolar disorder.
11. Describe which individual medications referred to above should be used as first-line agents in the treatment of bipolar disorder and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
12. Describe how treatment with the above agents differs based on age of the patient.

## PSYCHOPHARMACOLOGY: AGITATED & AGGRESSIVE BEHAVIOR

### Objectives

The resident will be able to:

1. Name the medications useful in the treatment of agitated and aggressive behavior, making a distinction between those used for acute therapy and those for maintenance therapy.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes produced by each of the pharmacological agents referred to above that are thought to be responsible for the positive effects of the agent.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe which individual medications referred to above should be used as first-line agents, and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
11. Describe how treatment with the above agents differs based on age of the patient.

## PSYCHOPHARMACOLOGY: DEMENTIA

### Objectives

The resident will be able to:

1. Name the medications useful in the treatment of dementia.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes seen in patients with dementia, and how each of the pharmacological agents referred to above affect these processes.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe how treatment with the above agents affects the course, prognosis and outcome of dementia.
11. Describe which individual medications referred to above should be used as first-line agents in the treatment of dementia and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
12. Describe how treatment with the above agents differs based on age of the patient.

## PSYCHOPHARMACOLOGY: SCHIZOPHRENIA & SCHIZOAFFECTIVE DISORDER

### Objectives

The resident will be able to:

1. Name the medications useful in the treatment of psychosis.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes seen in patients with schizophrenia and schizoaffective disorder, and how each of the pharmacological agents referred to above affect these processes.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe how treatment with the above agents affects the course, prognosis and outcome of schizophrenia and schizoaffective disorder.
11. Describe which individual medications referred to above should be used as first-line agents in the treatment of schizophrenia and other psychotic disorders and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
12. Describe how treatment with the above agents differs based on age of the patient.

## PSYCHOPHARMACOLOGY: OCD

### Objectives

The resident will be able to:

1. Name the medications useful in the treatment of OCD.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes seen in patients with OCD, and how each of the pharmacological agents referred to above affect these processes.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe how treatment with the above agents affects the course, prognosis and outcome of OCD.
11. Describe which individual medications referred to above should be used as first-line agents in the treatment of OCD and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
12. Describe how treatment with the above agents differs based on age of the patient.

## PSYCHOPHARMACOLOGY: PTSD

### Objectives

The resident will be able to:

1. Name the medications useful in the treatment of PTSD.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes seen in patients with PTSD, and how each of the pharmacological agents referred to above affect these processes.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe how treatment with the above agents affects the course, prognosis and outcome of PTSD.
11. Describe which individual medications referred to above should be used as first-line agents in the treatment of PTSD and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
12. Describe how treatment with the above agents differs based on age of the patient.

## PSYCHOPHARMACOLOGY: GENERAL ANXIETY & PANIC DISORDER

### Objectives

The resident will be able to:

1. Name the medications useful in the treatment of generalized anxiety disorder (GAD) and panic disorder.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes seen in patients with GAD and panic disorder, and how each of the pharmacological agents referred to above affect these processes.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe how treatment with the above agents affects the course, prognosis and outcome of GAD and panic disorder.
11. Describe which individual medications referred to above should be used as first-line agents in the treatment of GAD and panic disorder and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
12. Describe how treatment with the above agents differs based on age of the patient.

## PSYCHOPHARMACOLOGY: UNIPOLAR DEPRESSION

### Objectives

The resident will be able to:

1. Name the classes of medications (based on mechanism of action) useful in the treatment of unipolar depression.
2. Describe the most common and the most serious side effects seen with each class of medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each class of medications referred to above.
4. Describe the biological/neurochemical changes seen in patients with unipolar depression.
5. When given a specific name of a pharmacologic agent used in the treatment of unipolar depression, be able to identify to which class of medications (based on mechanism of action) the specific agent belongs.
6. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
7. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
8. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
9. Describe the common drug interactions seen with each class of medications referred to above.
10. State the therapeutic dose range for individual medications referred to above.
11. Describe how treatment with the above agents affects the course, prognosis and outcome of unipolar depression.
12. Describe which individual medications referred to above should be used as first-line agents in the treatment of unipolar depression, and which are recommended (either individually or in combination) inpatients who do not respond to first-line agents.

## PSYCHIATRY ETHICS

### Objectives

The resident will be able to:

1. Name the psychiatric core ethical principles. When given a description of any of these, be able to name the principle.
2. Identify the distinctions between ethics and morals.
3. Describe any sanctions that may be imposed by the APA for ethical violations.
4. Name the five categorical transgressions that psychiatrists most frequently commit.
5. Describe Tarasoff I and II and their impact on our roles as psychiatrists.
6. Describe the 3 APA guidelines for ethical practice in organized settings.
7. Name at least two sources that psychiatrists can refer to when questions regarding medical/psychiatric ethics arise.

## ECT

### Objectives

The resident will be able to:

1. Describe the components of a pre-ECT evaluation.
2. Describe the indications for treatment with ECT.
3. Describe any risks associated with the use of ECT, including any relative or absolute contraindications.
4. Describe any adverse effects associated with the use of ECT, including the mortality rate.
5. Describe any medications used prior to, during, or post-ECT treatment and state the purpose, dose range and possible adverse effects of these medications. Also, describe how any of these factors may vary with age.
6. Describe any pre-ECT education that should be given to patients or their families.
7. Describe the most commonly proposed theories for the mechanism of action of ECT.
8. Describe the mechanics of administering ECT, including electrode placement, length of seizure and frequency of treatments.
9. Describe the efficacy of ECT treatment, and if/how this varies with age and type of psychiatric disorder being treated.

## POST-TRAUMATIC STRESS DISORDER

### Objectives

The resident will be able to:

1. Describe the prevalence rate of PTSD and if/how this varies with sex, race and age.
2. Describe the most common traumatic events that lead to the development of PTSD and how these vary for men versus women.
3. Describe the risk factors for the development of PTSD and the most common comorbidities seen with this diagnosis.
4. Name the DSM-IV criteria needed for a diagnosis of PTSD.
5. Identify the signs and symptoms commonly seen in a patient with PTSD.
6. Describe the neurochemical processes thought to be affected in patients with PTSD.
7. Describe the most common psychodynamic themes seen in patients with PTSD and how these might be addressed in therapy.
8. Describe any psychotherapeutic techniques that might be useful in the treatment of PTSD.
9. When given a clinical case scenario of a patient with PTSD, identify the clinical signs and target symptoms present and formulate a differential diagnosis.
10. Describe the psychopharmacological treatment options for the various symptoms of PTSD and how these work, neurochemically.
11. Describe the suicide risk for patients with PTSD.

## SCHIZOPHRENIA

### Objectives

The resident will be able to:

1. Describe the pathophysiological and neurochemical changes thought to be involved in patients with schizophrenia, including the basis of the major biochemical theories.
2. Describe the various etiological processes thought to be involved in the development of schizophrenia.
3. Describe the DSM-IV criteria for the various types of schizophrenia.
4. When given a clinical case scenario of a patient with schizophrenia, be able to identify the signs and target symptoms that point to a diagnosis of schizophrenia and formulate a differential diagnosis.
5. Describe the course and prognosis expected for the various types of schizophrenia.
6. Name the first-line pharmacological treatment options available and describe how these are thought to work neurochemically. Be able to describe the efficacy of these treatments regarding their effect on symptoms, course and outcome.
7. Describe pharmacological treatment options available for those who do not respond to first-line agents.
8. Describe how the pharmacological treatment options referred to above differ regarding neurochemical mechanism of action, side effects and efficacy.
9. Describe if and when ECT should be pursued as a treatment option and the efficacy of this if used.
10. Describe any psychosocial factors that might affect the course and outcome of schizophrenia, and how these factors might be addressed in treatment.
11. Describe the prevalence rate of schizophrenia in the general population and how this varies sociodemographically (with age, sex, race, marital status, and socioeconomic status).
12. Name any known risk factors for the development of schizophrenia.
13. Identify the most common comorbidities seen in a patient with schizophrenia.
14. Describe the suicide risk for a patient with schizophrenia and how this varies compared to the suicide risk for other psychiatric disorders.
15. Describe any differences in treatment of an acute episode of schizophrenia versus maintenance therapy.

16. Describe any types of psychotherapy that might be useful in the treatment of schizophrenia, in conjunction with psychopharmacologic agents.

## DEMENTIA

### Objectives

The resident will be able to:

1. Describe how the prevalence of dementia varies with age and the various types of dementias. Also, be able to describe the most common types of dementia and how this varies by geographic location.
2. Describe the various causes of dementia, including any theories regarding the biological/neurochemical basis for the development of a particular dementia.
3. Recall any pathological and/or lab findings that may be present with each type of dementia. When given a patient with any such findings, be able to interpret these findings to formulate a differential diagnosis.
4. Name the pharmacological treatment options available for the various types of dementia, and describe any biochemical basis known as to how these agents work.
5. Describe the most expected course and prognosis of a given type of dementia, based on its cause.
6. Identify the differences between dementia and delirium, based on clinical presentation, history, and DSM-IV criteria.
7. Identify psychosocial factors that need to be addressed and describe how these might affect treatment course and outcome.
8. Identify clinical signs and symptoms present in a patient that point to a diagnosis of dementia.
9. Be able to describe any bedside testing and any neuropsychological testing that may be useful in making a diagnosis of dementia, and how these results impact prognosis.

## ANXIETY DISORDERS

### Objectives

The resident will:

1. Be able to name the various anxiety disorders listed in the DSM-IV.
2. When given the DSM-IV criteria for a particular anxiety disorder, be able to name the corresponding anxiety disorder.
3. Be able to describe the prevalence rates of the various anxiety disorders among different races, cultures, and age groups. Also, be able to describe any risk factors associated with each disorder and any common comorbidities.
4. Be able to describe the pathological mechanisms and/or neurochemical systems thought to be involved with each anxiety disorder.
5. Be able to list the most common treatments, both pharmacological and non-pharmacological, for the various anxiety disorders. Also, be able to describe dosages, length of treatment course, and efficacy of each treatment.
6. Be able to describe both pharmacological and non-pharmacological treatment options for those patients that do not respond to the most common treatments.
7. When given a clinical case scenario of a patient with an anxiety disorder, be able to identify signs and target symptoms and formulate a differential diagnosis based on this information.
8. Be able to describe which psychological treatments have been proven to be more efficacious for specific anxiety disorders.
9. When given a clinical case scenario, be able to identify any psychosocial aspects that might affect treatment course and outcome.

## MOOD DISORDERS

### Objectives

The resident will be able to:

1. Name the mood disorders listed in the DSM-IV.
2. When given DSM-IV criteria for a particular mood disorder, name the disorder.
3. Describe the lifetime prevalence rates of the various mood disorders listed in the DSM-IV and how these vary with age, sex and race.
4. Describe the major risk factors for development of Bipolar I Disorder and Major Depressive Disorder.
5. Describe the expected course and prognosis of the various mood disorders listed in the DSM-IV.
6. Describe the most common comorbidities associated with the various mood disorders listed in the DSM-IV and how these affect the course and prognosis of each.
7. Describe the pathophysiological changes and neurochemical processes thought to be affected in patients with a mood disorder.
8. Describe the various etiological theories proposed regarding the development of a mood disorder.
9. Identify the psychodynamic and other psychological theories for development of mood disorders, including the person responsible for development of that theory.
10. When given a clinical case scenario of a patient with a mood disorder, be able to identify signs and target symptoms, and formulate a differential diagnosis that includes the most likely mood disorder present in the patient presented.
11. Identify any psychosocial factors that affect course and prognosis of a mood disorder, and how these might be addressed in treatment.
12. Describe the various types of psychotherapy that might be useful in the treatment of a mood disorder.
13. Name the psychopharmacological treatment options recommended as first-line agents for the various mood disorders and those recommended for patients resistant to the first-line agents.
14. Describe the biological/neurochemical effects of the pharmacological agents referred to above, and any labs that should be followed with each.
15. Describe the role of ECT in the treatment of mood disorders, including indications for its use and its effects on course and outcome.

16. Describe the differences in treatment of an acute episode of mania or depression versus maintenance therapy for each.
17. Describe the suicide risk among the various mood disorders and how this differs from the suicide risk in other psychiatric disorders.

# **AUTISM, PDD, AND ASPERGERS DISORDER**

## **LEARNING OBJECTIVES**

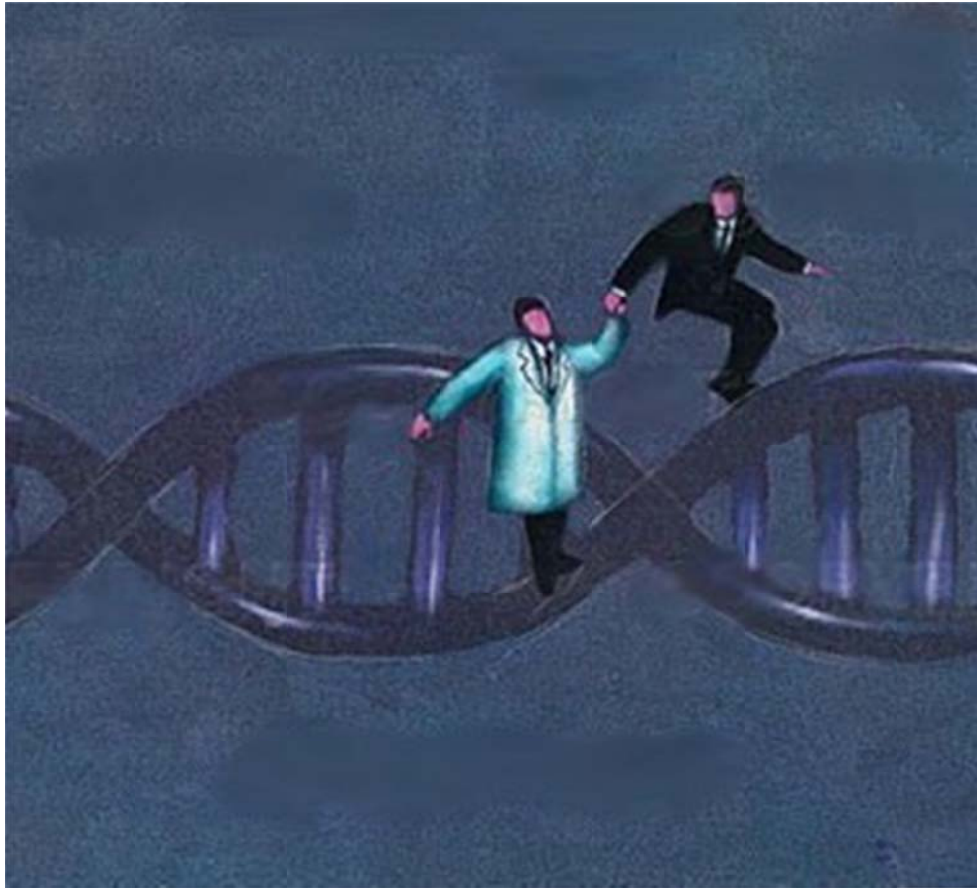
1. Learn the DSM IV diagnostic entities and diagnostic criteria for each of the Pervasive Developmental Disorders (PDDs).
2. Learn basic issues in the assessment and differential diagnosis of PDDs.
3. Become familiar with core deficits in the PDDs.
4. Understand basic treatment options for PDD..
5. Learn factors associated with outcome in PDD.

# FUTURE OF MEDICINE AND HEALTHCARE

Philip L. Mizell, MD, CPE  
Vice President, Clinical Affairs, Baptist Health

## Topics:

- I. Entering Practice
  - A. Necessary Concepts
    - 1. Money
    - 2. Location
    - 3. Type of Practice
    - 4. Overhead
    - 5. Revenue
    - 6. Other Stuff
  - B. Credentialing
    - 1. applying for hospital staff
    - 2. applying for managed care panels
  - C. Who's Watching?
    - 1. JCAHO
    - 2. HCFA
    - 3. Medicare
    - 4. Medicaid
    - 5. Arkansas Health Department
    - 6. NCQA
    - 7. National Practitioners Data Bank
    - 8. Arkansas Medical Board
    - 9. OIG
  
- II. Care Management & Utilization
  - A. Utilization of Psychiatry
  - B. Manpower Planning
  - C. Physician Profiling
  - D. Confidentiality
  - E. Practice Guidelines
  
- III. Trends in Health Care
  - A. Medical Specialties are tired
  - B. Baby Boomer effect
  - C. Mergers and Mayhem
  - D. Consumerism and the Internet
  - E. Technology/Biogenetics



# **GENERAL INFORMATION**

## Chief Resident

Each year a resident will be selected to serve as Chief Resident of the General Program. The function of this position is to act as liaison between the residents, the Residency Education Office, and the Department. Responsibilities of the chief resident include:

- Creation and maintenance of the UAMS/VA call schedule (ACH and ASH call schedules will be made by the Chief Resident of those services)
- Leadership and coordination of resident efforts during recruitment season
- Attendance at regular Residency Education meetings
- Leadership of weekly resident meetings
- Assistance in the negotiation of any conflicts between residents.

It is important to note that the chief resident's role is not simply to represent the residents to the administration, but rather to facilitate the flow of information in both directions. Because this role involves very close interaction with the Chair of the department, the Residency Education Office, and the residents themselves, all of these parties will have a role in the selection of the chief resident. The procedure for selection of the chief resident is outlined below:

**Second Thursday in January** – Individuals interested in becoming chief resident should inform the Residency Education Director in writing or by e-mail. This will be the final deadline for declaring candidacy for chief resident. The Residency Director and Department Chair will arrange individual meetings with each potential candidate to review their qualifications for the position; a resident may only be formalized as a candidate for chief resident if both the Residency Director and Department Chair feel that individual meets all the qualifications required to perform the duties listed above. This decision will be made based on each resident's academic standing, leadership experience, and history of service to the program.

**Fourth Thursday in February** – The Residency Education Director will announce the candidates for chief resident to the general residency.

**Third Thursday in February** - A vote will be held during the normally scheduled resident lunch meeting to determine the chief resident. The structure and conduct of this meeting will include comments from the candidates and a confidential, closed ballot process will be employed. The votes will be counted by the current chief resident, and the residents may request that an additional observer from the residency be present at the counting of the ballots. The winner will be determined by majority vote. The current chief resident will inform the candidates of the results of the election, including the ballot count, before a general announcement is made; the ballot count will not be made public unless all chief candidates unanimously agree to release this information.

## ASH Chief Resident

Each year a resident will be selected to serve as State Hospital Chief. The function of this position is to serve as a liaison between the residents and the Arkansas State Hospital (ASH) administration. Responsibilities of the chief resident include:

- Creation and maintenance of the ASH call schedule
- Assistance in communication between the residents and ASH administration.

The procedure for selection of the chief resident is outlined below:

**March 1** – Individuals interested in becoming State Hospital Chief should inform the Residency Education Director in writing or by e-mail. This will be the final deadline for declaring candidacy for ASH chief resident. The Medical Director of the Division of Behavioral Health Services, ASH Medical Director, and ASH Site Director will arrange individual meetings with each potential candidate to review their qualifications for the position; a resident may only be formalized as a candidate for chief resident if these directors feel that the individual meets all the qualifications required to perform the duties listed above. This decision will be made based on each resident's academic standing, leadership experience, and history of performance on ASH clinical services.

**Second Thursday in March** - The Residency Education Director will announce the candidates for ASH chief resident to the general residency.

**Fourth Thursday in March** - A vote will be held during the normally scheduled resident lunch meeting to determine the ASH chief resident. The structure and conduct of this meeting may include comments from the candidates. A confidential, closed ballot process will be employed. The votes will be counted by the current chief resident, and the residents may request that an additional observer from the residency be present at the counting of the ballots. The winner will be determined by majority vote. The current chief resident will inform the candidates of the results of the election, including the ballot count, before a general announcement is made; the ballot count will not be made public unless all chief candidates unanimously agree to release this information.

## MOONLIGHTING

External moonlighting is not permitted at this program. A variety of internal moonlighting options are available. Internal moonlighting is defined as clinical work at a facility with an affiliation with UAMS, and for which there is some level of supervision from a UAMS attending. Because internal moonlighting opportunities vary over time, they will not be listed here; the chief resident will inform residents of available internal moonlighting opportunities and implement all necessary scheduling.

In order to be eligible for internal moonlighting, residents must meet all program requirements for their PGY level, including attendance at didactics/grand rounds and compliance with administrative responsibilities such as keeping up with charting, etc. Internal moonlighting cannot interfere with a resident's ability to function on required rotations, and time spent moonlighting counts towards ACGME limits on duty hours.

The office of the Residency Training Director maintains the right to remove a resident from internal moonlighting opportunities should there be evidence, in the opinion of the Director or Associate Director of Residency Training, that internal moonlighting interferes with educational training or with clinical or administrative responsibilities.

## **CALL SCHEDULE**

### **Department of Psychiatry Policy**

Night and weekend call is considered an educational responsibility. Call may be traded but cannot be bought or sold. This policy includes both general and child residents. Please see Appendix, page 114 for FAQ regarding UAMS call.

## **EMERGENCY RESUSCITATION**

Emergency resuscitation is provided anywhere on the UAMS campus including hospital wards by an emergency code team. The team may be summoned by dialing 686-7333 and having the hospital operator announce a code. Check victim's respiration and pulse and provide Basic Life Support until team arrives. Advanced Cardiac Life Support (ACLS) protocols are followed by the team, and all team members must be certified ACLS Providers to participate. If you are on Internal Medicine rotation, you must complete an ACLS Provider Course before taking this call.

## **Grand Rounds Speaker Series**

The UAMS Department of Psychiatry Grand Rounds is a weekly lecture presentation (Thursdays at 4:00 p.m.) featuring a variety of national figures in American psychiatry as well as UAMS faculty. Grand Rounds is an educational activity for all faculty, residents, medical students, and associated mental health workers. This speaker series is a forum that supplements the formal didactic program and provides for the dissemination of new information from medical research and/or societal issues relevant to psychiatry.

## **ECT**

Many PGY 4s include this in their elective schedule, and all PGY 1s and 2s are required to read about ECT and attend ECT procedures on their patients while on rotations at the North Little Rock VA and at PRI. The REC requires proof that individual residents have adequate ECT experience before the planning of the fourth post-grad year. When attending ECT procedures the ECT form in the appendix (p. 122) should be completed and submitted to the Education Office.

## **Resident and Faculty Evaluation**

At the end of each clinical rotation, the faculty supervisor completes a written evaluation of the resident's performance during the rotation. (Copies of these forms are in the Appendix p. 123) Each resident is asked to complete a written evaluation of the educational aspects of the rotation, including an evaluation of the teaching abilities of faculty members. (A copy of this form is also in the Appendix p. 133).

In addition to the feedback which occurs between teacher and student, each resident meets semi-annually with the Director of Residency Education or Associate Director of Residency Education to discuss the resident's performance and educational progress. Sources of input include the evaluations done by each service chief, residents' evaluations from their instructors, information from psychotherapy supervisors, portfolio entries, and results from the PRITE. At this time, the resident's patient log can be reviewed as well.

At quarterly Promotion Committee (faculty members of the Residency Education Committee) meetings, the residents' academic progress and professional development are discussed.

### **Clinical Skills Verification (CSV)**

Beginning in 2012, the American Board of Psychiatry and Neurology will no longer be administering an oral examination as part of the board certification process for psychiatrists. Instead, residency education programs have been directed to institute a Clinical Skills Verification exam within the four-year training program to take the place of a nationally administered certification examination.

The two organizations overseeing the implementation of the CSV process (ABPN and ACGME) have issued differing benchmarks for completion of this requirement. It is mandatory that documentation of the CSV at the program level fulfill both the ABPN and the ACGME requirements in order for our residents to graduate from the program and achieve board certification.

For purposes of the ABPN, residents must be competent to:

- Establish rapport with patients
- Effectively interview patients
- Effectively present the psychiatric evaluation information

These competencies are to be judged *at the level of a practicing psychiatrist* (board eligible practitioner). Please see the enclosed ABPN publication for details and testing parameters.

For the purposes of the ACGME, competency of a resident is to be judged *at a competency level commensurate with his/her PGY level*. Find below the policy of the ACGME with respect to these issues:

The CSV evaluation form (in the Appendix p. 149) is designed to document both of these benchmarks. The majority of the form is to be completed per ABPN requirements (e.g. the standard of a practicing psychiatrist). Towards the end of the form is a section to document the ACGME requirements (e.g. with respect to PGY level).

Residents should make every effort to complete one of these evaluations on all PGY I and PGY II rotations. If any resident has not successfully completed three ABPN evaluations by the end of the PGY II year, a remediation plan will be designed and implemented.

### **ACGME Policy**

1. The program must formally conduct a clinical skills examination. A required component of this assessment is an annual evaluation of the following skills:

- (1) ability to interview patients and families;
  - (2) ability to establish an appropriate doctor/patient relationship;
  - (3) ability to elicit an appropriate present and past psychiatric, medical, social, and developmental history;
  - (4) ability to assess mental status; and
  - (5) ability to provide a relevant formulation, differential diagnosis and provisional treatment plan.
  - (6) ability to make an organized presentation of the pertinent history, including the mental status examination.
2. Performance on all evaluations must be documented and quantified, whenever possible, and provided to the resident. When necessary, remediation opportunities must be provided. Residents must not advance to the next year of education, or graduate from the program, unless the competence for their level of education in each area is documented.
  3. In at least three evaluations with any patient type, in any clinical setting, and at any time during the program, residents must demonstrate satisfactory competence in: establishing an appropriate doctor/patient relationship, psychiatric interviewing, performing the mental status examination and in case presentation. Each of the three required evaluations must be conducted by an ABPN-certified psychiatrist, and at least two of the evaluations must be conducted by different ABPN-certified psychiatrists. Satisfactory demonstration of the competencies during the three required evaluations is required prior to completing the program.

### **Psychotherapy Supervision**

In addition to the clinical supervision provided at the assigned clinical sites, each resident (2nd through 4th year) is assigned a psychotherapy supervisor. These supervisors are full-time faculty members or respected clinicians in the community who are on the clinical faculty. They provide a weekly opportunity for residents to discuss psychotherapy cases in detail and to discuss other professional issues.

All supervisory assignments are for the entire year. All residents on outpatient rotations will have additional supervision with the medical director of the clinic. If a resident has some difficulty with the supervisory assignment, this should be discussed with the Director of the Residency Program before changes are made. Residents who wish additional supervision -- especially PGY 3s who are seeing more than four patients in the Outpatient Clinic -- should see the Director of Residency Education. Supervisors should be contacted in early July.

All supervisory assignments are evaluated by both supervisors and residents. (See forms in the Appendix p.137)

## **6-Month Anonymous Evaluation of Rotations, Program, and Faculty**

This evaluation allows residents anonymously to evaluate didactics, the residency program in general, the rotations on which they have served, and the faculty who have taught them over the last 6 months, either from January through June, or from July through December. The residency director reviews all evaluations every 6 months and addresses any urgent problems. This data, in addition to feedback from the Chief Resident, is presented semi-annually at the Promotion subcommittee of the Residency Education Committee. Evaluated faculty may request copies of their evaluations after a year has passed.

### **Resident Transfers**

Prior to accepting a resident transferred from another program, the program director will receive written verification of previous educational experiences and a competency-based performance evaluation from the previous program director. Verification will include evaluation of the professional integrity of residents transferring from one program to another, including from a general psychiatry program to a child and adolescent psychiatry program. A transferring resident's educational program will be sufficiently individualized so that he/she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation.

### **CONTRACTUAL AGREEMENT**

House staff appointments are for a period not exceeding one year. A house staff agreement outlining the general mutual responsibility of the College of Medicine and house staff member is signed at the beginning of the term of service and is in effect for the full term of service (1 year). Renewal of an agreement for an additional term of service is at the discretion of the Residency.

### **HOLIDAYS**

Official UAMS holidays are:

- New Year's Day (January 1 – January 2, 2012)
- Martin Luther King Day (third Monday in January – January 16, 2012)
- Presidents' Day (Third Monday in February – February 20, 2012)
- Memorial Day (May 28, 2012)
- Independence Day (July 4 – July 4, 2011)
- Labor Day (first Monday in September – September 5, 2011)
- Veteran's Day (November 11, 2011)
- Thanksgiving Day (fourth Thursday in November – November 24, 2011)
- Christmas Eve (December 24 – December 23, 2011)
- Christmas Day (December 25 – December 26, 2011)

Holiday on-call schedules are arranged by the Chief Resident. **ASH and VA holidays may be different.**

## **LEAVE: ADMINISTRATIVE / EDUCATIONAL / ILLNESS / PROFESSIONAL**

Time spent attending meetings or taking Board examinations or other examinations will not be counted as vacation if the activity is sanctioned by the home department.

Three factors govern the circumstances under which a trip to attend a professional meeting will be approved or disapproved (Leave requests must be signed by the resident's immediate supervisor(s), and the Director of the Residency Program **prior** to attending a professional meeting): (1) whether adequate coverage is maintained for patient care responsibilities, (2) the availability of travel funds, and (3) the training value of the meeting the resident proposes to attend. Forms are available in the Education Office

If you are traveling on Departmental business which will require reimbursement from the Department, please tell the Education Office your departure and return dates, hotel information, etc., **BEFORE** you begin your trip. Upon return, all **ORIGINAL RECEIPTS** must be submitted to the Education Office. Failure to follow the above procedures could result in no reimbursement from the Department.

### **Effect of Leave on Completion of Training**

Resident physicians are in the unique position of having a role as students and employees. Although brief periods of leave can usually be accommodated, extended absences from the residency (fellowship) program for any reason may adversely affect both the resident's completion of the educational program on schedule and the program's responsibilities for patient care. Most specialty boards specify a minimum number of weeks of education (or training) that must be completed for a resident to receive credit for the educational (or training) time. The resident must take into account these factors when requesting extended periods of leave from the program.

## **VACATION**

Residents receive 21 days (15 work days plus weekend days) of paid vacation each year. This cannot be "carried over" from one year to the next.

## **SICK LEAVE**

### **Department Of Psychiatry Policy**

If you cannot come to work due to illness, notify the attending physician as well as the Office of Education. If you have a planned medical leave or appointment, a standard leave form should be submitted prior to the leave for planning purposes.

Residents have 12 days of sick leave (including weekend days if scheduled to work) for medical reasons during each year of training. The sick leave cannot be "carried over". Sick leave in excess of 12 days requires special review by the Associate Dean and Program Director.

## **UAMS LIBRARY**

The UAMS Library is housed in the Education II Building and occupies space on three levels. It also includes the Audio-Visual Library which occupies a part of the fifth floor. The library contains 41,965 books and regularly receives approximately 108 journals related to the behavioral sciences, 4,000 medical journals, and 57 neurology journals. Available databases include MEDLINE, PsycINFO, CLINICAL MEDICINE, and [ClinicalResource@ovid.com](mailto:ClinicalResource@ovid.com), among several others.

A small library is located on the first floor of Building 170 at the Ft. Roots (NLR) V.A.; computer search facilities are available free of charge.

The Department of Psychiatry houses a small library of key textbooks and journals in the PRI Risa Clothier Library on First Floor.

## **MAILBOXES**

Mailboxes are located in PRI Education Suite. Please retrieve your mail at least weekly.

## **NAME BADGES**

Each house officer will be furnished name badges for UAMS, VA, and ACH.

## **PAGERS**

Pagers are furnished by the separate services where appropriate. Each resident is issued a pager by the Department, and accepts full responsibility for the pager. If the pager is lost, the resident may be expected to reimburse the Department.

## **PARKING**

UAMS - All members of the house staff are granted parking privileges in 4 parking deck. A card key to operate the parking gate can be obtained from the Traffic Office (686-5856).

VA-McClellan -- UAMS lots are nearby and are suggested for residents working at the LRVA; no V.A. permits are furnished.

VA-Ft. Roots -- Parking stickers for placement on the resident's private vehicle are furnished at the beginning of the first Ft. Roots rotation.

Arkansas State Hospital -- Parking permits can be obtained from the ASH Public Safety Office (686-9000).

Arkansas Children's Hospital -- Parking permit stickers can be obtained from ACH Security Office (364-3474).

## PAY SCHEDULES

House staff members are paid monthly. Checks are distributed from the House Staff Office to the Department on the last working day of each month. Checks may not be obtained prior to this time.

Checks are delivered to the Residency Program Office, PRI Education Suite. Direct deposit to the bank of your choice is also available.

Pay for call is included in the monthly stipend check.

## PROFESSIONAL LIABILITY INSURANCE

Each house staff physician is provided professional liability insurance when on official duty. Additional coverage may be obtained from the insurance carrier. Moonlighting is not covered by residency liability insurance.

## TUITION DISCOUNTS

U of A Tuition discounts extend to interns, residents, fellows (both house staff and post-doctoral fellows in the basic sciences). The fringe benefit also applies to members of the immediate families in the same manner that it is available to other full-time employees of UAMS.

## WEBSITE

The address to access our department's website is: [www.psych.uams.edu](http://www.psych.uams.edu). This site contains information on our faculty, residency program, calendar of events, and other items of interest.

## RESIDENT AWARDS

When suitable candidates are available, residency faculty make nominations for several national awards, such as the NIMH Outstanding Resident Award and the APA Fellowship. Some of the following awards are voted upon within the Department and presented at the annual awards banquet:

**William G. Reese Award:** for achievement in psychiatric research as determined by a faculty residency research committee

**Outstanding Care Award:** to PGY I demonstrating outstanding care of psychiatric patients as determined by a vote of the PGY I's and II's

**Lloyd Rader Outstanding Resident Teacher Award:** to PGY III or IV demonstrating outstanding teaching of medical students/junior residents as determined by a vote of the teaching faculty

**Outstanding Graduating Resident Award:** to the outstanding graduating resident as determined by a vote of the teaching faculty

## RESIDENT PARTICIPATION IN NONDEPARTMENTAL ACTIVITIES/ PUBLIC SERVICE

When engaged in nonremunerative activities in which a resident might be reasonably perceived by the public to represent UAMS or the Department of Psychiatry, advance clearance from the Office of the Residency Director is required.

## SUICIDE OF A PATIENT

### **UNIVERSITY HOSPITAL**

The following are **UAMS** guidelines for management of the suicide of a patient under resident care.

- 1) Remember that death of the patient does not necessarily end the therapist's interaction with the patient's family. Further contact with the family should be discussed with the supervisor.
- 2) The supervisor(s) and the attending on call, and the head of the service (if different from the supervisor) should be notified immediately -- at any time of the day or night.
- 3) The University attorney and the malpractice insurance company defense attorney should be consulted by the UAMS faculty member involved.
- 4) A chart review should be arranged, involving the resident, the attending on the service, the supervisor, the residency education director, and any other staff with close involvement.
- 5) The hospital administrator should be notified.

### **Veterans' Administration**

Instructions for Conducting Morbidity/Mortality Review (Psychological Autopsy)

EXTRACT FROM G-15, M-2, PART X, CHAPTER 4 DATED DECEMBER 11, 1989

#### "4.03 THE ADMINISTRATIVE PROCESSING OF SUICIDES AND SUICIDE ATTEMPTS

- a. As required by VHS&RA Supplement MP-1, a morbidity/mortality review (often termed a psychological autopsy) will be conducted whenever there is a suicide or suicide attempt. Such a review will be considered a quality assurance investigation.
- b. This morbidity/mortality review is intended to serve the following purposes:
  - (1) To determine if the care provided was indicated, appropriate, and adequately done;
  - (2) To determine if, from the advantageous position of hindsight, other steps and interventions might have altered the outcome;
  - (3) To assess the adequacy of current policies and practices within the medical center or clinic, seeking to maximize safeguards and care while still promoting therapy and rehabilitation;

- (4) To identify actions that were appropriately performed and policies and procedures that are effective; and,
  - (5) To provide a forum for the involved staff members to share their thoughts, concerns, reflections, feelings and insights concerning the incident.
- c. The mental health morbidity/mortality review should be interdisciplinary. All members of the care-providing team should participate, as should any other person who may have knowledge of the event or patient. The review should occur as soon after the event as possible or at the latest within two weeks of discovery.
  - d. The Chief of the Service on which the suicide or suicide attempt occurred should appoint the chairperson for this morbidity/mortality review. The individual appointed should be someone who has not been involved with the patient and who has a mental health background and is knowledgeable in the area of suicidal behavior. If there is no eligible mental health clinician available, someone else with a knowledge of suicidal behavior should chair the review.
  - e. Participation in the morbidity/mortality review process for a particular incident may vary at the discretion of the chief of the service involved. For example, in some cases participation may be restricted to staff on the unit where the incident occurred, while in other cases participation may be open to other professional staff for educational purposes. In all cases the data considered during the review process should include:
    - (1) A review of the medical record, medication history, and a summary of the care provided;
    - (2) A presentation by the primary care provider of the treatment plan and its status, and a report of the patient's acceptance and compliance with the treatment plan;
    - (3) A report of the community/family influence and support factors available to the patient;
    - (4) Data on the patient's observed behavior and interactions on the ward or in the clinic;
    - (5) Reports of psychometric evaluations if performed; and,
    - (6) Reports by other staff members that may have knowledge pertinent to the incident.
  - f. This data should be collected prior to the review and presented by staff directly involved in the patient's care. The chairperson should then lead a discussion in order to review and determine, retrospectively, if there were any other factors or occurrences which may have contributed to the incident and whether action can be taken to prevent further similar incidents.
  - g. The findings of the morbidity/mortality review should be summarized by the chairperson in writing. This summary should be in the following format:
    - (1) A summary of the facts and events disclosed in the review;

- (2) Conclusions regarding what occurred, why it occurred, and whether the incident could have been anticipated and avoided.
- (3) Conclusions about appropriate measures taken by staff and policies/ procedures that were effective;
- (4) Recommendations regarding the clinical care of patients, administrative policies and procedures, environmental factors that may require alteration, and training deficiencies; and,
- (5) A recommendation to the medical center Director that an administrative investigation be conducted if the morbidity/mortality review suggests that such an investigation is necessary."

### **TELEPHONES**

The Department of Psychiatry has four telephones available for residents to use. They are in the Residents' Workroom in the PRI Education Suite. Please do not use telephones in private offices without asking permission.

### **EDUCATION MATERIAL AND TRAVEL**

The Residency Office of Education encourages residents to practice self-directed learning using resources outside the formal training program. This includes use of educational materials and literature and attendance at local and national meetings.

To this effect, each resident is offered a one-time \$500 stipend to pay for psychiatry-related books or educational material. The department cannot pay for computers or electronic hardware (such as PDAs).

In addition, the department will support attendance at national meetings by providing a \$1500 travel stipend to each resident. This stipend can be used to fund travel to one national meeting during the 4-year residency. It is the responsibility of the resident to follow UAMS policies regarding reimbursement including receipts for registration, meals and hotels, etc. Use of this travel stipend must be coordinated with the resident's clinical duties at the time of the conference; it is the resident's responsibility to arrange appropriate coverage on the clinical service and obtain timely approval for travel from the attending. Supported meetings include those listed below. Other suggested conferences can be submitted for approval to the residency director.

Funds that are not used in the above manner by the completion of residency are forfeited, and cannot be dispersed as cash pending graduation.

APA – American Psychiatric Association

AADPRT – American Association for Directors of Psychiatry Residency Training Programs

AAP – Association for Academic Psychiatry

AACAP – American Association for Child and Adolescent Psychiatry

AAPL – American Academy of Psychiatry and the Law

AAGP – American Association for Geriatric Psychiatry

APS – Arkansas Psychiatric Society

## UNIVERSITY PAID TRAVEL

**The Residency Education Director must approve trip before any travel arrangements can be made.**

### **Transportation – Original Receipts are required**

Receipts are required for the following items when requesting reimbursement:

- (1) Lodging (itemized receipt). A credit card receipt is not acceptable.
- (2) Commercial Airfare (include a copy of complete itinerary showing passenger name along with ticket stub.) If booking on the Internet, print the 1<sup>st</sup> and 2<sup>nd</sup> pages of the confirmation, showing amount paid for ticket.
- (3) Train/Subway
- (4) Registration Fee
- (5) Car Rental (agreement form showing amount paid)
- (6) Parking
- (7) Toll charges
- (8) Business Communication Expenses (Internet access, faxing, business telephone calls)

### **Airfare**

- (1) May be purchased by using the Internet, UAMS Contracted Travel Agencies, or by telephone
- (2) Travel Agencies normally do NOT offer a Southwest fare, always check to see if the destination is a Southwest one
- (3) Southwest should be booked through the UAMS SWABIZ website ([www.uams.edu/finance/travel](http://www.uams.edu/finance/travel))
- (4) Instances where any class fare, other than coach, is utilized will require detailed justification and must be pre-approved by the UAMS Travel Manager
- (5) Flights must be booked 4 weeks ahead of a scheduled conference or trip. (Psychiatry-Education requirement)

## **Taxi**

- (1) Taxi charges may be claimed on the Trip Reimbursement. Obtain a receipt when possible.

## **Lodging – Original Receipts are Required**

- (1) Reimbursement for lodging is limited to the single room rate. If a room is occupied by more than one person, the single room rate must be noted on the receipt.
- (2) The maximum daily allowance will be limited to the Federal-per-Diem rate depending on the location for both in state and out of state travel unless a special travel circumstance exists.

## **Parking Fees and Toll Charges**

- (1) Parking fees and toll charges for private, rental, or University owned vehicles are reimbursable and may be claimed on the Trip Reimbursement with appropriate receipts attached.

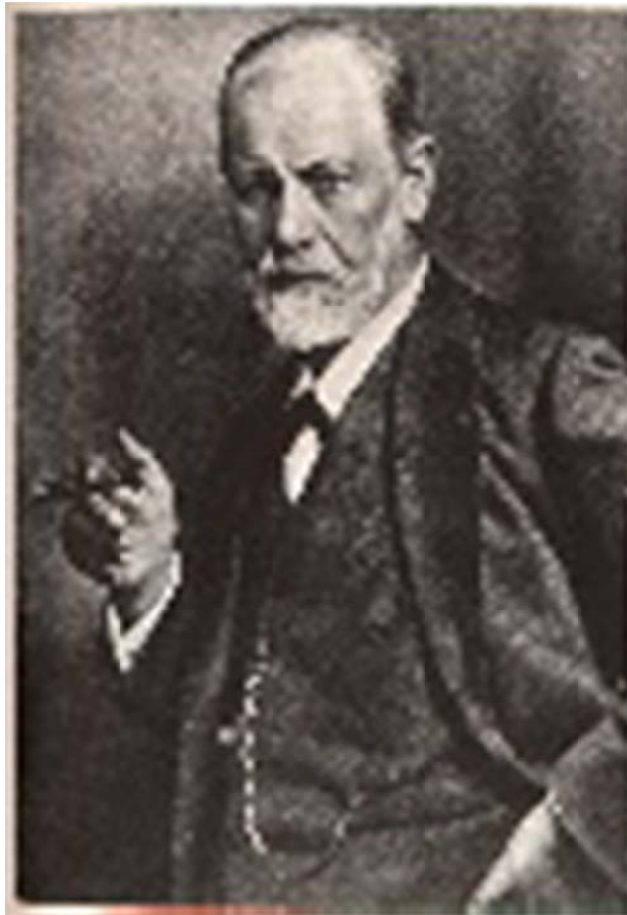
## **Meals – Receipts are required**

Reimbursement for meals is allowed ONLY in connection with overnight travel.

- (1) The maximum full day meal allowance will be the Federal-per-Diem rate depending on the destination location. The Federal-per-Diem rates may be viewed by going to the UAMS Travel site, click on the link 'Mileage/Per Diem Rates.' ([www.uams.edu/finance/travel](http://www.uams.edu/finance/travel))
- (2) Claims shall not exceed the maximum daily allowance and must be claimed for actual expenses incurred. **MAXIMUM MUST NOT BE CLAIMED** unless expenditures were actually made.
- (3) When travel is overnight, reimbursement of meals en route and from the employee's original station will be subject to the following: (for ease of calculation, note the % breakdown by each one, based on maximum per diem per day)
  - a) (15%) Breakfast may be claimed if the employee leaves their official station prior to 6:30 am.
  - b) (35%) Lunch may be claimed if the employee leaves their official station prior to 11:30 am, and when returning to home station if he/she arrives after 12:30 pm.
  - c) (50%) Dinner may be claimed if the employee leaves their official station prior to 5:00 pm; and when returning, they arrive after 6:30 pm.

Arkansas State Statute does not allow for reimbursement of tips or gratuities.

**Further Travel policies:** <http://www.uams.edu/finance/travel/policies.asp>



# APPENDIX

## UAMS Call FAQ

### Evaluation

#### What if I get an inappropriate consult?

Sometimes, the consulting team may not have formulated a good clinical question; talking with them may clarify the issue. In other cases, there is a good question, but the timing of the consult is not optimal (eg. pt. in the middle of a medical procedure, or a ventilated patient). If, after discussing the issue with the consulting team, you still feel the consult is inappropriate, go ahead and see the pt. (remember pt. care comes first) and report it to your attending and the C-L attending. Keep track of the pt.'s name, medical record number, resident, and attending who initiated the consult. It will be addressed at the discretion of the C-L attending.

#### Are we supposed to see all patients who have substance abuse/dependence issues?

Hospital policy #MS507 states that Psychiatry Consult and Case Coordination are *available* in such cases. It also states that the medical evaluation is to be completed and appropriate labs drawn prior to consult. Often, these are straight-forward consultations. Pts. can be referred to chemical dependency treatment options; a list of numbers is kept in the Psychiatry binder in the ED. It is also an opportunity to address possible withdrawal issues.

#### What if I get a call from a UAMS Adult Psychiatric Clinic patient?

You must get the patient's full name, telephone number and address, in case you get disconnected or Pt is suicidal and hangs up. Having the birth date helps with identification of the patient. Then you can dictate a clinic note with the above information. The note gets signed by the CL attending (Dr. Sokal) and eventually will be reviewed by that pt.'s psychiatrist. If it is an urgent matter, you may want to notify the psychiatrist directly.

### Disposition

#### What if a patient needs outpatient follow-up?

Pts. can be given the numbers to the PRI Walker Family Clinic (526-8200) or to his/her local Community Mental Health Clinic (for Little Rock, 686-9300). Some veterans can be seen at the VA Eval Clinic (257-1000 x55719). Insured pts. can also get referrals to psychiatrists on their panel. Be aware that it often takes several weeks to be able to get an appointment. In extreme cases when care is needed more urgently, you can call the UAMS Clinic the next business day and discuss with the CL attending the possibility of trying to find a more rapid appointment. There is a card in the Psychiatry folder in the ED with the names and numbers of chemical dependency treatment options.

#### What if a patient needs inpatient psychiatric hospitalization?

Advise the primary team that you are recommending hospitalization. They are responsible for contacting psychiatric hospitals and/or the screener. You may be asked to talk to a potential accepting MD to clarify psychiatric issues (the 'doc to doc'), and you may be able to facilitate a transfer (as with the PRI). However, it is *not* your responsibility to make the calls for placement to write discharge orders or orders for medications, refills or PRNs.

Determine whether the pt. is voluntary or not. If the pt. is involuntary, check for documentation of a court ordered 7 day evaluation, 45 or 180 day commitment. If not and there are sufficient

grounds for commitment, you may need to place the pt. on a 72h hold. In most cases, the primary team should write the order for a 72h hold. In the ED, the nurses have the responsibility of reading the rights at UAMS. However at the VA you may have to read them their rights. Ultimately, though, it is up to you to ensure that the orders and rights are done properly and documented. It is advisable to make a copy of the signed rights. Most of the time, the UAMS C-L team will make arrangements to file the petition (or family), but in rare cases, you may be asked to do this if you are the only one who witnessed something first hand.

If applicable, be explicit about the need for sitters or for calling Psych if the pt. wants to leave AMA. This type of info should be documented and personally communicated to the primary team.

#### What if a patient needs inpatient medical hospitalization?

Pts. should be medically stabilized before being admitted to a psychiatric hospital. If there are medical issues that require hospitalization, those take precedence. If the pt. is admitted to UAMS or VA, notify the next person on call or the C-L team for the respective hospitals the next business *morning* (or send an email to all of the CL team members) as the CL team will be following the pt.

## Screeners

#### What is the screener system?

The state of AR is responsible for emergent psychiatric hospitalizations in uninsured pts, most of whom are placed at the Arkansas State Hospital (ASH). To ensure appropriate and informative admissions, ASH uses a statewide Single-Point-of-Entry (SPOE) system to screen pts. for admission. The state mental health system is divided into various catchment areas depending on the pts. County of residence. For the pts catchment area (small counties are often in the same catchment) the local mental health division (ie MHC) provides a screener for the pt. to evaluate them in various settings such as in the hospital, jail, clinics or residential care facilities. The screeners are typically social workers who fill out the SPOE and they do have an MD backup.

#### What do the screeners do?

They verify that the pt. needs psychiatric hospitalization and use the ASHs SPOE form regardless of placement. Screeners theoretically know a particular pt. well as the pts are followed in their local MHC, and are helpful in providing information or alternative f/u. However, it is ultimately up to you and your attending to decide on the most appropriate disposition.

#### When should a screener be called?

Screeners should be called when a pt. may be a candidate for inpt psychiatric admission. The ED often initiates this process without Psych involvement. The sooner a screener is called, the sooner a patient is placed on the waiting list. However, if the pt. is clearly intoxicated, or so medicated that an evaluation is not possible, it is reasonable to wait until the pt. is assessable. For pts. who are not medically stable, the screeners should be called after stabilization since a screening is only valid for 48h.

#### Why do the screeners ask about UDS results?

Screeners have to come out to see pts 24 hours a day 365 days a year. They want to be ensured the pt is not too intoxicated to participate in the interview. However, it is certainly

possible for a pt. to have a positive UDS and still be assessable, and screeners should be advised if that is the case. Sometimes, pts. will require inpatient stabilization for their symptoms, regardless of whether the symptoms are primarily drug-induced or not (and it may be difficult to determine at the time). You may need to advocate for appropriate care for the pt.

#### What if the screener doesn't agree with my assessment?

Most conflicts can be resolved by talking to the screener. One or the other of you may have additional information that has influenced your decision. The screener may be able to offer other options that you find appropriate, such as the Crisis Stabilization Unit, day treatment, or outpatient follow-up in 1-2 days. If an agreement cannot be reached, you can involve the screener's MD backup and/or your attending. Document conversations thoroughly and tactfully.

#### What about patients coming from jail?

Prisoners do not have to undergo the same screening process, since the jail can serve as a point of entry into ASH. If a bed is not available, jails can provide a monitored environment for the pt., called suicide watch, while s/he awaits hospitalization. Be sure to clarify whether a pt. is still under custody; if they were brought from jail but have since been released, they would need a screener for ASH. Though screeners often see pts while in protective custody.

## **PEEP**

#### What is the PEEP program?

The Psychiatric Emergency Evaluation Program (PEEP) was developed to manage psychiatric patients who are awaiting hospitalization. The program was developed in response to an increase in psychiatric patients presenting to the UAMS ED and the increased length of stay while waiting for psychiatric admission. Patients are generally managed proactively, since we often do not know how long they will need to remain on PEEP.

#### How should PEEP patients be managed?

When PEEP pts. are first seen, they should receive a full consult. PEEP pts. should be rounded on daily. If a PEEP was initiated over the weekend, the C-L team should be notified of the pt.'s presence the next business morning. Work closely with the ED team to make recommendations for the care of the pt. Occasionally, we do write orders on these patients (this is the one exception in C-L), but only when coordinated with the ED team. You should always ask the ED physician prior to putting in orders in on their patients. If you are writing lab orders, make sure you are explicit in the documentation and orders about who is to follow-up on results. Check the sitters' and nurses' notes to see if there have been significant events since the pt. was last seen.

## **Signing Out**

#### When should I call my attending?

During your first year, you should call your attending about each patient. Even beyond the first year, it remains a good idea. During the weekend, you should coordinate with your attending about who will round on which pts.

#### What should I communicate to the rest of the Psych team?

Good communication with the next resident on call on the weekends or the C-L team during the weekday is important for continuity of care. You should tell them about any new consults that

have not yet been seen, as well as any pts. who need to be followed, including PEEP pts. You can expect to have this same information from your colleagues.

The resident on the C-L team tries to make it clear to consultees that most inpts. are not routinely seen over the weekend. However, problems do arise. If you are called to see an inpt. already followed by the C-L team, look for the Psych evaluation under the "Consultations" section of the chart and the most recent notes under the "Progress Notes" section of the chart. Also, some pts. seen by the C-L team are very unstable and need to be seen daily. You will be notified ahead of time about such patients and should make sure to pass it on the next resident on call as well.

## Billing

Where do I find the billing sheets?

They are located in the red "Psychiatry Consult" folder in the ED workroom ("fishbowl").

How do I fill them out?

- Obtain a patient sticker and place it on the billing sheet.
- Circle all of the psychiatric diagnoses that apply for Axis I-IV.
  - Be as accurate as possible, "MDD, recurrent, moderate" instead of "Mood DO NOS"
  - for delirium, also write the medical condition/s you think are most likely responsible
  - for substance-induced disorders, also put the substance(s) you think are most likely responsible. Ie circle SIMD as well as alcohol dependence, etc
- Circle the level of service. These are reviewed and adjusted for you if not accurate.
  - in general, your write-ups warrant a level 2 service code
    - o 99242 for patients in ED or Short Stay Unit
    - o 99252 for inpatients
  - if there is very limited history available and mental status exam is compromised (eg. very sedated patients), this may only warrant a level 1 code
    - o 99241 for patients in ED or Short Stay Unit
    - o 99251 for inpatients
- Circle the place of service, inpt or emergency room
- Sign the sheet\
- Circle name of attending on call with you
- Put the billing sheet back into the binder in the "Completed by Resident" section for the attending to sign.
- Make a copy of your write-up and place it in the binder with the billing sheet

## VA ON-CALL GUIDELINES

1. Always call the Staff Attending to check out each patient. If you cannot reach the designated attending on call, then contact Dr. Middleton or any other VA attending to discuss the patient.
2. Only the ER physician may accept transfers from outside ER's. The VA ER may contact you for your opinion on such transfers, but only the ER and AOD can officially accept them.
3. Only the Psychiatry Staff Attending may accept transfers to 3K from outside hospitals. (This pertains to inpatients only. Patients in ER's are considered outpatients and the ER physician accepts the pt.) Other VA's, such as Muskogee, OK, will sometimes send patients here for psychiatric care, and we have an agreement with them to often accept their veterans, barring 3K in not on diversion. Diversion is defined as the lack of inpt psychiatric beds and is only put into action by Dr. Mark Worley. Your attending or the ED staff is responsible for calling Dr. Worley or initiate psych diversion.
4. When you are called about patients in outside hospitals, you need to document that patient is voluntary, or that patient has a minimum 45 Day Court Order if patient is from *outside* Pulaski County. Review all court documents carefully, to ensure that they are in fact for a 45 day order. Also document that patient will be evaluated in the ER, but that the VA *does not guarantee* admission to the hospital. Therefore, whoever is transporting this patient (often law enforcement personnel), needs to stay at the VA until you have made a determination regarding admission or discharge.
5. Patients placed on 72 hour holds:
  - a. Read them their rights (forms in the Eval Conference Room). Document in your consult note that you read them their rights. Document on the original form whether or not patient signed, and that the original form was placed in patient's ER chart.
  - b. Always inform Police Officer that patient is being placed on a hold. The Police will need a signed order for a 72 hour hold (on an old-fashioned paper order sheet) before they can physically prevent a patient from leaving the hospital.
  - c. It's a good idea to have the police standing nearby when you inform the patient that he/she is being placed on a hold.
6. You are responsible for the Physical Exam and Review of Systems on weekends from Friday night to Sunday. You are always responsible for aiding in the medical clearance of the patient. So, review vitals signs and labs. All ER patients should be evaluated by the ER MD, and the ER MD should address any significant medical concerns. You do not have to accept a patient onto 3K if you do not think the patient is medically stable. Discuss your concerns with the ER MD. If any imaging or other testing is needed, or you recommend patient have a neurology (or other) consult, then recommend this before the patient is transported to 3K. Stress to the ER that patient needs to be medically stable for discharge before going to 3K, as there is not a readily available ICU or even IV access if patient crashes. If patient has a history of complicated alcohol withdrawal, such as being delirious even with benzodiazepine tapers, or requiring MICU care, then patient should be admitted to Medicine for detox. A sitter may be needed if patient is unable to contract for safety in the hospital.
7. Contact the Consult Resident/Attending the next day regarding any patients on Med/Surg units that need psychiatric follow-up.

## ACH Call – Rules and Guidelines

### When do you present for call?

ACH call in 'beeper call' from home

Monday-Friday call begins at 4:30 PM and ends at 8:00 AM

Weekend call begins at 8:00 AM and ends the following morning at 8:00 AM.

It is between you and the next resident on call where to exchange the pager.

Pages are should be returned within 5 minutes.

You must arrive at the ER within 30 minutes of being called and notify the physician placing the consult when you will arrive. If you are in the middle of a consult on the floor they are often understanding if you will be later in presenting to the ED.

You must perform floor consults within the period of time desired by the consulting team, unless you are delayed by a more urgent consult.

Call Changes – Written notice of changes must be given to Tanya Poole (email is acceptable); also the day of the call change you are to call the operator to inform them of who is actually on call.

You are expected to discuss every patient with your attending, no exceptions regardless of PGY year.

### Consult Refusals/Deferments

You must see any new consult about which you are called. Do not defer consults to the daytime consult team. Even in an overdose patient who cannot be aroused, we can provide valuable services – i.e. obtaining pertinent history from family members, communicating with the family, assisting the primary team, leaving safety recommendations, etc. We frequently obtain valuable information that the primary team did not get. It's fine to indicate on your mental status exam that the patient could not be aroused. The next day, the daytime consult team can perform a more thorough mental status exam and make further recommendations.

### Doc-to-doc/ACH Transport Sheets/MEMS Sheets

Dr. Taylor and the ER attendings want us to perform the doc-to-doc on all routine psychiatric transfers. The social worker will find placement and provide you with the contact number of the accepting physician or have them on the line for you. When you do the doc-to-doc, you should also fill out both transport sheets.

If the case has a major 'medical' issue, such as an overdose, encephalopathy, etc., and you think it is necessary to have the pediatrician vouch for the patient's medical stability (on the Transport sheet), the pediatrician should than do the doc-to-doc and transport sheets.

### Who should see the patient first?

We have made a concerted effort to inform ACH of our expectation that psychiatric patients will be seen by the ER physician prior to our being called. Typically, ACH also expects the social workers to screen the ER psychiatric patients before we are called. All parties involved are aware of these expectations.

From this point on, this issue will be handled at the *administrative* level. It is not appropriate for psychiatric residents to delay their arrival to the ER. When you are called, you must arrive within 30 minutes. Our primary responsibility is to provide the best possible care to each individual patient. Even if the patient has not been seen by the MD or social worker, it is not in the best interest of the patient to wait an extra hour or two before being seen by us.

When you receive consults for patients that have not been evaluated by the MD or social worker, go see the patient. If you prefer, you can nicely remind the ER of our expectations when you have completed the consult. Then, give the patient name, date, and time of the incident to the ACH chief resident. He/she and the program director will communicate these concerns to the appropriate ACH personnel.

#### Payment

Each resident is individually responsible for turning in their time sheets. Any time you are called to the hospital, you should leave the time sheet and copy of your work in the ER folder. Otherwise, you are responsible for getting the time sheet into the folder or into the program coordinator's hand.





**DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES  
SUPERVISOR'S EVALUATION OF RESIDENT ON ROTATION**

**Evaluator:**  
Status:  
Rotation:

**Subject:**

**Instructions:**

This evaluation form has been designed to provide a rapid and comprehensive way of evaluating a residents performance. In completing the form, please note the following.

A. All parts are not applicable for all rotations. If a question is not applicable, please indicate so in comments. If there has been no opportunity to observe the particular activity, please indicate - no information.

B. Please rate the resident in accordance with your expectation for that point in training. For example, we have different expectations for PGY 1 residents than for PGY 4 residents.

C. We encourage detailed comments, but all ratings of *unsatisfactory* and *needs to improve* **must** have documentation. Remember that the evaluation becomes a part of the permanent record and is shown to the resident.

D. The continuous rating line makes it possible to quickly rate a quality and make fine distinctions if desired.

PATIENT CARE Interviews and exams are complete. Review and analysis of clinical data is complete. Therapeutic decisions are based on evidence, sound judgment and patient preferences.

Unsatisfactory   Needs to Improve   Satisfactory   Very Satisfactory   Outstanding   N/A

**Comments**

Remaining Characters: 5000

PATIENT CARE Interviewing reflects the ability to establish rapport and results in the gathering of good information.

Unsatisfactory   Needs to Improve   Satisfactory   Very Satisfactory   Outstanding   N/A

**Comments**

Remaining Characters: 5000

MEDICAL KNOWLEDGE Demonstrates an investigatory and analytic thinking approach to clinical situations. For example, the ability to develop an appropriate differential diagnosis would be a measure.

Unsatisfactory   Needs to Improve   Satisfactory   Very Satisfactory   Outstanding   N/A

**Comments**

Remaining Characters: 5000

MEDICAL KNOWLEDGE Knowledge of basic science and clinical science is applied in patient care.

Unsatisfactory   Needs to Improve   Satisfactory   Very Satisfactory   Outstanding   N/A



Comments

Remaining Characters: 5000

Empty text input field with scrollbars.

PRACTICE-BASED LEARNING & IMPROVEMENT Facilitates learning of students, residents, and other health-care professionals. For example: is the resident able to communicate and reach teaching goals? Initiative, interest, motivation, and desire should be considered.

Unsatisfactory Needs to Improve Satisfactory Very Satisfactory Outstanding N/A



Comments

Remaining Characters: 5000

Empty text input field with scrollbars.

PROFESSIONALISM Demonstrates to patients and peers a respectful and altruistic attitude.

Unsatisfactory Needs to Improve Satisfactory Very Satisfactory Outstanding N/A



Comments

Remaining Characters: 5000

Empty text input field with scrollbars.

PROFESSIONALISM Sensitive to disabilities and differences (cultural, age, gender).

Unsatisfactory Needs to Improve Satisfactory Very Satisfactory Outstanding N/A



Comments

Remaining Characters: 5000

Empty text input field with scrollbars.

PROFESSIONALISM Assumes responsibility for appropriate, timely response to patient needs.

Unsatisfactory Needs to Improve Satisfactory Very Satisfactory Outstanding N/A



Comments

Remaining Characters: 5000

Empty text input field with scrollbars.

INTERPERSONAL & COMMUNICATION SKILLS Listening and non-verbal communication skills facilitate a positive working alliance with patients.

Unsatisfactory Needs to Improve Satisfactory Very Satisfactory Outstanding N/A



Comments

Remaining Characters: 5000

Empty text input field with navigation arrows.

INTERPERSONAL & COMMUNICATION SKILLS Creates therapeutic relationships with patients.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

Empty text input field with navigation arrows.

INTERPERSONAL & COMMUNICATION SKILLS Communicates effectively using verbal and written techniques; questioning and writing skills with patients as well as health care professionals; thoroughly and appropriately addresses patient's concerns.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

Empty text input field with navigation arrows.

SYSTEMS-BASED PRACTICE Advocates for patients. example might be for obtaining medication, parking or advocacy for political change.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

Empty text input field with navigation arrows.

SYSTEMS-BASED PRACTICE Able to understand the interactions of their practices with the larger system - able to identify and integrate treatment resources that may not be "strictly psychiatric." An example might be helping a patient use social work services to remain in a less restrictive environment.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

Empty text input field with navigation arrows.

**DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES  
SUPERVISOR'S EVALUATION OF RESIDENT ON MEDICINE ROTATION**

**Evaluator:**

**Subject:**

Status:

Rotation:

**Instructions:**

This evaluation form has been designed to provide a rapid and comprehensive way of evaluating a residents performance. In completing the form, please note the following.

A. All parts are not applicable for all rotations. If a question is not applicable, please indicate so in comments. If there has been no opportunity to observe the particular activity, please indicate - no information.

B. Please rate the resident in accordance with your expectation for that point in training. For example, we have different expectations for PGY 1 residents than for PGY 4 residents.

C. We encourage detailed comments, but all ratings of *unsatisfactory* and *needs to improve* **must** have documentation. Remember that the evaluation becomes a part of the permanent record and is shown to the resident.

D. The continuous rating line makes it possible to quickly rate a quality and make fine distinctions if desired.

**ABILITIES AS A PHYSICIAN ON A GENERAL MEDICINE SERVICE**

Competence and quality of physical examinations, medical histories, consideration of medical illness in the differential diagnosis, knowledge of medical diagnostic procedures and therapeutics, and thoroughness of physical examination

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Comments**

Remaining Characters: 5000

**KNOWLEDGE/ABILITIES OF MEDICAL DISORDERS/TREATMENT**

General medical knowledge, differential diagnosis, skill in interviewing, knowledge of pharmacology, and arranging follow up

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Comments**

Remaining Characters: 5000

**ADMINISTRATIVE ABILITIES**

Organization of time, capacity to appropriately lead a treatment team, and ability to work with nursing and other auxiliary staff. Accurate and timely completion of paperwork

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Comments**

Remaining Characters: 5000

PROFESSIONAL DEVELOPMENT

To what extent is there growth in knowledge and abilities over the rating period

- Unsatisfactory
- Needs to Improve
- Satisfactory
- Very Satisfactory
- Outstanding
- N/A

Comments

Text input field for comments with scrollbars and a character count indicator.

Remaining Characters: 5000

RELATIONSHIPS WITH PATIENTS/FAMILIES

What is the the ability to communicate, to establish working relationships? Is there an appropriate professional quality to such relationships

- Unsatisfactory
- Needs to Improve
- Satisfactory
- Very Satisfactory
- Outstanding
- N/A

Comments

Text input field for comments with scrollbars and a character count indicator.

Remaining Characters: 5000

RELATIONSHIPS WITH PROFESSIONAL STAFF

Are supervisors used appropriately? Quality of relationship with physicians from other services

- Unsatisfactory
- Needs to Improve
- Satisfactory
- Very Satisfactory
- Outstanding
- N/A

Comments

Text input field for comments with scrollbars and a character count indicator.

Remaining Characters: 5000

TEACHING ABILITIES

Teaching skills in the judgment of the individual faculty member. Initiative, interest, motivation, and desire may be included

- Unsatisfactory
- Needs to Improve
- Satisfactory
- Very Satisfactory
- Outstanding
- N/A

Comments

Text input field for comments with scrollbars and a character count indicator.

Remaining Characters: 5000

IS ETHICAL BEHAVIOR SATISFACTORY

- Yes
- No
- N/A

Comments

Text input field for comments with scrollbars and a character count indicator.

Remaining Characters: 5000

ADDITIONAL COMMENTS

comment

Remaining Characters: 5000

**DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES  
SUPERVISOR'S EVALUATION OF RESIDENT ON NEUROLOGY ROTATION**

**Evaluator:**

**Subject:**

Status:

Rotation:

Instructions:

This evaluation form has been designed to provide a rapid and comprehensive way of evaluating a residents performance. In completing the form, please note the following.

- A. All parts are not applicable for all rotations. If a question is not applicable, please indicate so in comments. If there has been no opportunity to observe the particular activity, please indicate - no information.
- B. Please rate the resident in accordance with your expectation for that point in training. For example, we have different expectations for PGY 1 residents than for PGY 4 residents.
- C. We encourage detailed comments, but all ratings of *unsatisfactory* and *needs to improve* **must** have documentation. Remember that the evaluation becomes a part of the permanent record and is shown to the resident.
- D. The continuous rating line makes it possible to quickly rate a quality and make fine distinctions if desired.

PATIENT CARE Interviews and exams are complete. Review and analysis of clinical data is complete. Therapeutic decisions are based on evidence, sound judgment and patient preferences.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

PATIENT CARE Interviewing reflects the ability to establish rapport and results in the gathering of good information.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

MEDICAL KNOWLEDGE Demonstrates an investigatory and analytic thinking approach to clinical situations. For example, the ability to develop an appropriate differential diagnosis would be a measure.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

MEDICAL KNOWLEDGE Knowledge of basic science and clinical science is applied in patient care.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

Empty text box with scrollbars and a small icon in the top right corner.

PRACTICE-BASED LEARNING & IMPROVEMENT Facilitates learning of students, residents, and other health-care professionals. For example: is the resident able to communicate and reach teaching goals? Initiative, interest, motivation, and desire should be considered.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

Empty text box with scrollbars and a small icon in the top right corner.

PROFESSIONALISM Demonstrates to patients and peers a respectful and altruistic attitude.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

Empty text box with scrollbars and a small icon in the top right corner.

PROFESSIONALISM Sensitive to disabilities and differences (cultural, age, gender).

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

Empty text box with scrollbars and a small icon in the top right corner.

PROFESSIONALISM Assumes responsibility for appropriate, timely response to patient needs.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

Empty text box with scrollbars and a small icon in the top right corner.

INTERPERSONAL & COMMUNICATION SKILLS Listening and non-verbal communication skills facilitate a positive working alliance with patients.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

← | →

INTERPERSONAL & COMMUNICATION SKILLS Creates therapeutic relationships with patients.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

← | →

INTERPERSONAL & COMMUNICATION SKILLS Communicates effectively using verbal and written techniques; questioning and writing skills with patients as well as health care professionals; thoroughly and appropriately addresses patient's concerns.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

← | →

SYSTEMS-BASED PRACTICE Advocates for patients. example might be for obtaining medication, parking or advocacy for political change.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

← | →

SYSTEMS-BASED PRACTICE Able to understand the interactions of their practices with the larger system - able to identify and integrate treatment resources that may not be "strictly psychiatric." An example might be helping a patient use social work services to remain in a less restrictive environment.

Unsatisfactory	Needs to Improve	Satisfactory	Very Satisfactory	Outstanding	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

← | →



**University of Arkansas for Medical Sciences  
Department of Psychiatry and Behavioral Sciences  
Resident's Evaluation of Supervisor and Clinical Site**

**Evaluator:** \_\_\_\_\_ **Subject:** \_\_\_\_\_  
Status: \_\_\_\_\_  
Rotation: \_\_\_\_\_

**Instructions:**

This evaluation form has been designed to provide a rapid and accurate assessment of clinical sites and supervisors. In completing the form, please note the following.

- A. All parts are not applicable to all rotations. If a question is not applicable, please indicate so in comments.
- B. Do not feel a need to fill space - keep comments relevant. Remember that evaluation forms are official documents and become part of the permanent record. Ratings of unsatisfactory, needs improvement, and very superior must have documentation/comments.
- C. The continuous rating line makes it possible to quickly rate a quality and make fine distinctions if desired.

---

**ATTENDING EVALUATION**

**PROVIDED AN ADEQUATE AMOUNT OF SUPERVISION TIME**

The attending was available for clinical supervision/education for an adequate amount of time to provide both an educational experience and to ensure the quality of patient care. Both undersupervision and oversupervision (lack of independent management) may be reported

Unsatisfactory    Needs to Improve    Satisfactory    Superior    Very Superior    N/A

**Comments**

Remaining Characters: 5000

**PROVIDED SUPERVISION IN PSYCHOPHARMACOLOGY/BIOLOGICAL PSYCHIATRY**

Supervision/education was provided in areas relating to biological psychiatry/psychopharmacology. Refer to A. & B. above. Evaluation of both strengths and weaknesses is helpful

Unsatisfactory    Needs to Improve    Satisfactory    Superior    Very Superior    N/A

**Comments**

Remaining Characters: 5000

**PROVIDED SUPERVISION IN PSYCHOTHERAPY/DYNAMIC PSYCHIATRY**

Supervision/education was provided in areas relating to biological psychotherapy and dynamic psychiatry. Refer to A. & B. above. Evaluation of both strengths and weaknesses is helpful

Unsatisfactory    Needs to Improve    Satisfactory    Superior    Very Superior    N/A

**Comments**

Remaining Characters: 5000

**PROVIDED EDUCATIONAL MATERIAL APPROPRIATE TO THE RESIDENT LEVEL**

Educational material was appropriate to the residents level in terms of prerequisite knowledge requirements, degree of complexity, and depth/specificity (e.g. review article or text reprints for PGY 1 versus research article for PGY 111/IV). Note: It is not the responsibility of attendings to be endless repositories for articles. Libraries and indexes are available and should be utilized

Unsatisfactory	Needs to Improve	Satisfactory	Superior	Very Superior	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Comments**

Remaining Characters: 5000

**PROVIDED ADEQUATE SUPERVISION CONCERNING LITERATURE**

Unsatisfactory	Needs to Improve	Satisfactory	Superior	Very Superior	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Comments**

Remaining Characters: 5000

**INTERACTED IN A PROFESSIONAL MANNER WITH THE RESIDENT**

Unsatisfactory	Needs to Improve	Satisfactory	Superior	Very Superior	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Comments**

Remaining Characters: 5000

**PROVIDED EDUCATIONAL EXAMPLE FOR INTERACTING WITH PROFESSIONAL/PARAPROFESSIONAL STAFF**

Attending provided an educational example of interaction with staff in terms of psychiatrist role, leadership, team work, and efficient management

Unsatisfactory	Needs to Improve	Satisfactory	Superior	Very Superior	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Comments**

Remaining Characters: 5000

PROVIDED EDUCATIONAL EXAMPLE FOR INTERACTING WITH PATIENTS

Attending provided an educational example in managing patients on an interactional level

Unsatisfactory	Needs to Improve	Satisfactory	Superior	Very Superior	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

**ROTATION EVALUATION**

ROTATION IS APPROPRIATE TO RESIDENTS LEVEL

Was the rotation experience appropriate for the level of the resident in terms of subject matter, prerequisites [e.g. required level of knowledge, maturity (in terms of professional identity, leadership, role requirements with professional staff), and capability of functioning dependently/independently]

Unsatisfactory	Needs to Improve	Satisfactory	Superior	Very Superior	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

ROTATION PROVIDED PERTINENT EDUCATIONAL EXPERIENCE

The educational benefit of the rotation was appropriate to the needs of a general psychiatrist in training - neither too specialized not too superficial

Unsatisfactory	Needs to Improve	Satisfactory	Superior	Very Superior	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

EXTENT OF CLINICAL RESPONSIBILITIES WAS SUFFICIENT TO PROVIDE AN ADEQUATE EDUCATIONAL EXPERIENCE

The patient population/work load was sufficient to provide an adequate base of clinical experience in terms of number of patients and diversity of patient population (e.g., demographics and psychopathology)

Unsatisfactory	Needs to Improve	Satisfactory	Superior	Very Superior	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Remaining Characters: 5000

CLINICAL RESPONSIBILITIES WERE ADEQUATELY LIMITED TO PROVIDE AN EDUCATIONAL OPPORTUNITY

The clinical responsibilities of the rotation were limited such that an educational opportunity was provided in terms of having an adequate amount of time to review pertinent literature, to seek supervision, and to utilize present educational examples. It should be noted that part of the educational experience is training in time management and efficient management of clinical responsibilities. Therefore, provision of adequate time is not necessarily synonymous with allowing leisurely execution of duties

Unsatisfactory Needs to Improve Satisfactory Superior Very Superior N/A

Comments

Remaining Characters: 5000

STRUCTURE OF ROTATION AND DEMANDS OF CLINICAL DUTIES ALLOWED ATTENDING ADEQUATE TIME FOR TEACHING/SUPERVISION

The rotation structure allowed the attending adequate time to provide educational instruction and supervision

Unsatisfactory Needs to Improve Satisfactory Superior Very Superior N/A

Comments

Remaining Characters: 5000

COMMENTS

comment

Remaining Characters: 5000

**PSYCHOTHERAPY SUPERVISOR'S EVALUATION OF RESIDENT**

Resident

Supervisor

Level of Training

Period of Supervision

Please evaluate this resident in the following areas. These comments will be shown to the resident, so please make them constructive, educational, and accurate.

**Ability to assess patient:**

**Ability to present patient:**

**Psychological mindedness:**

**Functioning as a psychotherapist:**

**Areas of strength:**

**Areas where improvement is needed:**

\_\_\_\_\_  
Date of Evaluation

\_\_\_\_\_  
Signature

Please return form in the attached envelope.







# ANONYMOUS RESIDENT RATING

RESIDENCY PROGRAM (not any individual faculty member)

1 Seldom	2 Only sometimes	3 Often	4 Usually	5 Very nearly always
-------------	---------------------	------------	--------------	----------------------------

**Please especially comment on any extreme ratings (1 or 5).**

1. Does it seem that the residency has fairness as a goal?

\_\_\_\_\_ 1                      2                      3                      4                      5 \_\_\_\_\_

Comments:

2. Are you treated with respect in the residency?

\_\_\_\_\_ 1                      2                      3                      4                      5 \_\_\_\_\_

Comments:

3. Is the ratio of work to education proportioned in a way to encourage your professional development?

\_\_\_\_\_ 1                      2                      3                      4                      5 \_\_\_\_\_

Comments:

4. Do you feel free to ask questions about the residency and/or UAMS policies?

\_\_\_\_\_ 1                      2                      3                      4                      5 \_\_\_\_\_

Comments:

5. Do you feel the evaluations residents complete are considered in residency planning?

\_\_\_\_\_ 1                      2                      3                      4                      5 \_\_\_\_\_

Comments:

6. Are you being taught what you need to know?

(Resident) met on (Date)

with Ben Guise, M.D. and reviewed the resident's

satisfactory      unsatisfactory

progress in the Psychiatry Residency Training Program.

### **SEMI-ANNUAL REVIEW TOPICS**

1. Comment on their evaluations.
2. How are things going? Stress level, satisfaction with educational and professional development, etc.
3. Faculty difficulty (suggestions)
4. Program difficulty (suggestions)
5. Study habits, PRITE scores, moonlighting
6. Suggestions for improvement or maintaining an already established strength in the program
7. How many long-term (>1 year) psychotic patients?  
GAIN or CMHC?
8. How many long-term (>1 year) psychotherapy patients?
9. Research interests and future job plans
10. Patient logs. Are they up to date?

## SEMI-ANNUAL REVIEW

Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_ Year in Training: \_\_\_\_\_

ABPN Requirements:	Months Completed		Portfolios
<b>Primary Care</b>	<b>4 months</b>		Biopsychosocial
<b>Neurology</b>	<b>2 months</b>		Crisis Management
<b>Inpatient Psychiatry</b>	<b>6 months</b>		Initial Evaluation & Diagnosis
<b>Emergency Psychiatry</b>	<b>1 month</b>		Legal
<b>Outpatient Psychiatry</b>	<b>12 months</b>		Medical Psychiatry
<b>Geriatric Psychiatry</b>	<b>1 month</b>		Neuropsychiatry
<b>Chemical Dependency</b>	<b>1 month</b>		Professional Communication
<b>Child and Adolescent</b>	<b>2 months</b>		Psychotherapy
<b>Consultation-Liaison</b>	<b>2 months</b>		Self-Directed Learning
<b>Forensic Psychiatry</b>	<b>experience</b>		Specific Treatment Modalities
			<b>Teaching &amp; Presentation</b>
			<b>Treatment Course</b>
Additional Program Requirements:			<b>Working with Teams &amp; Families</b>
<b>Patient Log completed</b>			
<b>Lecture Attendance</b>			PRITE
<b>CSV Evaluations</b>			<b>Psychiatry (at PGY Level)</b>
			<b>Neurology (at PGY Level)</b>
			<b>%tile</b>

1. Are you functioning at a level commensurate with your year of training? **Y or N** (circle one)

2. What are you doing well in this program?

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3. What do you need to work on in this program?

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---

4. How do you plan to address these issues?

---



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---

5. General Comments: \_\_\_\_\_

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Residency Training Director: \_\_\_\_\_

Date: \_\_\_\_\_

**DIDACTIC EVALUATION FORM**

PRESENTATION EVALUATED: \_\_\_\_\_ DATE: \_\_\_\_\_

This questionnaire gives you the opportunity to provide feedback on various aspects of didactic activities. This information will be used to guide scheduling of presentations in the future. Please answer all questions, if applicable, and make appropriate comments.

Circle a number under each column that best describes your degree of agreement or disagreement with each statement.

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
This presentation provided material beneficial to you. (applied to patient care)	1	2	3	4	5
-----					
This presentation was appropriate to your education level.	1	2	3	4	5
-----					
The material was presented in a stimulating manner.	1	2	3	4	5
-----					
This presentation should be given to future residents.	1	2	3	4	5
-----					
The material should be given to future residents by the same presenter.	1	2	3	4	5
-----					
The presenter was knowledgeable about the subject material.	1	2	3	4	5
-----					
Questions were allowed and answered appropriately.	1	2	3	4	5
-----					
An appropriate amount of time was provided for the topic.	1	2	3	4	5
-----					
Handout materials were helpful.	1	2	3	4	5
-----					

COMMENTS:

YOUR RESIDENT YEAR: \_\_\_\_\_

**Return form to LaTanya Poole, UAMS Slot 589**

## 360 Multi-Rater Evaluation of Resident

Evaluator:

Subject:

Status:

Rotation:

Program:

To provide an effective residency experience, it is important to systematically evaluate residents' professional performance from a variety of perspectives (eg. patient, attending doctor, nurse, other health care professional, peer and self). Your feedback is critical to understanding how residents develop professional skills, and how residency programs can be made more effective. In particular, your written comments will serve to extend the information that you provide on the checklist. Your comments and feedback are completely anonymous and confidential.

Please take a few minutes to respond to the following, **360 Comprehensive Multi-Rater Evaluation**, which measures five of the six ACGME competencies. Base your responses on how you think the resident **generally performed** his or her duties over the past rotation.

**THIS RESIDENT GENERALLY:**

***INTERPERSONAL AND COMMUNICATION SKILLS***

1) Is frank with patients, provides truthful and upfront information as appropriate	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Encourages the patient to ask questions	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Communicates well with referring and consulting physicians	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) Communicates well with other residents on the team	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) Effectively handles demanding interpersonal situations	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6) Shows interest in each patient as	Strongly	Agree	Neither	Disagree	Strongly	Do Not

a person

Agree		Agree Nor Disagree		Disagree	Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PRACTICE-BASED LEARNING AND IMPROVEMENT**

7) Responds to feedback receptively

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8) Uses scientific evidence in medical decision making

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9) Is adept at using information technology

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10) Acknowledges the limits of own medical knowledge as appropriate

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11) Demonstrates change in practice as a result of new information

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12) Demonstrates willingness to share knowledge and information in teaching others

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PROFESSIONALISM**

13) Maintains confidentiality	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14) Manages time well	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15) Dresses appropriately for work	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16) Makes ethically sound judgments regarding patient care	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17) Respects the roles of health care staff in patient care	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18) Demonstrates altruism in putting patient care above personal issues or desires	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19) Responds to requests, including pages, in a helpful and prompt manner	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20) Keeps medical records in an	Strongly Agree	Agree	Neither	Disagree	Strongly	Do Not

accurate and timely manner

Agree

Agree  
Nor  
Disagree

Disagree

Know



**SYSTEMS-BASED PRACTICE**

21) Advocates for quality patient care and optimal patient care systems

Strongly Agree

Agree

Neither  
Agree  
Nor  
Disagree

Disagree

Strongly Disagree

Do Not Know



22) Uses consultations and referrals appropriately

Strongly Agree

Agree

Neither  
Agree  
Nor  
Disagree

Disagree

Strongly Disagree

Do Not Know



23) Understands the relationship of the clinical specialty to the larger healthcare system

Strongly Agree

Agree

Neither  
Agree  
Nor  
Disagree

Disagree

Strongly Disagree

Do Not Know



24) Practices cost effective care

Strongly Agree

Agree

Neither  
Agree  
Nor  
Disagree

Disagree

Strongly Disagree

Do Not Know



25) Advocates for patient safety

Strongly Agree

Agree

Neither  
Agree  
Nor  
Disagree

Disagree

Strongly Disagree

Do Not Know



**PATIENT CARE**

26) Gathers essential and accurate information about patients

Strongly Agree

Agree

Neither  
Agree  
Nor  
Disagree

Disagree

Strongly Disagree

Do Not Know



- 27) Develops and carries out appropriate management plans
- |                       |                       |                            |                       |                       |                       |
|-----------------------|-----------------------|----------------------------|-----------------------|-----------------------|-----------------------|
| Strongly Agree        | Agree                 | Neither Agree Nor Disagree | Disagree              | Strongly Disagree     | Do Not Know           |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/>      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
- 28) Adequately counsels and educates patients and their families
- |                       |                       |                            |                       |                       |                       |
|-----------------------|-----------------------|----------------------------|-----------------------|-----------------------|-----------------------|
| Strongly Agree        | Agree                 | Neither Agree Nor Disagree | Disagree              | Strongly Disagree     | Do Not Know           |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/>      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
- 29) Displays sensitivity and individualizes care for diverse populations
- |                       |                       |                            |                       |                       |                       |
|-----------------------|-----------------------|----------------------------|-----------------------|-----------------------|-----------------------|
| Strongly Agree        | Agree                 | Neither Agree Nor Disagree | Disagree              | Strongly Disagree     | Do Not Know           |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/>      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
- 30) Considers the impact of the patient's condition and treatment on the quality of the patient's life
- |                       |                       |                            |                       |                       |                       |
|-----------------------|-----------------------|----------------------------|-----------------------|-----------------------|-----------------------|
| Strongly Agree        | Agree                 | Neither Agree Nor Disagree | Disagree              | Strongly Disagree     | Do Not Know           |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/>      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

- 31) During the past year, I have worked with this resident
- |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|
| Less than 1 Month     | 1-6 Months            | More than 6 Months    |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Comments extend and explain the numerical ratings on the survey. Comments also provide more specific information for resident feedback.

32) Comments:

- 33) I am a (an):
- |                       |                       |                                      |                           |
|-----------------------|-----------------------|--------------------------------------|---------------------------|
| Attending Physician   | Nurse                 | Resident Evaluating Another Resident | Other Healthcare Provider |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/>                | <input type="radio"/>     |

## ABPN CLINICAL SKILLS VERIFICATION FORM (CSV v. 1)

Resident: \_\_\_\_\_ PGY: \_\_\_\_\_ Date: \_\_\_\_\_ Examiner: \_\_\_\_\_

<b>OVERALL GRADE</b>		Fail	Pass	
<b>INTERVIEW STYLE</b>				
1.	Opening and closing	Awkward strategies	1 2 3 4 5 6 7 8	Appropriate strategies
2.	Informational cues	Ignored leads	1 2 3 4 5 6 7 8	Followed leads
3.	Affective cues	Ignored	1 2 3 4 5 6 7 8	Explored appropriately
4.	Communication style	Insensitivity interfered with data collection	1 2 3 4 5 6 7 8	Adequate language and cultural sensitivity
5.	Questioning techniques	Abrupt and forced choice questions	1 2 3 4 5 6 7 8	Open-ended but appropriately structured
6.	Control and direction of interview	Scattered and fragmented questions	1 2 3 4 5 6 7 8	Developed cohesive interview
Average score for Interview Style: _____				
<b>SUBSTANCE OF INTERVIEW</b>				
7.	Presenting problems and history of present illness	Inadequately obtained or too vague	1 2 3 4 5 6 7 8	Obtained adequate data
8.	Past history: Psychiatric	Ignored major issues	1 2 3 4 5 6 7 8	Gathered relevant data in at least brief form
	Family	Ignored major issues	1 2 3 4 5 6 7 8	Gathered relevant data in at least brief form
	Medical	Ignored major issues	1 2 3 4 5 6 7 8	Gathered relevant data in at least brief form
	Social/educational/occupational	Ignored major issues	1 2 3 4 5 6 7 8	Gathered relevant data in at least brief form
	Developmental	Ignored major issues	1 2 3 4 5 6 7 8	Gathered relevant data in at least brief form
9.	History of drug and alcohol abuse	Ignored or too limited	1 2 3 4 5 6 7 8	Sensitively gathered
10.	Assessment of suicidal risk	Ignored or too limited	1 2 3 4 5 6 7 8	Sensitively explored
11.	Assessment of homicidal risk	Ignored or too limited	1 2 3 4 5 6 7 8	Sensitively explored
12.	Mental status examination	Omitted or too limited	1 2 3 4 5 6 7 8	Organized approach and performed appropriately
Average score for Substance of Interview: _____				
<b>CASE PRESENTATION</b>				
13.	Summary of important data	Disorganized	1 2 3 4 5 6 7 8	Presented concisely and coherently
14.	Mental status exam	Incomplete	1 2 3 4 5 6 7 8	Accurately summarized
15.	Emergency issues: Suicide	Ignored	1 2 3 4 5 6 7 8	Considered
	Violence/abuse	Ignored	1 2 3 4 5 6 7 8	Considered
	Drugs/alcohol	Ignored	1 2 3 4 5 6 7 8	Considered
16.	Recognition of need for additional history and collateral information	Absent or no rationale	1 2 3 4 5 6 7 8	Appropriate
Average score for Case Presentation: _____				

DIFFERENTIAL DIAGNOSIS/FORMULATION											
17.	Differential diagnosis (pertinent Axes I-V)	Too narrow or too broad	1	2	3	4	5	6	7	8	Appropriate working diagnoses
18.	Biopsychosocial formulation	Unidimensional or inadequate	1	2	3	4	5	6	7	8	Included all three dimensions
<b>Average score for Differential Diagnosis/Formulation: _____</b>											
TREATMENT PLAN/PROGNOSIS											
19.	Treatment plan: Safety	Ignored key treatments or used inappropriately	1	2	3	4	5	6	7	8	Specific to this patient yet sufficiently comprehensive
	Level of care	Ignored key treatments or used inappropriately	1	2	3	4	5	6	7	8	Specific to this patient yet sufficiently comprehensive
	Medication	Ignored key treatments or used inappropriately	1	2	3	4	5	6	7	8	Specific to this patient yet sufficiently comprehensive
	Psychotherapy	Ignored key treatments or used inappropriately	1	2	3	4	5	6	7	8	Specific to this patient yet sufficiently comprehensive
	Community resources	Ignored key treatments or used inappropriately	1	2	3	4	5	6	7	8	Specific to this patient yet sufficiently comprehensive
20.	Prognosis: Positive/negative indicators	Ignored	1	2	3	4	5	6	7	8	Discussed
	Transference/countertransference	Not anticipated	1	2	3	4	5	6	7	8	Anticipated
<b>Average score for Treatment Plan/Prognosis: _____</b>											

TRAINING COMPETENCY
Is this resident functioning at a competency level commensurate with his/her PGY level? Yes ____ No ____

COMMENTS
(Please note key positives and negatives):

Resident Signature: \_\_\_\_\_  
 After comments entered and discussed

Examiner Signature: \_\_\_\_\_

## Competencies

At its February 1999 meeting, the ACGME endorsed general competencies for residents in the areas of:

- patient care,
- medical knowledge,
- practice-based learning and improvement,
- interpersonal and communication skills,
- professionalism, and
- systems-based practice.

Identification of general competencies is the first step in a long-term effort designed to emphasize educational outcome assessment in residency programs and in the accreditation process. During the next several years, the ACGME's Residency Review and Institutional Review Committees will incorporate the general competencies into their Requirements. The following statements will be used as a basis for future Requirements language. If you have any questions, comments and other requests for assistance, please address them to [outcomes@acgme.org](mailto:outcomes@acgme.org).

### **ACGME GENERAL COMPETENCIES Vers. 1.3 (9.28.99)**

The residency program must require its residents to develop the competencies in the 6 areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the competencies.

#### **PATIENT CARE**

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

- communicate effectively and demonstrate caring and respectful behaviors when interacting with
- patients and their families
- gather essential and accurate information about their patients
- make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- develop and carry out patient management plans
- counsel and educate patients and their families
- use information technology to support patient care decisions and patient education
- perform competently all medical and invasive procedures considered essential for the area of practice
- provide health care services aimed at preventing health problems or maintaining health
- work with health care professionals, including those from other disciplines, to provide patient-focused care

#### **MEDICAL KNOWLEDGE**

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

- demonstrate an investigatory and analytic thinking approach to clinical situations
- know and apply the basic and clinically supportive sciences which are appropriate to their discipline

## **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. Residents are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology
- locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
- obtain and use information about their own population of patients and the larger population from which their patients are drawn
- apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- use information technology to manage information, access on-line medical information; and support their own education
- facilitate the learning of students and other health care professionals

## **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 professional associates. Residents are expected to:

- create and sustain a therapeutic and ethically sound relationship with patients
- use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- work effectively with others as a member or leader of a health care team or other professional group

## **PROFESSIONALISM**

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

- demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- 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 and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- practice cost-effective health care and resource allocation that does not compromise quality of care
- advocate for quality patient care and assist patients in dealing with system complexities
- 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

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## Resident Portfolio

### What is a portfolio?

A portfolio consists of individual entries that demonstrate the your abilities within each of the thirteen skill areas listed below. An entry is a collection of documents that reflects actual work within each skill area, and may include chart documentation, laboratory or radiology records, literature searches, and various other relevant data. Also included in an entry is a self-evaluation cover letter. It is an opportunity for you to explain how the entry demonstrates your competency, and to clarify, acknowledge, or justify any potential shortcomings of the entry.

### How do I complete a portfolio entry?

#### GUIDELINES FOR PORTFOLIO ENTRIES

In order to meet requirements for graduation, each resident must provide portfolio entries as follows:

- 1 Biopsychosocial entry in each year of training (4 total). Only one of these entries needs to achieve a passing score to meet requirements for graduation.
- 1 Psychotherapy entry in the each of the PGY II, III, and IV years (3 total). Of these three, one must cover psychodynamic psychotherapy, one must cover cognitive behavioral therapy, and one must cover supportive therapy. All three entries must achieve a passing score to meet requirements for graduation.
- 1 entry from each of the other 11 topic areas (11 total). All of these must achieve a passing score to meet requirements for graduation.

Portfolio entries are collected on a semiannual cycle, in December and June. All entries are due by 4:30 PM on the due date. Earlier submissions are encouraged. Expectations for completion vary by PGY year as follows.

- PGY I: 3 entries on June 1
- PGY II: 3 entries on December 1, 3 entries on June 1.
- PGY III: 3 entries on December 1, 3 entries on June 1.
- PGY IV: 3 entries on December 1, all make-up entries due on March 1.

If a portfolio entry does not achieve a passing score, the resident will need to submit a make-up entry in that topic at a later date. A make-up entry may be either a revision of the original entry or completely new product. Make-up entries are due in addition to the expected entries detailed above. Submission of all outstanding make-up entries is expected in March of the PGY IV year, but residents are strongly encouraged to present make-up entries on earlier cycles of submission to avoid being overwhelmed by multiple last-minute requirements.

#### GUIDELINES FOR EVALUATION

Each portfolio entry will be sent to two qualified raters in the community. No identifying information will be sent to the raters, but it is the resident's responsibility to remove individual or patient identifying content from the body of the entry before submission. The raters will assign each entry a score from 1-6, based on the scoring rubric for that topic. Any score of 3 or above is considered a passing score. If both raters agree that an entry either passes or does not pass, the scores will be averaged and the entry will be returned to the resident with feedback. If the raters disagree about whether an entry should pass or not, that entry will be forwarded to a third rater for a tie-breaking vote. To prevent bias, the third rater will not know to the scores of the other two raters. The decision of the third rater will determine whether or not the entry passes, and the scores of all three raters will be averaged for a final score.

#### GUIDELINES FOR PREPARATION

Each portfolio entry should be accompanied by a cover letter explaining the background of the case and why this material is a good example of the resident's competency in the relevant skill area. The portfolio should include all relevant clinical notes, reports, communications, etc, to enable the reviewer to understand the case. Portfolios using presentation or education materials should include both the presentation and any available evaluation forms from the audience. Psychotherapy portfolios should include a typed transcript of one or more therapy sessions with enough content for the reviewer to verify your competency in that therapy modality.

All identifying information should be crossed out or deleted from the portfolio. This includes information that identifies the patient, yourself, and other clinicians or staff mentioned in the documentation. Please review the portfolio thoroughly, not just the first page, for identifying information. Be aware that identifying information may be more than just a name (for example, “Mrs. G is a 45 y/o African American nurse who works on in the GI clinic at the Little Rock VA” is still enough information to identify that individual).

Please make sure to keep a copy of each portfolio submission for your own records. Samples of cover letters and complete portfolios are available in the Residency Education Office.

## **PLAGIARISM**

The purpose of the portfolio is to highlight competency of the resident in each subject area. As such, reviewers must be able to identify the resident’s work. Plagiarism will not be tolerated. It is recognized that many portfolios, especially clinical cases, will contain work from multiple individuals. Similarly, presentations or educational material may be developed collaboratively with multiple contributors. Such material may still be submitted in a portfolio, but it must be made clear what part of the content was generated by the resident and what part was generated by others.

### **What happens to the entries?**

1. Once an entry is submitted, two board-certified psychiatrists in the community will rate the entries. Because the raters have no involvement in the cases themselves, and because patient and resident identifiers are obscured, potential bias is eliminated.
2. The trained raters will read the entries and assign each entry a score from the scoring rubric.

### **Who will see your portfolio?**

1. The residency program director will review your portfolio in the semi-annual evaluation and perhaps when writing letters of recommendation. They become part of your residency file.
2. You can use the portfolio as evidence of your performance when applying for positions or fellowships.

## **Bio-Psycho-Social-Spiritual Formulation**

### **Definition:**

A competent psychiatrist skillfully collects and synthesizes information involving the biological, psychological, and social including spiritual aspects of each patient. The careful, thoughtful, and sophisticated integration of each of these areas lays the groundwork for successful formulation of a clear, safe, and reasonable treatment plan.

### **Portfolio Entry Requirements:**

Select a case you managed from this academic year that best demonstrates the complex interplay between the biological, psychological, social and spiritual components of your patient's life. The case may come from any setting, including inpatient or outpatient psychiatric or other medical settings. The case should demonstrate the clinical need to address each of these components in treatment planning. Along with your documentation, furnish a cover letter describing why you think this is an excellent case. Discuss how the documentation demonstrates your ability to integrate the complex and diverse data to provide the bio-psycho-social-spiritual formulation.

### **Bio-Psycho-Social Formulation Scoring Rubric**

- 1 Important skills and/or knowledge missing to adequately manage the case; lacks even minimal information in the biological, psychological, social components of the case.
- 2 Appropriate approach, but weaknesses would likely lead to potential problems; lacks a formulation—includes biological, psychological, social information, but lacks sufficient integration.
- 3 Competent formulation for successful management of standard cases; sufficiently integrates the biological, psychological, and social components of the case.
- 4 Applies conventional approach to a more complex case; formulation clearly integrates the biological, psychological, and social components and lays the groundwork for the treatment plan.
- 5 Well-integrated knowledge and skills may facilitate resolution of complex problems; demonstrates a sophisticated integration of the biological, psychological, and social components of the case.
- 6 Wide breadth of knowledge and skills and a sophisticated, well integrated approach to a very complex case.

# Crisis Management

## Definition:

A competent psychiatrist maintains patient safety in life-threatening or potentially life-threatening situations. Crisis management could include successful acute interventions with extremely medically ill, agitated, combative, suicidal, homicidal, or grief-stricken patients.

## Portfolio Entry Requirements:

Select a life-threatening or potentially life-threatening case you managed from this academic year that best demonstrates your crisis management skills. In the cover letter, describe the situation and summarize how you managed the crisis. Include specific recommendations or interventions and their impact, even if the outcome was less than favorable.

## Crisis Management Scoring Rubric

- 1 Important skills and/or knowledge lacking to adequately manage the case; lacks skillful approach and/or fails to provide rationale for interventions; ignores or lacks plan for safety.
- 2 Appropriate approach, but weaknesses would likely lead to potential problems; rationale for interventions is inadequately supported.
- 3 Competent to successfully manage standard cases following a conventional approach; provides adequate rationale for interventions; disposition provides for maximum safety of patient and/or others as allowed by situation.
- 4 Applies standard approach to a more complicated case; formulates more sophisticated plan with patient/family involvement.
- 5 Well-integrated knowledge and skills facilitate resolution of a complex crisis; considers creative alternatives to standard treatments or interventions; shows knowledge base that supports decision-making.
- 6 Wide breadth of knowledge and skills and a sophisticated, well integrated approach; utilizes varied sources to manage a very complex crisis.

## Initial Evaluation and Diagnosis

### Definition:

A competent psychiatrist skillfully gathers data from appropriate resources and formulates a reasonable diagnosis at the time of an initial encounter.

### Portfolio Entry Requirements:

Select a challenging case from this year, which demonstrates your skill in conducting an initial evaluation and diagnosis. In your cover letter, describe the patient and clinical situation and elaborate upon your thought processes that justify or explain the diagnosis. Provide the initial evaluation and other supporting documents, such as laboratory or radiology reports, past medical records, or literature reviews. A differential diagnosis is necessary to achieve a high rating in this skill.

### INITIAL EVALUATION AND DIAGNOSIS SCORING RUBRIC

1. Important skills and/or knowledge lacking to adequately manage the case; lacks skillful approach and/or fails to provide rationale for diagnosis; gross lack of data.
2. Appropriate approach, but weaknesses would likely lead to potential problems; rationale for initial diagnosis is inadequately supported.
3. Competent to successfully evaluate and diagnose standard cases following a conventional approach; provides rationale for diagnosis; complete diagnostic impression.
4. Applies standard approach to evaluation to ensure the initial diagnosis by considering reasonable alternatives among various diagnoses.
5. Well-integrated knowledge and skills facilitate resolution of complex initial evaluation and diagnosis; considers new treatments or interventions; shows knowledge base that supports decision-making.
6. Wide breadth of knowledge and skills and a sophisticated, well integrated approach; utilizes varied sources to manage a very complex evaluation and initial diagnosis.

## Legal Issues

### Definition:

A competent psychiatrist possesses an adequate understanding of the legal system as it relates to physicians' obligations within psychiatric care, and skillfully manages the legal aspects of clinical cases.

### Portfolio Entry Requirements:

Select a challenging case with legal implications from your experiences this year that best demonstrates your understanding of the legal system and your obligations within it. The case may involve: matters of involuntary admissions; 72-hour holds; cases of suspected abuse or rape; decisions regarding instituting searches for patients who have eloped; interventions with intoxicated patients planning to drive; interventions with patients making specific threats (duty to warn versus confidentiality); consultations regarding capacity issues; clinical versus forensic quality urine toxicological screening, etc. In your cover letter, describe the situation, your specific legal obligations, and your intervention. Include the outcome of your intervention and/or interaction with the legal system.

### Legal Issues Scoring Rubric

1. Important legal knowledge lacking to adequately manage the case.
2. Appropriate approach to legal issues, but weaknesses could lead to potential problems.
3. Competent to successfully manage legal issues following a standard approach.
4. Applies standard approach that demonstrates an understanding of fairly complex legal issues.
5. Well-integrated knowledge and skills facilitate skillful management of complex legal issues beyond the standard approach.
6. Wide breadth of knowledge and skills and a sophisticated, well integrated approach; utilizes varied sources to manage very complex legal issues; thorough presentation; acknowledges short-term outcomes.

## Medical Psychiatry

### Definition:

A competent psychiatrist recognizes the critical link between medical and psychiatric conditions. Typically referred to as consultation-liaison psychiatry, this area involves cases commonly encountered in a general hospital setting.

### Portfolio Entry Requirements:

Select a case from residency training that best demonstrates your skill in managing patients with co-existing medical and psychiatric conditions. This may be a patient with co-morbid medical and psychiatric illnesses, a patient whose medical condition manifested psychiatric symptoms, a patient whose psychiatric condition complicated medical management, or a patient whose medical condition complicated psychiatric management. In the cover letter, describe the consultation question, summarize the communication between you and the treatment team, and briefly describe the outcome of your interventions. Provide your psychiatric evaluation, any relevant laboratory or radiology records or literature sources.

### Medical Psychiatry Scoring Rubric

1. Important skills and/or knowledge lacking to adequately manage the case; fails to realize significant medical conditions that might contribute to psychiatric management.
2. Appropriate approach, but weaknesses could lead to potential problems; lacks thorough assessment and/or management of all facets of the case.
3. Competent to successfully manage standard cases following a conventional approach. Shows probable relationship between medical condition and psychiatric management.
4. Applies a conventional approach to a complex case.
5. Well-integrated knowledge and skills facilitate resolution of complex problems beyond the standard approach.
6. Wide breadth of knowledge and skills and a sophisticated, well integrated approach; utilizes varied sources to manage very complex problems; thorough presentation; acknowledges short-term outcomes.

## **Neuropsychiatry**

### **Definition:**

A competent psychiatrist recognizes the interface between neurology and psychiatry. This skill area typically involves patients with acquired behavioral disorders secondary to neurological disease.

### **Portfolio Entry Requirements:**

Select a challenging case from residency training that illustrates your ability to identify the complex relationship between brain and behavior. The cover letter should include the rationale for the treatment and the outcome if known. Include the neuropsychiatric evaluation that explains the biologic basis for the observed symptoms. Additionally, provide documentation of the neurological examination and any relevant laboratory findings, neuroimaging, neurophysiologic studies, neuropsychological testing, literature sources, or other pertinent data.

### **Neuropsychiatry Scoring Rubric**

1. Important skills and/or knowledge lacking to adequately manage the case.
2. Appropriate approach, but weaknesses could lead to potential problems. Lacks thorough assessment and/or management of all facets of the case.
3. Competent to successfully manage standard cases following a conventional approach. Shows probable relationship between the neurological and psychiatric aspects of the case.
4. Applies a conventional approach to a complex case; documents the neurological system involved.
5. Well-integrated knowledge and skills facilitate resolution of complex problems beyond the standard approach.
6. Wide breadth of knowledge and skills and a sophisticated, well integrated approach; utilizes varied sources to manage very complex problems; thorough presentation; acknowledges short-term outcomes.

## Professional Communication

### Definition:

A competent psychiatrist effectively and professionally communicates with other professionals.

### Portfolio Entry Requirements:

Select a case from residency training that best demonstrates your skill in sharing information with other professionals in managing patients. Provide a cover letter describing the case and the role that professional communication played in the outcome. Professional communication may involve correspondence with medical professionals in other specialties or within psychiatry. It may include written or faxed letters, e-mails, or telephone conversations. Please provide relevant documents with your entry; communications described in the cover letter but not supported by the clinical documentation will not be sufficient for this portfolio entry.

### Professional Communication Scoring Rubric

1. Important skills and/or knowledge lacking to adequately communicate. Communication lacks clarity, fails to address important aspects of the case, and/or provides inadequate or poor recommendations.
1. Appropriate approach to communication, but lack of clarity and specificity could lead to potential problems.
2. Competent to successfully communicate within standard cases; follows a conventional approach.
3. Applies a conventional approach to a more complex case.
4. Well-integrated knowledge and skills facilitate resolution of complex problems.
5. Wide breadth of knowledge and skills and a sophisticated, well integrated approach; utilizes varied sources to manage very complex problems; thorough presentation; acknowledges short-term outcomes.

# Psychotherapy

**Definition:**

A competent psychiatrist can apply behavioral, brief, cognitive, psychodynamic, or supportive theory in treating or managing patients.

**Portfolio Entry Requirements:**

Select a case from residency training that best demonstrates your understanding of the underlying theory of a specific therapy, and your ability to apply that theory. Using an audiotape or process notes, transcribe a ten-minute segment that demonstrates your skill. In the cover letter explain why this case is suitable for the therapy you are using. As part of your self-assessment, comment upon therapeutic techniques you used that are consistent or inconsistent with the theory, the rationale for selecting the various therapeutic techniques you did, and details of how you implemented or modified them as needed. Please highlight relevant portions of your transcription to illustrate your points.

**Psychotherapy Scoring Rubric**

1. Important skills and/or knowledge lacking to adequately manage the case; case report is inadequate for the theory selected; the case report does not consider the evaluation of the patient for this specific therapy; or this type of therapy is contraindicated in the patient's diagnosis.
2. Appropriate approach, but weaknesses could lead to potential problems; case demonstrates a match of patient to theory, but is weak in application.
3. Competent to successfully manage standard cases following a conventional approach with the selected therapy; identifies therapeutic techniques and illustrates basic application of theory.
4. Applies a conventional approach to a more complex case; strategies reflect a clear understanding of the theory, and the application of theory is well demonstrated.
5. Well-integrated knowledge and skills facilitate therapeutic change in a complex case; modifies therapeutic techniques when necessary; innovatively implements techniques beyond a conventional approach.
6. Wide breadth of knowledge and skills and a sophisticated, well integrated approach; utilizes varied sources to manage a very complex case; interventions are well timed in response to the state of the patient; thorough presentation; acknowledges short-term outcomes.

## Self-Directed Learning

### Definition:

A competent psychiatrist incorporates self-directed learning into clinical practice. Self-directed learning promotes continuing education and fosters the clinical application of newly acquired knowledge gleaned from any source.

### Portfolio Entry Requirements:

Select a case from residency training in which you incorporated self-directed learning. If you did not have the opportunity to incorporate this newly acquired information into the management of the case, describe how it may affect your future practice. In your cover letter, describe the case, the educational resources you used and why, and if possible the impact of your application of new information on the clinical outcome. Provide documentation such as clinical notes, orders, notes by other staff before and after your intervention, abstracts from literature searches, textbook or journal material, notes from lectures, grand rounds, or professional meetings, documentation from personal communication with experts in the field, or other relevant information (if you are submitting material from textbooks, manuals, etc, please submit only relevant parts of this documentation. Do not copy entire chapters or manuals for this entry).

### Self-Directed Learning Scoring Rubric

1. Important skills and/or knowledge lacking to adequately manage the case; resources reviewed are irrelevant to the case.
2. Appropriate approach, but weaknesses could lead to problems; sources of information are relevant to the case but clinical application is weak.
3. Competent to successfully and independently pursue answers to basic medical questions using self directed learning.
4. Applies a conventional approach to a more complex case; pursues clarification when there is weak or no evidence for clinical application
5. Well-integrated knowledge and skillful research facilitates resolution of a complex case beyond a conventional approach; develops conclusions and plans from various sources.
6. Wide breadth of knowledge and skills and a sophisticated, well integrated approach to a very complex case; utilizes varied sources; considers alternatives in plans; considers strengths and weaknesses of the literature.

## Specific Treatment Modalities

### Definition:

A competent psychiatrist has expertise in various clinical treatment modalities such as psychopharmacology, electroconvulsive therapy, transcranial magnetic stimulation, biofeedback, or other areas.

### Portfolio Entry Requirements:

Select a case from residency training that best demonstrates your expertise within a specific treatment modality. In your cover letter provide a self-assessment of your experience and performance in this area. Clarify how theory directed your treatment. Provide evidence of theoretical knowledge by including material from courses, lectures, or academic meetings, literature searches, or other sources (if you are submitting material from textbooks, manuals, etc, please submit only specifically relevant parts of this documentation. Do not copy entire chapters or manuals for this entry). Provide evidence of clinical application by including progress notes or other existing documents that describe the application of your knowledge in an interesting or challenging case.

### Specific Treatment Modalities Scoring Rubric

1. Important skills and/ or knowledge lacking to adequately manage the case; lacks theoretical foundation or poorly applies theory to the case.
2. Appropriate approach, but weaknesses could lead to problems; must have a justifiable theoretical base.
3. Competent to successfully apply specialized treatment to standard cases following a conventional approach and provides adequate minimal consent.
4. Applies conventional approach to a more complex case; provides patient education beyond the informational level of a consent form.
5. Well-integrated knowledge and skills facilitate resolution of complex problems beyond a conventional approach; applies literature review to specific problem.
6. Wide breadth of knowledge and skills and a sophisticated, well integrated approach to a very complex case; utilizes varied sources; considers treatment alternatives and justifies decisions based on the literature; shows outcome of intervention.

## Teaching & Presentation Skills

### Definition:

A competent psychiatrist effectively imparts knowledge and skills to others—including students, physicians, other medical professionals, or lay people of all backgrounds—in one-on-one, small, or large group settings.

### Portfolio Entry Requirements:

Select a situation from this year that provides evidence of your skill for teaching and presenting information. In your cover letter, describe the context of the teaching situation or presentation, such as the number of learners and characteristics of the audience, and a description of how you prepared for it. Provide supporting documents such as handouts, literature reviews, copies of slides or notes, or other material relevant to the presentation. If available, provide a summary of didactic evaluation forms (scores and comments) completed by the audience. If the presentation occurred at a professional meeting or in a setting outside of the routine teaching settings of residency, provide relevant material and discuss that in the cover letter.

### TEACHING AND PRESENTATION SKILLS SCORING RUBRIC

1. Important skills and/or knowledge lacking for a coherent, meaningful presentation; content of the presentation does not match with stated objectives, goals, or purpose.
2. Appropriate approach, but weaknesses in style or content point to overall ineffective teaching or presentation skills; content of the presentation weakly matches with stated objectives, goals, or purpose.
3. Competent to teach or present coherent and meaningful material to the average learner in an average learning environment; applies basic teaching methods.
4. Applies conventional teaching or presentation skills to complex material; shows evidence of ability to successfully manage difficult learning environments and to adjust presentations or material to learners of varying backgrounds and abilities; shows insight into why a particular presentation was effective or successful.
5. Well-integrated knowledge and skills facilitate effective teaching or presentation for all learners in all environments.
6. Wide breadth of knowledge and skills and a sophisticated, well-integrated approach; presentation is coherent, engaging, and successfully imparts knowledge regardless of learner type or learning environment.

## Working With Teams & Families

### **Definition:**

A competent psychiatrist is skilled in mobilizing, coordinating, and collaborating with nurses, psychologists, social workers, technicians, other physicians, and patients' families in order to optimize treatment and functional outcome.

### **Portfolio Entry Requirements:**

Select a case from this year that illustrates your ability to identify and coordinate resources and people in the care of a patient. In your cover letter elaborate on your choice of resources and use of the resources. Additionally, describe how your work with the treatment team and/or family improved the outcome for a patient. Documents to provide may include progress notes, letters of correspondence, written evaluations by other professionals, records of phone calls, family-meeting notes, or other material as needed. A brief summary of the case and the role of the treatment team and/or family in affecting the patient's outcome may be helpful if existing documentation is inadequate.

### **WORKING WITH TEAMS & FAMILIES SCORING RUBRIC**

1. Important skills and/or knowledge lacking to adequately manage the case; fails to involve critical person/people or agency.
2. Appropriate approach, but weaknesses could lead to potential problems.
3. Competent to mobilize, coordinate, and collaborate with others in the care of a patient.
4. Applies a conventional approach to a more complex case; documentation indicates a plan of how the team will work together.
5. Well-integrated knowledge and skills facilitate resolution of complex problems. Documents ongoing meetings with family and team, and presents a plan for future facilitation of team functioning.
6. Wide breadth of knowledge and a sophisticated, well integrated approach utilizing varied sources to resolve a very complex case; develops a highly functioning team that works over a period of time.

# Teaching Tips

## **Determine purpose of the lecture:**

To motivate

To explain materials not readily available elsewhere

To ensure that everyone learns some important principles

Organize the content

Break it into 10-20 minute sections since that is the typical learner's attention span

Decide what to cover and list topics; estimate time needed and then increase that by 50%; set objectives

Make sure the sequence of topics is meaningful

## **Different kinds of lectures:**

Expository: single topic covering major and minor points

Interactive: learners respond to prompts, questions, or examples

Problems solving: begin with posing a question, paradox, or enigma

Case study: follows a realistic situation step by step to illustrate principles

Short lecture/discussion: 20 minute lecture sets stage; 15-minute discussion; summarize

## **Preparation:**

Visit lecture room so you know what is available and how to use it

Carefully prepare your own lecture notes but do not lecture from a script

If using Power Point, keep your notes on the note sheet to go with each slide; practice to make sure it "sounds" right; carefully prepare for transitions

Summarize occasionally and use questions to verify understanding

Structure lecture to suit the audience and subject matter

## **To help people retain the most:**

Attention getting introduction

Brief overview of main points to be covered

Quick statement of background or context

Detailed explanation of roughly three major points, starting with most important first; incorporate a change of pace every 10-15 minutes

Concluding summary of main points to reinforce

Budget time for questions

## **Keep their attention:**

Eye contact

Vary style of delivery

Be enthusiastic

Be conversational

Use concrete, simple, and colorful language

Incorporate anecdotes

Use movement to emphasize important points

Laugh at yourself when you make a mistake  
Keep track of time

Provide concrete and simplified conclusions

**Delivery:**

Vary speaking pace

Project voice

Pause

Watch for “um,” “well,” “you know,” “ok,” “so” etc.

Adopt a natural speaking stance

Breathe normally

Finish forcefully—don't let lecture trail off

**Handouts:**

Learners tend to like them; should guide structure of lecture

Leave space for note taking

\* \* \* \* \*

## Generic Teaching Evaluation Form

(May be used with any lecture/seminar)

**Teaching Evaluation Form:**

Name of lecturer:

Date:

Topic:

Please blacken in the bubble that corresponds to your experience with this lecture. Your responses are anonymous. All comments will be given to the lecturer, so adjust your writing if you wish to ensure anonymity

This lecturer	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Was organized	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed concern for learners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was enthusiastic about teaching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Encouraged participation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stimulated my interest in the subject	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gave clear explanations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spoke clearly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Presented at an enjoyable pace	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Used AV effectively	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Answered questions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was effective	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Should be recommended for future lectures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments on what the lecturer did well and on how to improve future lectures