# Educational Workshops Session 1

## Don't sue me! – Teaching residents essential principles of malpractice to reduce fear and improve quality of care

**Presenters**
Cathleen Cerny-Suelzer, MD
Selena Magalotti MD
Victoria Kelly, MD
Michael Greenspan, MD
Brianne Newman, MD

**Educational Objective**

1. By the end of the presentation portion of the workshop, participants will be able to explain and discuss the basics of malpractice with their trainees.
2. Participants will be able to recognize ways in which technology might be altering the standard of care and introducing potential new causes of legal action.
3. Participants will analyze fictional example(s) to detect the elements of malpractice and debate whether the standard of care was met.
4. Participants will solidify their learning by applying their knowledge to the appraisal of case examples, which they can in turn discuss with their trainees as part of teaching.

**Practice Gap**

In our increasingly litigious society, getting sued is a major concern of residents. Even though the risk of malpractice is often on the minds of trainees, this topic may not be a formal part of the residency curriculum. Teaching residents about malpractice early on in their training not only helps to dispel fears, but also helps trainees to reflect on why they do what they do. It is also important for trainees to be aware of how technology is changing the standard of care and subsequently impacting a physician's level of medicolegal risk. To address these gaps, this interactive workshop is aimed at preparing faculty to teach about malpractice, risk management, and the related use of technology in the ever-changing clinical learning environment.

**Abstract**

"Like spouses in a dysfunctional marriage, we can't live with lawyers, but we can't live without them" [1].

The AMA has cited that 16.1% of psychiatrists practicing in the United States report facing at least one medical liability claim in their careers [2]. Although the topic of malpractice connects to various ACGME core competencies [3-5], there are no ACGME general psychiatry training milestones directly assessing knowledge of medical malpractice and related risk management [6]. Further, the ACGME description of the required forensic psychiatry experience in general training makes no mention of malpractice [7]. Thus, this leaves training programs with little

guidance on what to teach about malpractice, or how to assess trainee mastery of this essential knowledge base.

Malpractice issues are often taught to residents informally or through anecdotes by people with their own biases and varying levels of expertise [1]. This lack of adequate understanding can increase fear, but it does not provide the tools to know how to decrease one's risk of litigation. Put aptly, "In light of today's litigious medical practice environment, graduating newly fledged psychiatrists from residency without specific education and training about malpractice and the standard of care is in our view educational malpractice" [8]. With growing awareness of this issue, some training programs have published on their initiatives to teach about medical malpractice and risk management in their curriculum [5, 9-11]. Further, it is important for programs to include education about how technology can be an aide in decreasing risk of malpractice, but also has the potential to change the standard of care and introduce new causes of legal action (12-13).

For all of these reasons, an increased focus on training residents about basic principles of law and malpractice is of vital importance. In this workshop, faculty will be trained on how to teach residents about the basic principles of medical malpractice law, the four Ds of malpractice, risk management, and the related use of technology. Teaching will be interactive through small and large group discussion of cases. The goal of this workshop is for faculty to leave feeling prepared to train residents on these important topics at their institutions. The intended audience includes general program directors, fellowship program directors, teaching faculty, and trainees. This workshop will help to bridge the gap on training residents for a medicolegally sound career.

**Agenda**

1. 5 minutes – Speaker introductions
2. 5 minutes – Large group discussion of the challenges to educating trainees on the topic of malpractice
3. 15 minutes - Presentation on basic malpractice concepts that are important to be taught to general trainees, including the role of the psychiatrist, basic legal terminology, the four "D"s of malpractice, defining the standard of care, and causes of action in psychiatric malpractice lawsuits
4. 10 minutes – Small group discussion involving patient scenario, resident's note, and giving feedback on malpractice related risks
5. 5 minutes – Presentation on the Do's and Don'ts of documentation
6. 5 minutes – Presentation on tips for speaking in court
7. 15 minutes – Small group discussions of case involving technology and malpractice risk
8. 20 minutes – Mock-Trial
9. 10 minutes – Summary and final discussion

**Scientific Citations**

1. Tellefsen C. Commentary: Lawyer Phobia. J Am Acad Psychiatry Law. 2009; 37:162-4.

2. Guardado JR. Policy Research Perspectives: Medical Liability Claim Frequency Among U.S. Physicians. 2017. https://www.ama-assn.org/sites/default/files/media-browser/public/government/advocacy/policy-research-perspective-medical-liability-claim-frequency.pdf. Accessed 19 Oct 2018.
3. American Board of Psychiatry and Neurology. Psychiatry Core Competencies Outline. 2011. https://www.abpn.com/wp-content/uploads/2015/02/2011_core_P_MREE.pdf. Accessed 19 Oct 2018.
4. Frierson RL, Campbell NN. Commentary: Core Competencies and the Training of Psychiatric Residents in Therapeutic Risk Management. J Am Acad Psychiatry Law. 2009; 37:165-167.
5. Nissen K, Angus SV, Miller W, et al. Teaching Risk Management: Addressing ACGME Core Competencies. J Grad Med Edu. 2010; 2:589-94.
6. Accreditation Council for Graduate Medical Education, American Board of Psychiatry and Neurology. The Psychiatry Milestone Project. 2015. https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf?ver=2015-11-06-120520-753. Accessed 19 Oct 2018.
7. Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry. 2017. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf?ver=2017-05-25-083803-023. Accessed 19 Oct 2018.
8. Rogers JE, Neumann CL, Myers WC. Commentary: Bringing Order to Chaos - How Psychiatrists Know the Standard of Care. J Am Acad Psychiatry Law. 2015; 43:451-5.
9. Ping Tsao CI, Layde J. Three-Session Psychiatric Malpractice Curriculum for Senior Psychiatry Residents. Acad Psychiatry. 2009; 33:160-2.
10. Hochberg MS, Seib CD, Berman RS, et al. Perspective: Malpractice in an Academic Medical Center: A Frequently Overlooked Aspect of Professionalism Education. Acad Med. 2011; 86:365-68.
11. Schlicher NR, Ten Eych RP. Medical Malpractice: Utilization of Layered Simulation for Resident Education. Acad Emer Med. 2008; 15:1175-80.
12. Sokol AJ, Molzen CJ. The Changing Standard of Care in Medicine. J Legal Med. 2002; 23:449-90.
13. Cooke BK, Worsham E, Reisfield GM. The Elusive Standard of Care. J Am Acad Psychiatry Law. 2017; 45:358-64.

## Embracing our responsibility for inclusion: Implementing the 2019 ACGME Common Program Requirement on diversity and inclusion

**Presenters**
Tracey Guthrie, MD
Saira Kalia, MBBS, MD
Francis Lu, MD
Ana Ozdoba, MD

**Educational Objective**

1. Understand the meaning and significance of the new ACGME Common Program Requirement (CPR) on diversity and inclusion that is an accreditation standard for all residencies and fellowships of all specialties effective July 1, 2019.
2. Define and identify the important relationship between the terms “diversity” and “inclusion.”
3. Recognize that the creation of an inclusive environment is not a “one size fits all” approach, but must be tailored to the specific institution, mission, and community.
4. List and describe specific action steps that training(residency/fellowship) programs, departments, and sponsoring institutions including hospital systems can take towards inclusion.

**Practice Gap**

On June 29, 2018, the ACGME released its new Common Program Requirements (CPR) effective July 1, 2019 including a new one on diversity and inclusion that applies to all residencies and fellowships of all specialties:

“I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)”

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution’s mission and aims. The program’s annual evaluation must include an assessment of the program’s efforts to recruit and retain a diverse workforce, as noted in V.C.1.c). (5). (c).”

Until now, ACGME has not had a diversity/inclusion accreditation standard, although it has had ones that related to cultural competence, which is a related, but not synonymous topic. This action closes the gap between the 2009 LCME accreditation standard on diversity/inclusion for U.S. and Canadian medical schools and the ACGME graduate medical education accreditation standards for all residencies/fellowship programs of all specialties in the U.S. This is the relevant LCME accreditation standard effective July 1, 2019; note the similarity in language of 3.3 and the new ACGME CPR on diversity and inclusion:

“Standard 3: Academic and Learning Environments

A medical school ensures that its medical education program occurs in professional, respectful, and intellectually stimulating academic and clinical environments, recognizes the benefits of diversity, and promotes students’ attainment of competencies required of future physicians.

3.3 Diversity/Pipeline Programs and Partnerships

A medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.”

Both the LCME accreditation standard and the new ACGME CPR on diversity and inclusion advance diversity/inclusion as a driver for health equity and disparities reduction (Nivet, 2011). Since this is a new ACGME accreditation standard effective July 1, 2019, that all residencies and fellowships must implement, this general session will help attendees understand the new CPR on diversity and inclusion and how to take concrete action steps towards meeting the accreditation standard. Evaluating the inclusive nature of one's institution is one such concrete action. The Diversity and Engagement Survey (DES) is a survey tool that can be used to evaluate and assess institutions for engagement and inclusion (Sharina, et al., 2015)

**Abstract**
This workshop will first describe the meaning and significance of the new ACGME Common Program Requirement (CPR) on diversity and inclusion that is an accreditation standard for all residencies and fellowships of all specialties effective July 1, 2019. Secondly, the general session presenters will summarize a checklist of concrete specific action steps that residency and fellowship programs can take towards meeting this new accreditation standard based on the work of the AADPRT Diversity and Inclusion Committee's review of the literature. Recruitment of a diverse physician workforce is a necessary step, but it is not the only step that programs and organizations should undertake. Recruitment and retention will only occur if there are culturally competent, welcoming and safe environments for individuals to thrive within. Many programs are grappling with how to attain and adhere to this standard of inclusion in an effective and meaningful way. Everyone, including department chairs, hospital administration, residency leadership, faculty, staff, and other allies have a role in this mission of attaining a diverse and inclusive environment. We will define and describe action steps institutions have taken to increase the eight inclusion factors that form the framework for the Diversity Engagement Survey (DES) to highlight the behaviors necessary for an inclusive environment: common purpose, trust, appreciation of individual attributes, sense of belonging, access to opportunity, equitable reward and recognition, cultural competence, and respect. An interactive audience-response exercise will allow participants to assess their own institution for these eight inclusion factors. Finally, the general session will engage the participants in focused small group discussions to identify opportunities, challenges, and resources for increasing inclusion factors in their own institutions.

**Agenda**
0:00: Introduction to workshop and presenters: Chair Tracey Guthrie
0:05: Presentation on the meaning and significance of the new ACGME Common Program Requirement on diversity and inclusion: Francis Lu
0:13: Review of a framework for a strategic plan on diversity and inclusion: Francis Lu
0:20: Review of the DES (Diversity and Engagement Survey) and the 8 inclusion factors that form the framework of the DES: Tracey Guthrie
0:40: Assessing your institution's climate for inclusion: Interactive experience with the DES for participants using poll everywhere: Ana Ozdoba and Saira Kalia
0:45: Discussion of the results of the interactive experience: Ana Ozdoba and Saira Kalia
0:55: Small group with each presenter leading a small group
0:80: Report back and Large group discussion: Tracey Guthrie

**Scientific Citations**

1. ACGME Common Program Requirements, effective July 1, 2019: https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements. Note that the same CPR accreditation standard on diversity and inclusion exists in both the "Residency" and "Fellowship" documents.
2.. LCME Functions and Structure of a Medical School - (contains the LCME Standards), effective July 1, 2019: http://lcme.org/publications/
3. AAMC Roadmap to Diversity: Integrating Holistic Review Practices into Medical School Admission Processes, 2010 https://members.aamc.org/eweb/upload/Roadmap%20to%20Diversity%20Integrating%20Holistic%20Review.pdf
4. Nivet, M. Commentary: Diversity 3.0: A Necessary Systems Upgrade. Acad Med. 2011;86:1487–1489.
5. University of California Office of the General Counsel. Guidelines for Addressing Race and Gender Equity in Academic Programs in Compliance with Proposition 209, July 2015: https://www.ucop.edu/general-counsel/_files/guidelines-equity.pdf
6. Lim, R.F., Luo, J.S., Suo, S. et al. Diversity Initiatives in Academic Psychiatry: Applying Cultural Competence. Acad Psychiatry (2008) 32: 283. https://doi.org/10.1176/appi.ap.32.4.283
7. Stewart, A. Diversity and Inclusion Matter in Continuing Education Efforts. Published Online:12 Oct 2018 https://doi.org/10.1176/appi.pn.2018.10b15
8. Measuring Diversity and Inclusion in Academic Medicine: The Diversity Engagement Survey Sharina Person;C. Jordan;Jeroan Allison;Lisa Fink Ogawa;Laura Castillo-Page;Sarah Conrad;Marc Nivet;Deborah Plummer; Academic Medicine. 90(12):1675–1683, December 2015. https://www.ncbi.nlm.nih.gov/pubmed/26466376

## Screening strategies for the next generation of successful residents – Balancing metrics and holistic review

**Presenters**

Robert Cotes, MD
Gretchen Gavero, DO
Alan Koike, MD
Amy Adams
Jessica Kovach, MD

**Educational Objective**

1. Identify a program-specific definition of the "successful resident" and describe potential predictors of success at the screening stage of the interview process
2. Consider how and which metrics (i.e. USMLE scores, class rank, medical school ranking) play a role in the screening process

3. Define the term holistic review and describe the AAMC's Experience-Attributes-Metrics Model
4. Identify practical, program-specific methods of incorporating metrics with holistic review when screening applicants

**Practice Gap**

The average ACGME-accredited Psychiatry Residency received over 1000 applications in each of the last three years. Data from the 2018-2019 recruitment season indicate that the number of US and Canadian graduates applying to psychiatry has more than doubled since 2012, and, by traditional metrics, such as USMLE scores and AOA status, the quality of applicants is rising. Many programs struggle to find the resources to adequately screen the large number of applications they receive each year, and programs may be tempted to increasingly rely on a metric-driven approach. Per the 2018 NRMP Program Director Survey, psychiatry programs identified the USMLE Step 1 score and the Medical Student Performance Evaluation (MSPE) as the two most frequently cited factors in selecting an applicant to interview (each at 91%). While evaluating and prioritizing metrics can save time, program directors could miss well-qualified applicants, as it is unclear to what extent USMLE scores predict residency performance in psychiatry. Furthermore, beginning in July 2019, Common Program Requirements now require that programs, in partnership with their sponsoring institutions, engage in "mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce." When faced with this growing number of applications, how can program directors approach each applicant in a holistic way?

**Abstract**

This workshop will present strategies for programs to help select the applicants that are the best fit for an individual program at the screening stage. The audience will initially reflect inward about how a successful resident is defined, and what may be the predictors of success at their individual program.

The workshop will consist of the following components: 1) participants will reflect inward about the predictors of success at one's own program, 2) presenters will discuss an ongoing, multi-site project to identify possible predictors of success among psychiatry trainees, 3) presenters will introduce the concept of holistic review, and 4) presenters will provide an example of a holistic review being utilized at two programs and discuss how other programs may implement these concepts.

According to the AAMC, "Holistic review is a flexible, individualized way of assessing an applicant's capabilities by which balanced consideration is given to experiences, attributes, and academic metrics and, when considered in combination, how the individual might contribute value as a medical student and physician." In fact, 91% of medical schools self-reported in 2013 that they utilized a holistic review process. While this review process may be more time-intensive than that utilized by most Psychiatry residency programs, the AAMC reports that it has been successful in achieving more diverse undergraduate medical classes.

Beginning in July 2019, Common Program Requirements now require that programs, in partnership with their sponsoring institutions, engage in "mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce."

By contrast, the AAMC reported that 91% of schools self-reported in 2013 that they utilized a "holistic review" process. According to the AAMC, "Holistic review is a flexible, individualized way of assessing an applicant's capabilities by which balanced consideration is given to experiences, attributes, and academic metrics and, when considered in combination, how the individual might contribute value as a medical student and physician." While this review process may be more time-intensive than that utilized by most Psychiatry residency programs, the AAMC reports that it has been successful in achieving more diverse undergraduate medical classes.

**Agenda**

0:00 – 00:10: Introductions, goals & objectives

00:10 – 00:15: Individual exercise - Define program-specific definition of resident success. On a worksheet, participants will identify what experiences, attributes, and metrics they think best predict their program-specific definitions of success.

00:15 – 00:25: Group exercise - Discuss potential top 5 predictors of success in applicants and list 3 ways that programs try to screen for each predictor in the recruitment process

0:25 – 0:35: Large group debrief

0:35 – 0:45: Presentation of the "Predictors of Success" research project. We will discuss the methodology, preliminary results, and limitations.

0:45 – 0:55: The presenters will introduce the holistic review process at the undergraduate medical education level, including potential impact of this process on mission-specific diversity outcomes.

0:55 – 1:15: Application of holistic review at two psychiatry residency programs.

1:15 – 1:25: Large Group Debrief, focused on the practical application of holistic review.

1:25 – 1:30: Conclusion

**Scientific Citations**

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf
https://www.aamc.org/services/eras/stats/359278/stats.html
https://www.aamc.org/initiatives/holisticreview/

# Assessing Competency in Psychodynamic Psychotherapy

**Presenters**
Randon Welton, MD
Deborah Cabaniss, MD
Erin Crocker, MD
Sindhu Idicula, BA, MD
Bianca Nguyen, MD, MPH

**Educational Objective**
By the end of this workshop participants will be able to:
- Discuss what priorities, attitudes, and techniques define competency in psychodynamic psychotherapy
- Describe psychodynamic psychotherapy evaluation forms created by the American Association of Directors of Psychiatry Residency Training's (AADPRT) Psychotherapy Committee
- Practice using AADPRT tools to evaluate the conduct of psychodynamic psychotherapy
- Evaluate the usefulness of the AADPRT tools to evaluate psychodynamic psychotherapy

**Practice Gap**
Psychodynamic Psychotherapy has long been a cornerstone of psychiatric practice. The ACGME requires that psychiatry residents demonstrate competency in psychodynamic psychotherapy. The ACGME's Psychiatry Milestones include "providing psychodynamic psychotherapy to patients with moderately complicated problems" as one of the Level 4 anchor points for Patient Care 4 - Psychotherapy. Measuring competence in psychodynamic psychotherapy presents a challenge to psychiatry residency programs. This challenge has increased as fewer psychiatrists have extensive training or experience in psychodynamic psychotherapy. There are no widely available tools to assist in directly measuring competence in psychodynamic psychotherapy.

**Abstract**
The Accreditation Council for Graduate Medical Education requires that all graduating psychiatry residents are competent in managing and treating patients using brief and long-term cognitive behavior therapy, supportive psychotherapy, and psychodynamic psychotherapy. Developing didactics covering the basics of psychotherapy is relatively straightforward. Evaluating knowledge about psychotherapy can be conducted through simple multiple-choice questions. Measuring competency in psychotherapy is more difficult. Cognitive Behavior Therapy can be assessed using the Cognitive Therapist Rating Scale. AADPRT's Psychotherapy Committee has previously created tools to assess competency in Supportive Therapy. Assessing competency in psychodynamic psychotherapy, however, presents a new challenge. Often competency is merely assumed based on the number of hours a resident spends providing therapy. Assessment of psychodynamic psychotherapy competency is often relegated solely to the individual psychotherapy supervisor based on discussions of the care provided or observing video/audio recordings of therapy sessions. This interactive workshop presents new assessment tools created by the AADPRT Psychotherapy Committee. One of the tools evaluates the resident's demonstrations of the priorities and attitudes of a psychodynamic

psychotherapist while the other assesses the resident's use of psychodynamic interventions. The tools will be explained and then participants will practice using the tools to evaluate video examples of psychodynamic psychotherapy. Participants will then share ideas for improving the usefulness of these tools.

**Agenda**

Introduction and goals (Didactic presentation)
5 minutes
The difficulties in demonstrating competency in psychodynamic psychotherapy (Didactic presentation)
15 minutes
How might competency in psychodynamic psychotherapy be demonstrated? (Large Group Discussion)
10 minutes
Introducing the tools (Didactic presentation)
- Psychodynamic Psychotherapy – Priorities
- Psychodynamic Psychotherapy – Interventions
15 minutes
Video presentations of psychodynamic psychotherapy (video)
15 minutes
Using the Psychodynamic Psychotherapy Tools to rate psychodynamic psychotherapy (Small group discussion)
15 minutes
Improving the tools (Large Group Discussion)
10 minutes
Closing comments (Large Group Discussion)
5 minutes

**Scientific Citations**


- Bienenfeld D., Klykylo W., Lehrer D. Closing the Loop: Assessing the Effectiveness of Psychiatric Competency Measures. Academic Psychiatry. 2003; 27: 131-135.
- Liston EH., Yager J., Strauss G.D. Assessment of Psychotherapy Skills: The Problem of Interrater Agreement. American Journal of Psychiatry. 1981; 138: 1069-1074.
- Manring J., Beitman B.D., Dewan M.J. Evaluating Competence in Psychotherapy. Academic Psychiatry. 2003; 27: 136-144.
- Ravitz P., Lawson A., Fefergrad M., Rawkins S., Lancee W., Maunder,R., Leszcz M., Kivlighan D.M. Psychotherapy Competency Milestones: an Exploratory Pilot of CBT and Psychodynamic Psychotherapy Skills Acquisition in Junior Psychiatry Residents. Academic Psychiatry. 2019; 43: 61-66.
- Weerasekera P., Manring J., Lynn D.J. Psychotherapy Training for Residents: Reconciling Requirements With Evidence-Based Competency-Focused Practice. Academic Psychiatry. 2010; 34: 5-12.
- Yager J., Bienenfeld D. How Competent Are We to Assess Psychotherapeutic Competence in Psychiatric Residents. Academic Psychiatry. 2003; 27:174-183.

# Innovations for Clinical Teaching on a Busy CL Service

**Presenters**
Amelia Dubovsky, MD
Thomas Soeprono, MD

**Educational Objective**
By the end of this workshop, learners will be able to:
1. Identify barriers to education in the unique confines of a busy CL service.
2. Apply strategies necessary to foster a healthy learning environment in a complex setting.
3. Practice multimodal approaches of education grounded in learning theory specific to CL clinical work.

**Practice Gap**
Providing education on a busy psychiatric consultation service is challenging due to complex patient and provider schedules and frequent interruptions necessary to provide urgent medical attention. The team is often fractured, covering multiple cases at once to ensure timely patient care. The rapid turnover of patients, team members, and students presents a need for redundancy in reviewing common consult-liaison educational topics. Despite attempts to incorporate teaching into clinical practice, education is often separated in space and time from relevant clinical cases, and at times neglected entirely when a service is busy.

**Abstract**
Providing education on a busy psychiatric consultation service is challenging due to complex patient and provider schedules and frequent interruptions necessary to provide urgent medical attention. The team is often fractured, covering multiple cases at once to ensure timely patient care. The rapid turnover of patients, team members, and students presents a need for redundancy in reviewing common consult-liaison educational topics. Despite attempts to incorporate teaching into clinical practice, education is often separated in space and time from relevant clinical cases, and at times neglected entirely when a service is busy.

This workshop will address these unique challenges in clinical education by proposing 4 alternate educational strategies for incorporating teaching into a busy clinical practice. First, helping learners approach difficult consult subjects requires an environment of safety and a growth-mindset. Dr. Dubovsky will demonstrate and explain the methods and principles she has used to open the minds of her learners in the midst of the chaos of a busy consult service.

Second, Dr. Soeprono has developed the “Layered Teaching Model” which is method of teaching that incorporates clinical education into practice using brief video lectures, clinical guidelines summarized in flowchart maps, and questions to help learners assess their knowledge and to facilitate larger medical team discussions. Learners utilize this multimodal teaching model through the use of technology which enables just-in-time education based on Adult Learning Theory principles. Learners are able to optimize their education in real time with real clinical patient encounters.

Third, we will describe and exhibit ultra-brief chalk talks and Socratic questioning techniques specific to the CL setting. While bedside teaching remains a critical form of resident teaching, a new generation of learners has become accustomed to a more systematized teaching approach. Attendees will learn Dr. Dubovsky's use of the "Daily Pearl" to both ground education and provide a framework for teaching points. Lastly, Dr. Soeprono's "Patient-Centered Clinical Didactics" will be described and put to use. This is an innovative way to provide relevant patient focused education for those seeking CL educational approaches for the outpatient setting.

**Agenda**

1. Current state of CL education EXERCISE: Groups of 3 will discuss the ways that residents and medical students are currently educated on the CL service at their home institution. (10 min)
2. Unique barriers to CL education DIDACTIC: Explanation of how CL is different in its learning environment and subject matter. Discussion of CL clinical pedagogical knowledge and the implications thereof. (10 min)
3. Proposals for learner barrier solutions EXERCISE: Groups of 3 will create proposals for solutions to the previously discussed barriers to CL education. (15 min)
4. Layered Teaching Model DEMONSTRATION (10 min)
5. Role play with Dr. Dubovsky and Dr. Soeprono presenting the "Daily Pearl" DEMONSTRATION (10 min)
6. Patient-Centered Clinical Didactics DEMONSTRATION (10 min)
7. CL education change commitment EXERCISE: Groups of 3 will formulate plans for implantation and practice of newly acquired methods of education for their home CL service. We will ask that learners provide support and accountability for one another in these efforts though a point of contact at a deadline beyond the AADPRT meeting. (15 min)
8. QUESTIONS (10 min)

**Scientific Citations**

Asher A, Kondziolka D, Selden NR. Addressing deficiencies in American healthcare education: a call for informed instructional design. Neurosurgery. 2009 Aug;65(2):223-9; discussion 229-30. doi: 10.1227/01.NEU.0000348010.12339.1E.

Goldman S. The Educational Kanban: promoting effective self-directed adult learning in medical education. Acad Med. 2009 Jul;84(7):927-34. doi: 10.1097/ACM.0b013e3181a8177b.

Gonzalez CM, Bussey-Jones J. Disparities education: what do students want? J Gen Intern Med. 2010 May;25 Suppl 2:S102-7. doi: 10.1007/s11606-010-1250-z.

Irby, David M. Excellence in clinical teaching: knowledge transformation and development required. Medical Education 48: 776-784; 2014.

Kassirer JP. Teaching clinical reasoning: case-based and coached. Acad Med. 2010 Jul;85(7):1118-24.

Kern, David E. et al. Curriculum Development for Medical Education: A Six-Step Approach. Johns Hopkins University Press: Baltimore and London, 2006.

Ruiz J, Mintzer M, Leipzig R. The Impact of E-Learning in Medical Education. Academic Medicine, Vol. 81, No. 3 / March 2006.

Shulman, Lee S. Knowledge and Teaching: Foundations of the New Reform. Harvard Educational Review Vol. 57, No. 1 Feb 1987.

Sisson SD1, Hill-Briggs F, Levine D. How to improve medical education website design. BMC Med Educ. 2010 Apr 21;10:30. doi: 10.1186/1472-6920-10-30.

Wei, Marlynn H. et al. Teaching Trainees about the Practice of Consultation-Liaison Psychiatry in the General Hospital. Psychiatr Clin N Am 34, 689-707, 2011.

## The Impact of Patient Suicide on Psychiatry Trainees: How do we respond?

**Presenters**
Zheala Qayyum, MBBS, MD
Jeffrey Hunt, MD

**Educational Objective**

- Participants will understand the impact of patient suicide on trainees in psychiatry, with a focus on appreciating the expected emotional and psychological responses.
- Participants will explore how academic and non-academic medical settings respond to patient suicide.
- Participants will be better prepared to respond to the needs of trainees as supervisors, in the event the trainee's patient dies by suicide.
- Participants will appreciate the challenges of transition into independent practice in the context of completed suicides during the early years out of training.

**Practice Gap**

Suicide is now the second leading cause of death in adolescents and young adults. Center for Disease control and National Institute for Mental Health have reported continued rise of 24 % in the suicide rates over the last fifteen years. Many of our trainees will experience this during their General Psychiatry residency years or during their Child and Adolescent Fellowship training. However, the supervision and guidance around managing the emotional burden is highly variable. The impact of patient loss is often unrecognized and many training institutions do not have formal programmatic supports in place for such an occurrence. Timely oversight and support from supervisors can provide a safe place to explore and process the difficult

experience of patient loss due to suicide. The improved comfort and knowledge of supervisors around providing this type of supervision in particular can have a positive impact on trainee experience and learning. Furthermore, focus on adolescent cases will better prepare trainees to respond to the current increase in suicidal behavior in that population. However, there are no formal guidelines that indicate what should be expected in supervision by the trainee.

**Abstract**
Background:

Suicide has become the second leading cause of death in adolescents and young adults ages 15-34 and the third leading cause of death in individuals between the ages of 10-14 in the US. About 30-60% of General Psychiatry Residents experience patient suicide during their training; however, currently there are no formal guidelines for either the supervisor or supervisee in educational practice.

Methods:

This study is a qualitative research project and utilized individual semi-structured interviews of trainees and supervisors identified by criterion sampling. Participants were recruited from General Psychiatry resident training and Child & Adolescent Psychiatry fellowship programs in New England. Eligible participants included: current psychiatry trainees and trainees who graduated in the last 2 years who have experienced the death of a patient they cared for from suicide; participants also included supervisory psychiatrists of psychiatry trainees when their patient committed suicide. Inductive thematic analysis of the transcribed interviews was performed to identify emerging themes.

Results:

Thematic analysis of the interview data identified a central theme of patient suicide being a life changing event for a psychiatrist. This was impacted by a sense of general unpreparedness at multiple levels, and affected by several medicating and complicating factors such as shared loss, supervisor credibility, patient characteristics and societal expectations.

Conclusions:

There is a significant lack of preparation on the part of institutions, on how to deal with the aftermath of a patient suicide. Key factors appear to influence the distress associated with the experience, and these findings together may inform the development of educational, programmatic and mentorship interventions to best support this process.

**Agenda**
1.Introduction
2.Physician experiences of patient suicide
3.Presentation of pertinent research and available data

4.Discussion regarding the impact of patient suicide on trainees and early career psychiatrists
5.Small group discussions of strategies for improving supports for trainees (15 min discussion + 10 mins to report out and discuss). Depending on the number of attendees, we will divide the audience into small groups or do a large-group discussion if needed.
- 3-5 small groups (or a large group) facilitated by presenters
- ask the groups to discuss the following question:
a) What would be helpful to you when dealing with patient suicide? What would work in your institution?
b) Is there anything that the training program could do to help anticipate the impact of suicide on trainees and early career psychiatrists?
- in the last 10 min, ask each group to share their answer with the large audience
6.Proposed recommendations & Concluding remarks
7. Questions

**Scientific Citations**

1) Balon, R. (2007). Encountering patient suicide: The need for guidelines. Academic Psychiatry. https://doi.org/10.1176/appi.ap.31.5.336
2) Biermann, B. (2003). When depression becomes terminal: the impact of patient suicide during residency. The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 31(3), 443–457. https://doi.org/10.1521/jaap.31.3.443.22130
3) Cazares, P. T., Santiago, P., Moulton, D., Moran, S., & Tsai, A. (2015). Suicide Response Guidelines for Residency Trainees: A Novel Postvention Response for the Care and Teaching of Psychiatry Residents who Encounter Suicide in Their Patients. Academic Psychiatry. https://doi.org/10.1007/s40596-015-0352-7
4) Deringer, E., & Caligor, E. (2014). Supervision and responses of psychiatry residents to adverse patient events. Academic Psychiatry, 38(6), 761–767. https://doi.org/10.1007/s40596-014-0151-6

## Curriculum Development: Step By Step From Finish to Start

**Presenters**

Jacqueline Hobbs, MD, PhD
Paul Lee, MD, MPH

**Educational Objective**

Upon completion of this workshop, participants will be able to 1) (re-)define curriculum, 2) apply different models of curriculum design and development, 3) conceptualize short and comprehensive residency/fellowship curricula, 4) identify and discuss goals for short- and long-term curriculum development.

**Practice Gap**

Curriculum development can be a daunting challenge for any program director, whether new to the job or seasoned. The AADPRT Curriculum Committee's goal is to empower and assist

program directors and other teaching faculty in their efforts to develop new curricula or re-design existing curricula by providing foundational education, skills and resources.

**Abstract**
Curriculum development is both an art and science that many program directors and teaching faculty in academia likely were not taught during their medical education. Curriculum development is often thrust upon training directors and may have to be learned in a very random way via on-the-job learning and training. The AADPRT Curriculum Committee seeks to encourage and assist members in their curriculum development journey. In this workshop, graduate medical education curriculum will be broadly defined. Participants will receive an overview of two major and well-known curriculum development models: Wiggins and McTighe's backward design and Kern's 6-step approach. The co-leaders will elaborate on their own curriculum development journeys that are each based off the two major models and elicit participants' similar and different experiences.

Curriculum development goal-setting will be demonstrated and practiced. Practical suggestions as well as textbook, journal, and web-based resources (including the AADPRT Virtual Training Office curricular offerings) for curriculum development will be shared with participants. This workshop and the leaders will provide guidance, support, templates, resources, and encouragement for members to reach their goals for developing their curricula that can be submitted for peer review to the AADPRT Curriculum Committee. Each participant will have produced overall short- and long-term goals and plans for their own curriculum development by the end of the session for their professional use.

**Agenda**
This workshop will be interactive with individual and small-group participation and feedback. Participants are strongly encouraged to bring their ideas for areas they would like to consider for curriculum development to this workshop, but an open mind and blank slate are welcome as well. Participants are encouraged to bring a laptop computer, tablet, or their phones for taking notes and reviewing web-based information.

- Introduction/Didactic: 25 minutes
- Individual/Small-Group Discussion:10 minutes
- Goal-Setting Demonstration and Practice: 20 minutes
- Interactive demonstration of online and other resources: 15 minutes
- Q&A: 15 minutes
- eedback and evaluation: 5 minutes

**Scientific Citations**
Benson NM, Puckett JA, Chaukos DC, Gerken AT, Baker JT, Smith FA, Beach SR: Curriculum overhaul in psychiatric residency: an innovative approach to revising the didactic lecture series. Acad Psychiatry 42:258-261, 2018.

Sexton JM, Lord JA, Brenner CJ, Curry CE, Shyn SI, Cowley DS: Peer mentoring process for Psychiatry Curriculum Revision: Lessons Learned from the "Mod Squad". Acad Psychiatry 40:436-440, 2016.
Thomas PA, Kern DE, Hughes MT, Chen BY (Eds). (2016). Curriculum Development for Medical Education: A Six-Step Approach (3rd ed). Baltimore,MD: Johns Hopkins University Preess.
VanLehn K: Cognitive skill acquisition. Annu Rev Psychol 47:513-539, 1996.
Wiggins G, McTighe J: Understanding by Design, 2nd Edition. Alexandria, VA, Association for Supervision and Curriculum Development, 2005.

## Separating Signal from Noise: Is Your Program being Viewed Accurately by Applicants?

**Presenters**

Lia Thomas, MD
Anna Kerlek MD
Daniel Gih, MD
Shambhavi Chandraiah, FRCP(C), MD
Marcy Verduin, MD

**Educational Objective**

1. Describe and assess the various tools and resources that are currently available to residency applicants for learning about psychiatric residency programs (eg. ApplySmart, Residency Explorer, and third party programs like Doximity, Reddit, podcasts, etc.)
2. Analyze potential proactive use of social media in residency recruitment.
3. Develop a promising plan to bolster one's online presence in order to market a program's unique missions and attributes.

**Practice Gap**

There are numerous sites and programs that now offer applicants information about how to apply to residency programs. It is important for psychiatry program directors and coordinators to be aware of this information of how this information is being accessed and viewed by medical students, medical student deans, and graduate medical education leadership. Awareness of this information can allow a program to better assess their program's image, and to provide correction to better reflect the program. In addition, program directors and coordinators may need to actively manage program perceptions and promote more accurate information.

Coupled with the growth of new ways to look at psychiatry programs, the number of new accredited psychiatry residency programs has been increasing rapidly in recent years. According to the Accreditation Council for Graduate Medical Education, twelve new psychiatry residencies were accredited between 2012 and 2015, while fifty-six new programs were accredited between 2015 and 2018. Newer programs may have a disadvantage over more established ones as there is not a track record to reference. However both new and established programs

can benefit from strategic marketing and identifying novel ways to present their programs to applicants.

**Abstract**
The AAMC notes that medical student enrollment has been increasing at a far greater pace than residency positions. With the recent elevation in interest in Psychiatry as a career choice, competition for residency slots has amplified. Students and advisors thus want more nuanced information to help students better determine program fit. Similarly program directors may want to better identify applicants with genuine interest by highlighting specific aspects of their program. Programs need to carefully attend to the various venues in which information is being obtained, shared, and exchanged about their programs, and how applicants might utilize this in decisions to apply or interview.

Participants will be encouraged to bring laptops and their programmatic mission statement to the workshop for active group work. They will examine their program's data on at least one external site during this workshop.

This workshop will describe the existing websites and sources commonly used by students. Presenters will review advantages and disadvantages of each current method of information dissemination and describe program directors' experiences attempting to edit such information. Participants will also be asked to share their experiences in editing data as well. A demonstration of Twitter and a new program's plan to highlight their unique features will be shared for group discussion.

Finally, participants will be asked to identify a new plan for enhancing their presence on websites and social media. There will be small group and large group discussion so that all attendees can identify resources and resolve potential barriers.

**Agenda**
Presentation: 15 min - Advantages/disadvantages of various existing websites commonly used by students to gather information about programs. (Specific institutions may be selected for these searches)
Small group activity: 20 min - Established programs and newer programs will discuss and share the pros and cons of the current resources and practices.
Large group: 5 min - presentation of small group summaries
Presentation: 15 min - New program's plan to highlight their unique aspects on social media
Small group activity: 20 min - Identify barriers and ways to promote your program on websites and social media.
Large group: 5 min - presentation of small group summaries
Summary & Homework: 10min - Each person identifies one task and a partner to be held accountable to enhance their own program presence on websites/social media.

**Scientific Citations**
Agapoff JR 4th1, Tonai C2, Eckert DM2, Gavero G2, Goebert DA2. Challenges and Perspectives to the Rise in General Psychiatry Residency Applications. Acad Psychiatry. 2018 Oct;42(5):674-676. doi: 10.1007/s40596-018-0923-5. Epub 2018 Jul 5
Apply Smart :Data to Consider when applying to Residency, American Association of Medical Colleges. https://students-residents.aamc.org/applying-residency/apply-smart-residency/.html, Accessed October 16, 2019
Guide to Applying for Psychiatric Residency. https://www.psychiatry.org/residents-medical-students/medical-students/apply-for-psychiatric-residency Accessed 10/16/19

Sterling et al. "The Use of Social Media in Graduate Medical Education: A Systematic Review" Academic Medicine 2017, 2(7): 1043–1056

## Once Again, It Wasn't Done!: How to have Professional Accountability Conversations that Promote Learning and Lessen Stress

**Presenters**
Jane Ripperger-Suhler, MA, MD
Kari Wolf, MD
Charla Clark
Kari Whatley, MD

**Educational Objective**

- Prepare yourself for a productive accountability conversation
- Create a safe environment in which to have an accountability conversation
- Determine a plan which includes WWWF (who, what, when, follow up)

**Practice Gap**
Physicians have many responsibilities for which they must account. Part of the development of professionalism in residents involves learning to balance and a willingness to be held accountable for those responsibilities. At the same time, residents are employees of an organization and provide a crucial segment of the workforce. Their actions have an impact on the success of the organization. Program directors often find themselves in conflict between their role as a support for residents' growth and learning and as the manager with expectations for performance and as such sometimes find it challenging to hold residents accountable for their actions without resorting to punitive means.

**Abstract**
Holding others accountable for actions or lack of actions can often involve conversations that seem awkward and confrontational and therefore is a task often avoided. The development of accountability skills is a crucial component of the leadership toolbox. Kerry Patterson and his colleagues in the book, Crucial Accountability: Tools for Resolving Violated Expectations, Broken Commitments, and Bad Behavior present a framework for developing these skills that

we will share with participants as we practice and strengthen our skills together. There are three main parts to having successful accountability conversations. In this workshop, we will explore how to prepare oneself for a productive accountability conversation, when and if to have a conversation and how to plan for an honest discourse when emotions are high. We will discuss and practice creating a safe environment in which to have an accountability conversation. And finally we will learn to finish the conversation by determining a plan with who, what, when, and follow up actions.

**Agenda**
Self assessment - warm up
Intro ppt 5 min
1-2-4-all discussion of accountability situations 15 min
“Work on me first” ppt 5 min
1-2 discussion of getting your story straight 10 min
"Creating safety” ppt 5 min
Scripted role play practice - 20 min (10 min each)
“Move to action”ppt 5 min
Role play practice eliciting an action plan using template 15 min
Wrap-up with discussion and re-assessment - 10 min

**Scientific Citations**
Patterson K, et al: Crucial Accountability: Tools for Resolving Violated Expectations, Broken Commitments, and
Bad Behavior, McGraw-Hill, 2014.
Sanfey H et al: Pursuing professional accountability: An evidence-based approach to addressing residents with behavioral problems, Arch Surg 147(7):642-647, 2012.
Bhatt A, et al: Improving compliance: Pediatric resident accountability using peer pressure, Academic Pediatrics, 19(6): E33, 2019

## Saving Dr. Caufield: Modeling Vulnerability to Shift Away from a Culture of Maladaptive Perfectionism

**Presenters**
Sansea Jacobson, MD
Julie Chilton, MD
Colin Stewart, MD
Kayla Isaacs, BA
Andres Martin, MD

**Educational Objective**
1. Participants will examine their own implicit bias related to perfectionism, making medical errors, and physician mental health struggles

2. Participants will be able to describe positive and negative consequences related to self-disclosures of their own vulnerabilities at different stages within one's career
3. Participants will learn how to counsel physician trainees and colleagues on how and when they might choose to engage in self-disclosure as a means to promote the acceptance of our own humanity and to normalize self-care
4. Participants will be introduced to practical evidence-based approaches to destigmatize physician mental illness and stress-related conditions and decrease obstacles to care within their home institutions

**Practice Gap**

Physicians have long held themselves to unattainable standards. With ever increasing systemic pressures, our resiliency as a professional body is being tested. Furthermore, there are growing concerns about untreated physician mental illness given increasing rates of physician depression, substance use disorders, and death by suicide. It is critical that physicians are able to access care confidentially and easily with as little disruption to their careers, professional identities, and personal lives as possible. Furthermore, there needs to be a focus on changes to healthcare systems and the culture of medicine to improve physician and trainee well-being, but systemic change will take time. In the meantime, we need to increase the likelihood that the growing numbers of struggling physicians and trainees access care and confront the inevitability that we will all make mistakes and all have personal flaws. Medical errors or even the perception of having made an error is a significant risk factor for physician suicide, yet senior physicians do not commonly discuss their own mistakes and imperfections to trainees. It is not surprising, then, that study after study show that stigma-related concerns are the oft-cited reasons physicians and trainees do not seek help for mental health and stress-based issues. In a recent survey of almost 900 medical students, only one-third sought help for burnout, and more than half of those trainees believed that residency directors would pass over their application and supervisors would see them in a less favorable way if they were aware the student had an emotional and/or mental health problem. These findings are not only discouraging, they are dangerous. It is known that transitioning from medical school to residency is a period of heightened risk with one study showing suicidal ideation increasing 370% over the first 3 months of internship. In response to growing concerns related to burnout and factors threatening physician wellness, the Accreditation Council for Graduate Medication Education (ACGME) updated the Core Program Requirements to include language related to resident and faculty well-being. While these new requirements exist, there continues to be a lack of best practices for program directors to follow in order to address physician well-being comprehensively or in an evidence-based fashion. Program directors invested in leading such well-being initiatives need specific evidence-based approaches and guidance to do so safely.

**Abstract**

By promoting physician vulnerability and self-care as the norm, rather than something to be ashamed of, physicians and trainees would be more likely to get help when they begin to struggle, preventing progression to impairment. Preliminary findings in a recent study show that more than 90% of medical students surveyed agreed with the statement that "knowing doctors further along in their careers (residents, deans, attendings, professors) who struggled

with mental health issues, got treatment, and are now doing well, would make me more likely to access care if I needed it." Fortunately, residency program directors are uniquely positioned to help. Given their bridging role between training and practice, program directors are more likely to be aware of physician leaders within their academic communities who may be willing to serve as such wellness role models. In this workshop, we propose a method to enact meaningful change within a residency wellness initiative by teaching local physician leaders how to judiciously self-disclose overcoming personal, professional, and/or mental health struggles. This will in turn serve to decrease maladaptive perfectionism, destigmatize mental illness and promote self-care and help-seeking behaviors among physicians where such change is implemented. During the session, we will define "self-disclosure" in the context of physician well-being education and advocacy. Audience members will then be guided in an examination of their own implicit biases related to vulnerabilities like making medical errors and physician mental illness. We will then explore the potential positive and negative consequences of physician self-disclosure at different stages of one's career. Lastly, self-disclosure will be modeled, and participants will have an opportunity to learn how to be an effective mentor to individuals who are contemplating self-disclosure at their home institutions. By the end of the workshop, participants will have a practical understanding of an easy-to-implement intervention to promote a shift in perceptions and a more humane and accepting culture within their own academic community.

**Agenda**

During this interactive workshop, we will provide a summary of the prevalence of mental health and stress-related issues that physicians and trainees face as perfectionistic individuals in a high-pressure system, within a culture that historically has not encouraged help-seeking. We will then define the concept of physician "self-disclosure" as it pertains to overcoming personal and professional struggles and/or seeking treatment for mental illness. Presenters from different institutions and at every level of professional development (from medical student, to resident, to attending, to national physician leaders) will help provide a framework and facilitate small-group interactive exercises: (1) exploring implicit bias related to imperfection and mental illness, (2) determining the pros and cons of different methods of self-disclosure at different stages of one's career, (3) learning how to counsel physicians on productive self-disclosure in order to improve self-care and help-seeking behaviors among colleagues and trainees. Finally, we will engage our audience in a panel discussion. Topics likely to be discussed during the panel include: how to assure appropriate services are in place to support the changing culture, discussion of other evidence-based methods to improve access to mental health care for physicians, and next steps for sharing ideas, resources and best practices going forward.

The format of the 90min session will be organized as follows:

1. Introduction (5min)
2. Why don't Physicians Seek Mental Health Care? (10min)
3. Exercise 1 – Explore your own implicit bias related to physician mental illness (10min)
4. Self-Disclosure: How can we assure self-disclosure narratives are intentional and safe (10min)
5. Exercise 2 – Examine the natural consequences of self-disclosure (10min)

6. A case example: How a prominent physician leader recognizes their radar is broken (10min)
7. Exercise 3 – Practice coaching physicians who intend to self-disclose (15min)
8. Panel Discussion (15min)
9. Wrap-up (5min)

**Scientific Citations**

Dyrbye, LL, Eacker, A, Durning, SJ, Brazeau, C, Moutier, C, Massie, FS, Satele, D, Sloan, JA & Shanafelt, TD 2015, 'The Impact of Stigma and Personal Experiences on the Help-Seeking Behaviors of Medical Students with Burnout', Academic Medicine, vol. 90, no. 7, pp. 961-969. https://doi.org/10.1097/ACM.0000000000000655

Javier FG, Chilton J, Martin A: Wellbeing: Identification and prevention of burnout, depression and suicide among clinicians. J.M. Rey's IACAPAP e-Textbook of Child and Adolescent Mental Health 2019: J.12: 1-11

Martin A, Chilton J, Gothelf D, Amsalem D. Physician self-disclosure of lived experience improves mental health attitudes among medical students: a randomized study. Journal of Medical Education and Curriculum Development (in press).

S Rees, D Cohen, N Marfell, M Robling, Doctors' decisions when disclosing their mental ill-health, Occupational Medicine, Volume 69, Issue 4, June 2019, Pages 258–265, https://doi.org/10.1093/occmed/kqz062

van Uum RT, de Groot E, Mol SSL. Physician, disclose thyself! Self-disclosure as an educational tool (2018). Ned Tijdschr Geneeskd. 2018 Aug 30;162. pii: D2977. PMID: 30212004

NA Yaghmour, TP Brigham, T Richter, et al. Causes of Death of residents in ACGME-accredited programs 2000 through 2014: implications for the learning environment. Acad Med, 92 (2017), pp. 976-983. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5483979/

## The Hidden Factor In Trainee Wellness: Supporting Trainees who Experience Patient Aggression and Discrimination-Based Aggression/Harassment

**Presenters**

Sarah Mohiuddin, MD
Michael Jibson, MD, PhD
Adrienne Adams, MD, MSc

**Educational Objective**

1. Attendees will review the frequency and types of patient-related aggression that occur towards psychiatric trainees.
2. Attendees will identify risk factors for verbal aggression and harassment from patients including female gender and racial and ethnic minority status
3. Attendees will identify the role that faculty and training directors play in supporting trainees from minority populations following an episode of aggression
4. Attendees will design training and didactics around discrimination-based aggression

**Practice Gap**

Patient aggression and violence is a serious and unfortunate reality experienced by psychiatrists as well as psychiatric trainees over the course of their careers. Though aggression and violence directed towards psychiatrists have been addressed in the literature, few studies study the intersection of aggression from patients towards trainees and discrimination/harassment of minority trainees. As such, training programs and faculty often lack an understanding of how to prepare and support minority trainees when these events occur. There are even fewer programs that provide specific training in the assessment and management of discrimination-based aggression in psychiatric settings.

**Abstract**

Patient aggression towards training physicians is a well-known phenomenon. Despite a focus on physical aggression and assault, verbal aggression and harassment is reported as the most common form of aggression from patients towards trainees, with up to 86% of psychiatry residents reporting being verbally threatened by a patient. However, few studies have looked at the intersection of patient aggression and discrimination-based harassment and aggression. This is of particular importance as up to 60% of residents describe experiencing harassment or discrimination during their training. Verbal harassment is the most commonly cited type of discriminatory behavior, including high rates of reported harassment and discrimination from patients or patients' families. Current studies suggest under-reporting of aggressive episodes given that it may not be clear to trainees which behaviors warrant reporting or notification, as well as perceived risk for negative outcomes from training program. Residents also describe aggression-based harassment impacting decision-making related to program continuation and an overall sense of well-being. Recently, educational interventions focusing on addressing discrimination from patients have been described, but no current interventions specifically address harassment-based aggression. This workshop seeks to help educate training directors on the intersection of patient-aggression and discriminatory behavior towards trainees and help to design training and didactics around harassment-based aggression that meet the needs of our trainees.

**Agenda**

15 minutes Mohiuddin – Presentation on available data on patient aggression towards trainees in psychiatry

10 minutes Adams - Presentation on discrimination-based harassment towards trainees from supervisors, staff, and patients

10min - Small group discussion: Participants will break into groups and detail events related to aggression a that have taken place at their own institutions

10 Minutes Jibson – Presentation on addressing patient aggression/harassment as residency/fellowship programs and as program directors

45 minutes (all presenters): Two-part active learning session, will break into small groups with facilitators

Part 1: Specific scenarios of discrimination-based aggression are given to each group for discussion. We will plan to have each group discuss one scenario and describe acute safety

management, reporting strategies, debriefing, and how to support the trainee. Each group will then report their findings and thoughts to the larger group.
Part 2: Each person will then be given an opportunity to reflect on their own program, events that have occurred in the past, and their current state for training and education around harassment-based aggression towards trainees. They will then brainstorm ideas together on how to address barriers to the implementation of safety protocols and educational programming. Each group will then report their findings and thoughts to the larger group.

**Scientific Citations**

1) Schwartz, T. L., & Park, T. L. (1999). Assaults by patients on psychiatric residents: a survey and training recommendations. Psychiatric Services, 50(3), 381-383.
2) Whitgob, E. E., Blankenburg, R. L., & Bogetz, A. L. (2016). The discriminatory patient and family: strategies to address discrimination towards trainees. Academic Medicine, 91(11), S64-S69.
3) Wheeler, D. J., Zapata, J., Davis, D., & Chou, C. (2019). Twelve tips for responding to microaggressions and overt discrimination: When the patient offends the learner. Medical teacher, 41(10), 1112-1117.
4) Wasser, TD. (2015).How do we keep our residents safe? An educational intervention. Academic psychiatry, 39(1), 94-98.
5) Kwok, S., Ostermeyer, B., & Coverdale, J. (2012). A systematic review of the prevalence of patient assaults against residents. Journal of graduate medical education, 4(3), 296-300.
6) Coverdale, J., Gale, C., Weeks, S., & Turbott, S. (2001). A survey of threats and violent acts by patients against training physicians. Medical education, 35(2), 154-159.
7) Dvir, Y., Moniwa, E., Crisp-Han, H., Levy, D., & Coverdale, J. H. (2012). Survey of threats and assaults by patients on psychiatry residents. Academic psychiatry, 36(1), 39-42.
8) Goldenberg, M. N., Cyrus, K. D., & Wilkins, K. M. (2019). ERASE: a new framework for faculty to manage patient mistreatment of trainees. Academic Psychiatry, 43(4), 396-399.
9) Brenner, A. M., Coverdale, J., Guerrero, A. P., Balon, R., Beresin, E. V., Louie, A. K., & Roberts, L. W. (2019). An Update on Trainee Wellness: Some Progress and a Long Way to Go.

## Parenting in Residency: How parent-learners strengthen programs and how programs can best support them

**Presenters**

Jonathan Homans, MD
Lora Wichser, MD
Sandra DeJong, MD, MSc
Anne Ruble, MD, MPH

**Educational Objective**

1) Recognize the strengths parents bring to educational environments
2) Identify systematic approaches to improve educational environments for parent trainees
3) Develop program structures and policies that support parent-learners

**Practice Gap**

There is a knowledge gap about how to best support trainees during residency who are parents or who will become parents. There is a growing body of literature on the impact of parenting on practicing physicians, but limited exploration of the same areas amongst trainees. There has been one small study of 14 family medicine residents who collected qualitative data on the experience of being a parent in residency and potential recommendations to training programs2. In addition, surveys of program directors in family medicine indicate that there are not adequate system supports in place, and that a majority of trainees who take parental leave are required to extend their training3. Related equity and diversity concerns continue as parenting responsibilities disproportionately impact women in medicine at multiple points in their career1. A second practice gap, is that existing literature focuses predominantly on negatives, whereas it has been established that parenting is actually protective against burnout4. Apart from burnout, there has been limited investigation of the potential benefits of having children during medical training. This workshop seeks to address this gap by focusing on understanding the benefits of having children during medical training and how training programs can implement policies to support these learners.

**Abstract**

Reproduction is a biological necessity for humans. Medical training often occurs during eight consecutive years of peak fertility. Given these facts, we should expect pregnancy, birth and parenting to be a normal part of the medical training experience. Despite this, pregnancy, parental leave, and parenting are often described as barriers or complications that interfere with medical training. This workshop seeks to recast the trainee-as-parent narrative by highlighting the positives of having parent-trainees in our educational programs and what programs can do to support such learners. We will examine the current state of parenting while in medical training, work on reframing common 'problems' with being a parent during training, and finally aim towards participants leveraging the content of this workshop into practical steps to improve their programs. The content of this workshop is drawn from contemporary scientific literature, lived experience of having children during training, and also from experience as directors of training programs. Participants will be actively engaged throughout the workshop with opportunities to learn from other programs and leave with concrete action steps to improve the parent-learner experience in their own programs.

**Agenda**

0-10 min: Introduction of presenters and parenting journey in training
10-25 min: Participants think, then pair to discuss their parenting journey and/or other goals that brought them to the workshop, including struggles with parent trainees.
25-30 min: Large group share general themes, specific goals
30-40 min: Brief didactic on the data, population changes, personal and institutional benefits, challenges with parenting in training
40-55 min: small group work on participants' educational settings, opportunities to benefit from trainee parents, opportunities in implementing support structures

55-65 min: large group share of specific goals from the beginning of the workshop, specific examples of opportunities.
65-75 min: small group work on challenges and strategies to overcome
75-85 min: large group share and discussion
85-90 min: wrap up, participants make commitment to next steps in implementing opportunities for their educational setting.

**Scientific Citations**

Adesoye, T., Mangurian, C., Choo, E. K., Girgis, C., Sabry-Elnaggar, H., & Linos, E. (2017). Perceived discrimination experienced by physician mothers and desired workplace changes: A cross-sectional survey. JAMA Internal Medicine, 177(7), 1033–1036. https://doi.org/10.1001/jamainternmed.2017.1394

Chan, M. K., Chew, Q. H., & Sim, K. (2019). Burnout and associated factors in psychiatry residents: a systematic review. International Journal of Medical Education, 10, 149–160. https://doi.org/10.5116/ijme.5d21.b621

Frank, E., Zhao, Z., Sen, S., & Guille, C. (2019). Gender Disparities in Work and Parental Status Among Early Career Physicians. JAMA Network Open, 2(8), e198340. https://doi.org/10.1001/jamanetworkopen.2019.8340

Morris, L., Cronk, N. J., & Washington, K. T. (2016). Parenting during residency: Providing support for Dr mom and Dr dad. Family Medicine, 48(2), 140–144.

Morris, L. E., Lindbloom, E., Kruse, R. L., Washington, K. T., Cronk, N. J., & Paladine, H. L. (2018). Perceptions of Parenting Residents Among Family Medicine Residency Directors. Family Medicine, 50(10), 756–762. https://doi.org/10.22454/FamMed.2018.978635

# Educational Workshops Session 2

## N.O. S.H.A.M.E--A Framework for Empowering and Supporting Trainees to Manage Mistreatment in Academic Settings

**Presenters**
John Chamberlain, MD
Tammy Duong, MD
Hannah Potvin, MD
Juliet Morgan, MD

**Educational Objective**
At the conclusion of this workshop, participants will be able to:
1. Describe common forms of mistreatment experienced by trainees in academic settings.
2. Explain factors in and characteristics of academic settings that increase the risk of trainees being subjected to mistreatment
3. Discuss responses to reports of mistreatment that fail to appropriately support trainees
4. Describe steps that faculty and training programs can take to empower trainees to lower the risk of mistreatment and to encourage trainees to report instances of mistreatment
5. Explain how faculty and training programs can properly support trainees who have experienced mistreatment

**Practice Gap**
Mistreatment of trainees (e.g. physical violence, bullying, discrimination, sexual harassment, verbal abuse, etc) in academic settings and the negative impacts of such experiences have been recognized for decades. However, in spite of this recognition and associated efforts to address the issue, mistreatment continues to be an all too common experience among trainees in academic settings. Trainees may be subjected to mistreatment by supervisors (e.g. faculty members, senior residents), administrative staff, clinical staff, peers, patients, friends and family members of patients, strangers, and other hospital staff. Trainees are often unsure of how to respond to such behavior and what resources are available to them following the experience of mistreatment. They may hesitate to discuss mistreatment with colleagues and supervisors due to fears of being perceived negatively. Moreover, they may not receive education on relevant skills (e.g. de-escalation, limit setting, interpersonal efficacy, etc). At the same time, supervisors are often ill-equipped to provide effective and appropriate support to trainees who experience mistreatment. Acquiring skills to recognize factors that increase the risk of mistreatment, to identify forms of mistreatment, and to minimize the risk of experiencing mistreatment are critical career development skills for trainees and faculty. Likewise, fostering an understanding of the negative impacts of mistreatment on personal and professional well-being as well as developing an awareness of resources and strategies available to support trainees who experience mistreatment are vital skills for the career growth of trainees and faculty. This workshop will address these gaps in academic practice.

**Abstract**
Mistreatment of trainees (e.g. physical violence, bullying, sexual harassment, verbal abuse, etc) in academic settings and the negative impacts of such experiences have been recognized for decades. In spite of this recognition and associated efforts to address the issue, mistreatment continues to be an all too common experience among trainees in academic settings. Further, the problem of trainees' suffering mistreatment in academic settings is an issue of international concern. For example, studies from Peru, the United States, Saudi Arabia, Europe, and Australia have demonstrated high rates of mistreatment during training. Such experiences have been associated with substance use, poorer mental health, burn-out, lower self-esteem, and decreased career satisfaction.

Trainees may be subjected to mistreatment by supervisors (e.g. faculty members, senior residents), administrative staff, clinical staff, peers, patients, friends and family members of patients, strangers, and other hospital staff. Trainees are often unsure of how to respond to such behavior and what resources are available following the experience of mistreatment. Trainees may feel they must tolerate what would otherwise be viewed as unacceptable behaviors from patients because they are ill and under stress. Moreover, they may believe that, in the high stress environment of academic settings, inappropriate behavior by faculty, staff, and other trainees is expected. Faculty, more senior trainees, and peers may implicitly or explicitly communicate expectations that trainees tolerate or excuse mistreatment.

Trainees may hesitate to discuss mistreatment with colleagues and supervisors due to fears of being perceived negatively. For example, they may fear being perceived as thin-skinned, overly sensitive, or incompetent. Moreover, they may not receive education on relevant skills (e.g. de-escalation, limit setting, interpersonal efficacy, etc) that would better equip them to manage inappropriate behavior. At the same time, supervisors are often ill-equipped to provide appropriate support to trainees who experience mistreatment. For instance, supervisors may not understand their responsibilities to support and protect trainees who have experienced mistreatment. Further, they may struggle with finding the time to talk with trainees about these issues. They may also be unaware of the local resources in their institution to which they can refer trainees for additional support. Lastly, they may feel uncomfortable discussing issues related to mistreatment with trainees.

Acquiring skills to recognize factors that increase the risk of mistreatment, to identify forms of mistreatment, to support victims of mistreatment, and to minimize the risk of experiencing mistreatment are critical career development skills for trainees and faculty. Likewise, fostering an understanding of the negative impacts of mistreatment on personal and professional well-being are vital skills for the career growth of trainees and faculty. This workshop will provide an overview of a framework developed at the University of California San Francisco for helping faculty, staff, and trainees recognize mistreatment; to empower trainees to manage and report mistreatment; and to support trainees who have experienced mistreatment. Participants will have an opportunity to apply this framework to relevant examples of trainee mistreatment. In

addition, participants will share how this framework could be applied to their home institutions in facilitated group discussions.

**Agenda**

0:00 – 0:10: Introductions
0:10 – 0:20: PowerPoint facilitated overview of common forms of mistreatment in academic settings, common mistakes when mistreatment is reported by trainees, and framework for H.A.L.T.S.
0:20 – 0:50 Small group application activity (review vignettes; discuss types of mistreatment identified in the vignettes; analyze responses to mistreatment; examine systemic issues contributing to the occurrence of mistreatment)
0:50 – 1:20: Small group experiential activity (use the H.A.L.T.S. framework to identify steps that could have been taken to both empower trainees to manage inappropriate behavior, facilitate trainees' reporting of mistreatment, and support trainees who were subjected to mistreatment; discuss how this framework may be applied at participants' home institutions)
1:20 – 1:30: Facilitated Group Discussion and Q&A

**Scientific Citations**

Ayyala MS, Chaudhry S, Windish D, et al. (2018) Awareness of Bullying in Residency: Results of a National Survey of Internal Medicine Program Directors. Journal of Graduate Medical Education, April: 209 - 213.

Chadaga AR, Villines D, Krikorian A. (2016) Bullying in the American Graduate Medical Education System: A National Cross-Sectional Survey. PLoS ONE 11(3): e0150246.

Cook AF, Arora VM, Rasinki KA, et al. (2014) The Prevalence of Medical Student Mistreatment and Its Association with Burnout. Acad Med. 89(5): 749–754.

Crebbin W, Campbell G, Hillis DA, et al. (2015) Prevalence of bullying, discrimination and sexual harassment in surgery in Australasia. ANZ J Surg. 85: 905–909.

Fnais N, al-Nasser M, Zamakhshary M, et al. (2013) Prevalence of harassment and discrimination among residents in three training hospitals in Saudi Arabia. Ann Saudi Med. 33(2): 134-139.

Fnais N, Soobiah C, Chen MH, et al. (2014) Harassment and Discrimination in Medical Training: A Systematic Review and Meta-Analysis. Acad Med. 89: 817–827.

Forel D, Vandepeer M, Duncan J, et al. (2018) Leaving surgical training: some of the reasons are in surgery. ANZ J Surg. 88: 402–407

Hamblin LE, Essenmacher L, Ager J, et al. (2016) Worker-to-Worker Violence in Hospitals: Perpetrator Characteristics and Common Dyads. Workplace Health Saf. 64(2): 51–56.

House JB, Griffith MC, Kappy MD, et al. (2018) Tracking Student Mistreatment Data to Improve the Emergency Medicine Clerkship Learning Environment. West J Emerg Med. 19(1): 18–22.

Johansen IH, Baste V, Rosta J, et al. (2017) Changes in prevalence of workplace violence against doctors in all medical specialties in Norway between 1993 and 2014: a repeated cross-sectional survey. BMJ Open. 7: e017757.

Kulaylat AN, Qin D, Sun SX, et al. (2017) Perceptions of mistreatment among trainees vary at different stages of clinical training. BMC Medical Education. 17:14.

Leisy HB and Ahmad M. (2016) Altering workplace attitudes for resident education (A.W.A.R.E.): discovering solutions for medical resident bullying through literature review. BMC Medical Education. 16: 127.

Nieto-Gutierrez W, Toro-Huamanchumo CJ, Taype-Rondan A, et al. (2018) Workplace violence by specialty among Peruvian medical residents. PLoS ONE 13(11): e0207769.

Price O and Baker J. (2012) Key components of de-escalation techniques: A thematic synthesis International Journal of Mental Health Nursing. 21: 310–319.

Price O, Baker J, Bee P, et al. (2015) Learning and performance outcomes of mental health staff training in de-escalation techniques for the management of violence and aggression. The British Journal of Psychiatry. 206: 447–455.

Robertson T, Daffern M, Thomas S, et al. (2012) De-escalation and limit-setting in forensic mental health units. Journal of Forensic Nursing. 8: 94–101.

Siller H, Tauber G, Komlenac N, et al. (2017) Gender differences and similarities in medical students' experiences of mistreatment by various groups of perpetrators. BMC Medical Education. 17: 134.

Volz NB, Fringer R, Walters B, et al. (2017) Prevalence of Horizontal Violence Among Emergency Attending Physicians, Residents, and Physician Assistants. West J Emerg Med. 18(2): 213-218.

## Helping patients plan for a mental health crisis: How to implement the use of psychiatric advance directives within residency training programs.

**Presenters**
Tristan Gorrindo, MD
John Torous, MD

**Educational Objective**

1. Describe psychiatric advance directives and how they promote patient autonomy

2. Demonstrate use of tools which facilitate the creation of psychiatric advance directives
3. Create a plan for implementing an educational activity on psychiatric advance directives within a residency training program

**Practice Gap**

A psychiatric advance directive (PAD) is a legal tool recognized in the majority of U.S. states that allows a person with mental illness to state their preferences for treatment and hospitalization in advance of a crisis. They can serve as a way to protect a person's autonomy and ability to self-direct care. They are similar to living wills and other medical advance planning documents used in palliative care, times of intubation, and times of resuscitation. Individuals with serious mental illness (SMI) such as bipolar disorder, schizophrenia, and recurrent major depression may have limited ability to express their wishes for the types of care that they receive during times of high symptoms burden. PADs can include advance instructions, establish power of attorney, or both. Without such information, clinicians are often times left to make surrogate decisions for a patient — often through a complicated court-ordered process — without knowing if a patient would make those same decisions for himself/herself during times of clearer cognition and decisional capacity. There is a national effort to ensure that all patients being discharged from an inpatient psychiatric unit have a valid PAD. Given that PADs are a relatively new construct and that the role of completing PADs with patients may fall to trainees rotating on inpatient unites, trainees need knowledge and tools to complete these documents with patients.

**Abstract**

This workshop will focus on the hands-on implementation of psychiatric advance directives within residency training programs using: 1) a new app created by the American Psychiatric Association's SMI Adviser initiative, and 2) a training module which can be used by program directors in their residency programs. A relatively new construct in psychiatry, a psychiatric advance directive (PAD) is a legal tool recognized in the majority of U.S. states that allows a person with mental illness to state their preferences for treatment and hospitalization in advance of a crisis. They can serve as a way to protect a person's autonomy and ability to self-direct care. They are similar to living wills and other medical advance planning documents used in palliative care, times of intubation, and times of resuscitation. Individuals with serious mental illness (SMI) such as bipolar disorder, schizophrenia, and recurrent major depression may have limited ability to express their wishes for the types of care that they receive during times of high symptoms burden. Efforts are underway to ensure every psychiatric inpatient has an opportunity to create a psychiatric advance directive. This workshop will walk attendees through the process of how a clinician would work with a patient to create advance instructions within a digital PAD with a focus on the use of medication, willingness to be hospitalized, and consent to share information with individuals outside of a treatment team (such as a family member). Lesson plans and slide decks will also be provided to assist program directors in providing PAD-related education to trainees. At the end of this workshop, attendees will have the knowledge and tools to implement PAD related education within their institutions.

**Agenda**
This workshop will focus on the hands-on use of a digital app that can be used to create a psychiatric advance directive. The agenda below promotes kinetic and action-oriented learning of attendees, especially training program directors who are looking implement similar training in their residency programs.
10 Minutes – Review purpose and structure of psychiatric advance directives (PAD)
40 Minutes – Download a psychiatric advance directive app and walk through the steps of creating a PAD
20 Minutes – Review tools designed for program directors to teach residents about PADs
10 Minutes – Complete an action plan for implementing PAD training within training programs
10 Minutes – Questions and answers with faculty, Whova app

**Scientific Citations**
The Substance Abuse and Mental Health Services Administration (SAMHSA) released a PAD toolkit for mental health clinicians in 2019. The toolkit and background information can be found at:
Substance Abuse and Mental Health Services Administration: A Practical Guide to Psychiatric Advance Directives. Rockville, MD: Center for Mental Health Services. Substance Abuse and Mental Health Services Administration, 2019.
https://www.samhsa.gov/sites/default/files/a_practical_guide_to_psychiatric_advance_directives.pdf

## Reading Between the Lines: Deciphering Letters of Recommendation in Psychiatry

**Presenters**
Anne McBride, BA, MD
William Newman, MD
Alan Koike, MD, MS
Brianne Newman, MD
Paula Wadell, MD

**Educational Objective**
1. Gain knowledge regarding the challenges and limitations involved in reviewing and writing letters of recommendation.
2. Identify significant LOR features, applicant abilities, and commonly used phrases.
3. Receive feedback on whether the participant's written LOR is consistent with how other readers interpret the LOR.

**Practice Gap**
The ACGME requires program directors to recruit and select appropriate applicants for general psychiatry residency and subspecialty fellowships. A typical program may receive numerous applications for each available residency position, and program directors are often tasked with

reviewing hundreds of applications during each recruitment cycle. With multiple ACGME-accredited and non-accredited fellowships available to trainees, fellowship directors must also review substantial numbers of fellowship applications. The ability to accurately and efficiently decipher an applicant's letters of recommendation (LOR) becomes critical. Of equal importance, program directors and faculty in general are often asked to write LORs for prospective applicants. Given that LORs can serve as such important sources of information to round out an individual's application portfolio, writing LORs that are both meaningful and accurate is imperative. Careful and deliberate reading and writing of LORs is not typically a skill taught to new (and sometimes more seasoned) faculty including program directors. This workshop is a first step in closing the gap in this necessary skill.

**Abstract**
Acceptance into a psychiatric residency has become increasingly competitive. A typical program may receive numerous applications for each available residency position, and program directors are often tasked with reviewing hundreds of applications during each recruitment cycle. With multiple ACGME-accredited and non-accredited fellowships available to trainees, fellowship directors must also review substantial numbers of fellowship applications. The ability to accurately and efficiently decipher an applicant's letters of recommendation (LOR) becomes critical. Of equal importance, program directors and faculty in general are often asked to write LORs for prospective applicants. Given that LORs can serve as such important sources of information to round out an individual's application portfolio, writing LORs that are both meaningful and accurate is imperative. Careful and deliberate reading and writing of LORs is not typically a skill taught to new (and sometimes more seasoned) faculty including program directors. This workshop is a first step in closing the gap in this necessary skill.

In this workshop, participants will be asked to bring in two to three de-identified LORs that they have previously written. Ideally this would include LORs regarding a variety of applicants who range from exceptional to mediocre to problematic. Upon arrival to the workshop, participants will fill out a one-item survey for each LOR they bring, evaluating on a scale from 1 (lowest) - 10 (highest) their own perception of the quality of the applicant. LORs will then be collected and shuffled. After a brief overview on the challenges and limitations associated with reading and writing LORs, participants will break into smaller groups. Each group will review multiple LORs. As a group, participants will identify significant letter features, applicant abilities, and commonly used phrases. Each group member will rate each letter on the overall quality (scored 1-10) of the applicant described in the LOR and generate comments on why they arrived at each score. The overall quality (scored 1-10) of each applicant as viewed by the LOR author will be revealed and the group will identify letters that were consistent with the intent of the author and letters that were discrepant.

Finally, the large group will come back together to compare and consolidate findings in order to identify overall significant letter features, applicant abilities, and commonly used phrases (for the basis of a future survey).

**Agenda**
00:00 Lecture format by presenters to provide overview on LORs including challenges and limitations in writing and deciphering LORs.
00:10 Small groups will be tasked with two challenges. As a group, a review of individual LORs will yield: 1. Significant letter features, applicant abilities, and commonly used phrases, and 2. Each group member will rate each letter on the overall quality (scored 1-10) of the applicant described in the LOR.
00:40 The overall quality (scored 1-10) of each applicant as viewed by the LOR author will be revealed and the group will identify letters that were consistent with the intent of the author and letters that were discrepant.
01:10 Large group discussion to compare and consolidate findings in order to identify overall significant letter features, applicant abilities, and commonly used phrases (for future survey).
01:20 Q&A
01:25 Evaluation

**Scientific Citations**
The ACGME requires program directors to recruit and select appropriate applicants for general psychiatry residency and subspecialty fellowships. (Common requirement. 11.A.4.)

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf

The number of psychiatry positions has grown every year since 2008 and the 98.9% fill rate is among the highest on record. From NRMP's 2019 Main Residency Match, Results and Data, accessed at: https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2019/04/NRMP-Results-and-Data-2019_04112019_final.pdf

## Teaching Relationship-Centered Communication to Psychiatry Trainees

**Presenters**
Rebecca Rendleman, MD
Oliver Stroeh, MD
Steven Kaplan, MD
Helen Ding, MD
Sara VanBronkhorst, MD

**Educational Objective**
At the end of the workshop, participants will be able to:
1. Recognize communication as a fundamental skill that can be explicitly taught and deliberately practiced
2. Appreciate the relevance of communication training in psychiatry residency
3. Identify relationship-centered communication as one model of communication training
4. Communicate more effectively diagnosis and treatment recommendations to patients using a relationship-centered communication skill

5. Consider strategies for implementing communication training in psychiatry residency

**Practice Gap**

Communication is a fundamental skill and is one of the six Core Competencies identified by the Accreditation Council of Graduate Medical Education (The Milestone Project, 2014). Effective communication improves patient outcomes and enhances patient, family and caregiver satisfaction (Chou et al, 2014). Increased provider satisfaction helps mitigate burn-out and improve wellbeing (Krasner et al, 2009). Historically, limited attention has been given during residency to explicit training in effective communication (Ericsson, 2004). While psychiatry training frequently focuses on psychotherapeutic techniques, competence in the more fundamental and universal physician-patient communication skills is often assumed.

**Abstract**

Communication is a fundamental skill and is one of the Accreditation Council of Graduate Medical Education's six Core Competencies (The Milestone Project, 2014). It is a procedure in which the average clinician engages approximately 200,000 times during an average practice lifetime. Effective communication has been associated with improved outcomes, including greater patient and provider satisfaction, increased likelihood of adherence to a treatment plan, and reduced malpractice risk (Chou et al, 2014; Levinson et al, 1997; Levinson et al 2010). However, other than addressing some circumscribed domains such as "delivering bad news" or "managing the angry patient," few graduate medical education programs' curricula incorporate formal communication skills training. In 2013, leadership at NewYork-Presbyterian (NYP) collaborated with the Academy of Communication in Healthcare to develop a relationship-centered communication (RCC) workshop to enhance providers' skills and improve patient experience. Relationship-centered communication (in contrast to patient- or provider-centered communication) recognizes explicitly the importance of the patient-provider relationship to the delivery of care, and emphasizes the providers' abilities to empathize with patients and understand their perspectives. To date, over 1,000 NYP healthcare providers have completed the NYP RCC workshop. Feedback collected through 2016 indicated that, immediately following the workshop, participants regarded the training positively and, six weeks later, endorsed significant improvements in their self-efficacy, attitudes, and behaviors related to communication with patients (Saslaw et al, 2017). Since 2016 and as part of their first-year summer orientation, over 50 residents in the NYP Child and Adolescent Psychiatry (CAP) Residency Training Program have completed the RCC workshop. Eighty-five percent of those CAP residents who completed a follow-up survey agreed or strongly agreed that the RCC workshop was useful to their education. The aims of this AADPRT workshop are to increase recognition that communication is a fundamental skill that can be taught and practiced, and that communication training is relevant to psychiatry residency education. This workshop will utilize (1) a brief overview of the RCC workshop's three modules, (2) live demonstration of targeted communication skills, and (3) opportunities for participants to practice one RCC skills through observed role-play with real-time feedback. A debrief will allow participants to share their experiences and address potential barriers to the use of the skill. As a result of this workshop, participants will learn about and experience first-hand through active learning one

model by which to teach psychiatric residents communications skills and to consider how to potentially bring communication skills training to their home institutions.

**Agenda**

1. Welcome and introductions – 5 minutes
2. Presentation of evidence in support of communication skills training – 10 minutes
3. Overview of relationship-centered communication (RCC) workshop at NewYork-Presbyterian (NYP) – 15 minutes
4. Interactive skill-building exercise (demonstration by workshop leaders and role play by participants) – 45 minutes
5. Debrief/discussion – 10 minutes
6. Wrap-up – 5 minutes

**Scientific Citations**


1. The Psychiatry Milestone Project. J Grad Med Educ. 2014 Mar;6(1s1):284-304.
2. Chou CL, Cooley L, Pearlman E et al., Enhancing patient experience by training local trainers in fundamental communication skills. Patient Experience Journal. 2014;1(2);36-45.
3. Ericsson KA. Deliberate practice and the acquisition and maintenance of expert performance in medicine and related domains. Acad Med. 2004;79:S70-S81.
4. Krasner MS, Epstein RM, Beckman H et al., Association of an education program in mindful communication with burnout, empathy, and attitudes among primary care physicians. JAMA. 2009;302(12):1284-1293.
5. Levinson W, Lesser CS, Epstein RM. Developing physician communication skills for patient-centered care. Health Affairs. 2010:29:1310-1318.
6. Levinson W, Roter KL, Mullooly JP et al., Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. JAMA. 1997:277:553-559.
7. Saslaw M, Sirota DR, Jones DP et al., Effects of a hospital-wide physician communication skills training workshop on self-efficacy, attitudes and behavior. Patient Experience Journal. 2017;4(3);48-54.


## Assessing an IMG Application: Diamonds and Pearls!

**Presenters**


Vishal Madaan, MD
Consuelo Cagande, MD
Ellen Berkowitz, MD
Donna Sudak, MD
Manal Khan, MBBS

**Educational Objective**

1. Recognize the nuances of assessing an International Medical Graduate (IMG) residency application
2. Employ techniques to assess communication skills and cultural competence
3. Identify features of IMG applications that predict success in psychiatry training
4. Develop an assessment tool/check list specific to IMG application

**Practice Gap**

There is a paucity of literature and training, including in Psychiatry, on how to assess IMGs for a residency, with majority of the focus on the certification and immigration process. IMGs are vital to the provision of care to the underserved and enrich the diversity of practicing psychiatrists. Given the increasing number of United States Medical Graduates (USMG), it is even more competitive for IMGs to obtain residency positions. In 2018, the American Medical Association (AMA) listed Pathology, Internal Medicine, Neurology and Family Medicine as the top four medical specialties that matched the most IMGs, and yet IMGs constitute about 30% of trainees in general psychiatry and sub-specialties. Psychiatry training directors must thoroughly review applications beyond USMLE scores to find IMGs who will be a good fit and successful in training.

**Abstract**

"What do I look for in an IMG application?" This is one of the most common questions a program director (PD) may have when reviewing hundreds of applications. There is a paucity of literature on guiding PDs regarding this issue. Most of the focus is on certification and immigration process for IMG applicants, and not recommendations for the PDs. PDs must assess the quality of the medical school to the quality of work experience in the United States. In addition, how do their medical school grades translate into the US context. Furthermore, how do IMGs compare to US medical graduates? How do you define IMG success? What value would the IMG(s) add to your program? This session aims to answer many similar questions. Utilizing interactive polling Dr. Cagande will discuss the nuances of assessing an IMG application. Dr. Berkowitz will review techniques to assess communication skills and cultural competence. Dr. Sudak will point out highlights of the application that predict success in training. Based on these topics, the audience will review sample applications and develop their own check list specific to their program needs. Ultimately, the session will provide the audience an understanding of IMG applications and a skill set and tool to use when assessing t. As residency program leaders, we know good fit with a diverse pool of applicants is essential for the success of the trainee (diamond) and the program (pearl).

**Agenda**

1) Welcome/overview of agenda/introduction of speakers: Dr. Madaan (5 min)
2) Learn the nuances of assessing an IMG residency application: Dr. Cagande (10 min)
3) Employ techniques to assess communication skills and cultural competence: Dr. Berkowitz (10 min)
4) Identify features of IMG applications that predict success in psychiatry training: Dr. Sudak (10 min)

5) A chief resident's perspective: Dr. Khan (5 min)
6) Pair-Think-Share: Develop an assessment tool/check list specific to IMG application in small groups (45 min)
7) Regroup, feedback and questions: Dr. Madaan (5 min)

**Scientific Citations**


1. Kokosis G, Leto Barone AA, Grzelak MJ, et al. International Medical Graduates in the US Plastic Surgery Residency: Characteristics of Successful Applicants. Eplasty. 2018;18:e33. Published 2018 Nov 27.PMC6263251
2. Cardenas Lara F, Naik ND, Pandian TK, Gas BL, Strubel S, Cadeliña R, Heller SF, Farley DR. A Comparison of Objective Assessment Data for the United States and International Medical Graduates in a General Surgery Residency. Journal of Surgical Education. Volume 74, Issue 6, November–December 2017, Pages e1-e7
3. https://www.yousmle.com/img-guide/
4. https://www.ama-assn.org/residents-students/specialty-profiles/4-medical-specialties-among-friendliest-img-pgy-1-matches


## Managing the Millennial Struggling Learner: Creating a Team Approach

**Presenters**


Sourav Sengupta, MD, MPH
Elizabeth Sengupta, BS, MA
Cynthia Pristach, MD
Paula DelRegno, MD


**Educational Objective**

1. Participants will be able to discuss results of several studies regarding millennial attitudes toward training and feedback.
2. Participants will be able to describe key components of Hauer's model for remediation of physician learners.
3. Participants will consider how the use of Milestones may help programs meet the changing needs and expectations of millennial learners.
4. Participant will be introduced to the way that two programs (one smaller fellowship program and one larger general psychiatry program) use Milestones to create a team-based approach to addressing the needs of struggling millennial learners.
5. Participants will discuss the unique features of their home programs and brainstorm ways to design and implement a team-based approach to defining learning targets and monitoring the progress of struggling learners.

**Practice Gap**

Programs are required to hold bi-annual clinical competency committee meetings to assess resident performance using the ACGME Milestones. But what do we do when a resident isn't making sufficient progress? Several studies have been published offering practical tips for

aiding learners struggling with specific Milestones but there is a lack of practical implementation tips to create a programmatic system to address these issues as a teaching team. Furthermore, we have been witnessing a generational shift in the way residents interpret, respond to and expect feedback. Millennials have been shown to value mentorship, personalized learning, and teamwork as well as continuous, explicit, direct feedback (Desy 2017). Milestones can be used not only as a way to identify struggling learners, but also as a tool to create a team-based, comprehensive approach to remediation that plays to the expectations and preferences of this new generation of learners.

**Abstract**

The goal of this workshop is to aid programs in designing a team-based, comprehensive approach to addressing struggling learners that incorporates the expectations and preferences of millennials while working within the context of the individual program.

We will begin by considering the results of several studies surveying millennial attitudes toward motivation, training and achievement, as well as millennial expectations regarding mentorship and feedback. We will then consider the implications of these unique attitudes and expectations on residency training. Furthermore, we will examine research on current best practices to address struggling learners, focusing on Hauer's model of assessment, diagnosis of deficiency, development of individualized learning plan, remediation via deliberate practice, feedback and reflection, and reassessment (2009), and illustrate how Milestones can be used not only as a tool to identify learning gaps, but also as a way to address these gaps while addressing the needs and expectations of millennial trainees.

We will discuss how the unique pre-existing features of individual programs can be leveraged to create a team-based approach to identify targeted learning goals by outlining the process used in two different programs. The first approach is used in a small, two-year fellowship program whose faculty work at many sites around the city. The second approach is used in a larger, four-year general psychiatry program whose faculty meet more regularly in one location. Both programs utilize the Milestones as a tool both to create individualized learning plans for struggling trainees, and to keep all members of the team focused on the targeted learning goals. Participants will then be given time to consider the unique features of their individual programs and begin to design a team-based, Milestones-driven approach to remediation that fits within their program's structure and addresses the needs and expectations of millennial learners.

**Agenda**

10 minutes: The generational change in expectations and attitudes in residency training
10 minutes: What we already know about best practices in remediation (Hauer's model)
5 minutes: The application of Milestones in addressing millennial feedback expectations
20 minutes: The application of a systematic, team-based approach to addressing resident learning gaps in two different programs
15 minutes: Small group breakout: leveraging pre-existing features of your training program in designing a systematic, team-based approach to aiding struggling learners

20 minutes: Discussion and troubleshooting
10 minutes: Wrap-up

**Scientific Citations**

1. Desy, J., Reed, D., & Wolanskyj, A. (2017). Milestones and Millennials: A Perfect Pairing—Competency-Based Medical Education and the Learning Preferences of Generation Y. Mayo Clinic Proceedings, 92(2), 243–250. https://doi.org/10.1016/j.mayocp.2016.10.026
2. Rumack, C., Guerrasio, J., Christensen, A., Aagaard, E., & Rumack, C. (2017). Academic Remediation: Why Early Identification and Intervention Matters. Academic Radiology, 24(6), 730–733. https://doi.org/10.1016/j.acra.2016.12.022
3. Ketteler, E., Auyang, E., Beard, K., Mcbride, E., Mckee, R., Russell, J., … Nelson, M. (2014). Competency Champions in the Clinical Competency Committee: A Successful Strategy to Implement Milestone Evaluations and Competency Coaching. Journal of Surgical Education, 71(1), 36–38. https://doi.org/10.1016/j.jsurg.2013.09.012
4. Hauer, K. E., Ciccone, A., Henzel, T. R., Katsufrakis, P., Miller, S. H., Norcross, W. A., Papadakis, M. A., Irby, D. M. (2009). Remediation of the deficiencies of physicians across the continuum from medical school to practice: a thematic review of the literature. Academic Medicine, 84(12), 1822-32. https://doi.org/10.1097/ACM.0b013e3181bf3170
5. Wu, J., Siewert, B., & Boiselle, P. (2010). Resident evaluation and remediation: a comprehensive approach. Journal of Graduate Medical Education, 2(2), 242–245. https://doi.org/10.4300/JGME-D-10-00031.1

## Psychological Safety: It's Not Just for Snowflakes

**Presenters**

Jennifer O'Donohoe, MD
Kristi Kleinschmit, MD
T. Eric Spiegel, MD
Luke Dwyer, MD
Thomas Gethin-Jones, MD

**Educational Objective**

1. Define the primary tenants of psychological safety
2. Describe several ways to assess the psychological safety of trainees and faculty
3. Practice implementing strategies that improve psychological safety
4. Explore obstacles and solutions to enhancing psychological safety in each participants' setting

**Practice Gap**

Psychological safety is a critical part of optimizing the learning environment. For learning to occur, trainees must feel safe to take risks and make mistakes. If they feel that they will be punished, humiliated or unfairly remediated for making mistakes, this can lead to burnout, depression, lack of empathy, and decreased career satisfaction [1]. The ACGME tasks GME programs with creating an appropriate and safe environment for trainees to learn

competencies. It has been shown that psychological safety is an important factor for residents in their assessment of their learning environment/program [2]. The ACGME also makes it clear that psychological safety is something that they value. One of the reported responses on the Annual Resident Survey is, “Residents can raise concerns without fear.” In 2018, 82% of adult and child psychiatry programs were compliant with this metric. It is troubling that 1 out of 5 trainees does not feel that they can raise concerns without fear. Program directors need a systematic way to describe and assess the psychological safety of their departments. They also need strategies for addressing any deficits in psychological safety with faculty and trainees.

**Abstract**

The goal of this workshop is to help attendees address the importance of psychological safety in the training environment within their home departments in a systematic way. The workshop will be co-led by senior child psychiatry and general psychiatry trainees who have first-hand experience with psychological safety within training. The workshop will start with an ice breaker designed to engage the participants and simultaneously build psychological safety within the group. We will have the group define the important factors that contribute to psychological safety and create our own ground rules for the workshop. Next, using an interactive and anonymous tool (Poll Everywhere), we will have the participants take the Psychological Safety Survey. We will also identify common obstacles to psychological safety using the interactive tool and discuss other assessments for psychological safety that participants can utilize to assess their own programs. We will then have interactive breakout sessions where we will use previously recorded videos of scenarios experienced by the residents in their training during which there was an absence of psychological safety. The small groups will reenact the scenarios using the tenants of psychological safety and process the differences. Large group discussion will focus on the experiences of the participants. There will be a brief presentation of practical strategies to strengthen psychological safety in a department and resident work environments. We will have the participants make a commitment to themselves to trial one of the strategies. Then we will conclude with a review of the importance of psychological safety, obstacles to it and commitments to assess it and intervene when necessary.

**Agenda**

1. Introduction: Interactive ice breaker (5 min)
2. Group definition of psychological safety and setting norms (5 min)
3. Interactive assessment of psychological safety and obstacles (20)
4. Small Groups role play scenarios (30 min)
5. Large Group Report Back (10 min)
6. Presentation of practical ways to actively create psychological safety (10 min)
7. Conclusion (10min)

**Scientific Citations**

1. Bynum WE, Haque TM. Risky business: psychological safety and the risks of learning medicine. J Grad Med Edu. 2016; 8 5:780-782.

2. Torralba KD, Loo LK, Byrne JM, et al. Does Psychological safety impact the clinical learning environment for resident physicians? Results from the VA's Learners' Perception Survey. J Grad Med Educ. 2016; 8 5:699-707.

## Lights...Camera...Action!: A Lesson on Educating Trainees to Address Social Determinants of Mental Health Through Interactive Theater

**Presenters**
Margaret Wang, MD
Antara Banik, MD
Evelyn Ashiofu, MD, MPH
Karen Duong, DO
Lia Thomas, MD

**Educational Objective**

1. Recognize common social factors that play a role in individuals' mental health statuses and experiences across the life span
2. Practice identifying how these social factors manifest in patient interactions and how to address them using scripted scenes, interactive theater, and role play
3. Learn how to incorporate discussion regarding "social determinants of (mental) health" with patients, and how this can be incorporated into daily clinical practice
4. Identify specific resources that can be used with patients with mental health disorders from disadvantaged backgrounds
5. Encourage implementation of a social determinants of mental health topics into general residency education curriculum

**Practice Gap**

"Social determinants of mental health" refer to social and environmental factors that interact with and influence the genetics and life experiences of individuals with mental health disorders, and the systems in place to deal with mental illness. Understanding the social factors allows for population-level interventions for primary and secondary prevention of mental illness. Teaching of this topic is not uniform throughout residency training programs and clinicians often feel unequipped to address mental illness from this angle. Current literature shows that individuals who experience adverse environmental effects, from living in low-income neighborhoods, having inadequate access to healthcare or quality education, living with food insecurity, to being of a minority race, have a higher likelihood of mental health conditions but also have poorer mental health treatment outcomes. Examples include experiencing race-based major discrimination as a predictor of lifetime depressive and mood disorders, neighborhood depravation and poverty being associated with higher incidence of overdose, schizophrenia, depression and worse mental health outcomes. If psychiatrists could be taught about these social and environmental factors and ways to mitigate them during patient interactions early in residency training, these skills could then be incorporated into clinical practice as a tool to help improve patients' mental health. Health care disparities may be touched on, especially at the

medical school education level, and are typically taught through the teachings of cultural competency. As medical students transition into the resident level and are now directly working with different patient populations, it is important that lessons are taught that go beyond cultural competency and take a deeper look at the structural factors in place that affect the delivery of mental health care. There have been very few reports in the literature describing how often these topics are taught during residency, how to teach these topics, or a standardized method of teaching.

**Abstract**
For psychiatrists in training, it is important to understand how the social determinants of mental health play an important role in the diagnosis and treatment of individuals who are faced with such challenges. This workshop aims to showcase the importance of shedding light on these influential factors of mental health and to also provide an approach on how to effectively teach psychiatry residents about the topic of social determinants of mental health in an innovative and interactive way: through theater and role-play. Interactive theater has been used to facilitate discussion and train trainees on patient interactions. Scenes can be frozen and audience members can engage in dialogues with the characters regarding their experiences, thoughts and motivations. Audience members can help direct alternative endings to the scenes with their input, therefore allowing for audience discussion and teaching. This session is based on a special seminar created at the University of Texas Southwestern Medical Center to teach residents about social determinants of mental health. Concepts from this session may be adapted to help teach this topic in other residency programs. Our session will teach common "social determinants" that affect mental health and use interactive theater to help teach participants about the experiences and contexts of, and approach to, patients whose mental health are affected by environmental factors through enacting a scripted patient-doctor scene with underlying "social determinants" themes. These themes include discrimination, limited income, poor access to health care and poor education. Moderators will facilitate discussion around addressing these issues in clinical care and provide participants with resource tools. Participants will then be able to practice addressing these issues with patients through role-play, while incorporating reflections from the large group audience discussion and the provided resource tools into their interactions. By the end of the session, participants will have learned strategies to teach colleagues on how to address some social determinants of mental health in clinical practice.

**Agenda**
0:00 Introductions / Objectives
0:05 Overview of social determinants of mental health
0:20: Presenters enact scene with indicated pauses/pauses in scene to discuss with audience and characters regarding themes in the scene and moderate alternative endings/how they would respond to the scenario presented.
0:40: Each group assigned scripted scene and roundtable discussion regarding social determinants themes with group with guiding questions
1:10: Groups share with larger group their responses and larger group discussion

1:20 Wrap up/Tools to address social determinants of mental health, including resource handouts to use with patients
1:25: Participant review of session via Whova app

**Scientific Citations**

1) Compton, M.T. and Shim, RS (2015). The Social Determinants of Mental Health. Arlington, VA: American Psychiatric Publishing.
2) King, T.E. (2007). Medical Management of Vulnerable and Underserved Patients: Principles, Practice, and Populations. Chicago, IL: McGraw-Hill Companies, Inc.

3) Patel et al (2014). Global Mental Health Principles and Practice. New York, NY: Oxford University Press.

4) Skye, E. P., Wagenschutz, H., Steiger, J. A. & Kumagai, A. K. Use of Interactive Theater and Role Play to Develop Medical Students' Skills in Breaking Bad News. J. Cancer Educ. 29, 704–708 (2014).

5) Hansen, H., Braslow, J., & Rohrbaugh, R. M. (2018). From Cultural to Structural Competency—Training Psychiatry Residents to Act on Social Determinants of Health and Institutional Racism. JAMA Psychiatry, 75(2), 117. doi: 10.1001/jamapsychiatry.2017.3894
6) O'Brien, M. J., Garland, J. M., Murphy, K. M., Shuman, S. J., Whitaker, R. C., & Larson, S. C. (2014). Training medical students in the social determinants of health: the Health Scholars Program at Puentes de Salud. Advances in medical education and practice, 5, 307–314. doi:10.2147/AMEP.S67480

## We get by with a little help from Our PEERS: Developing and implementing a relevant well-being curriculum for trainees

**Presenters**

Anne Hart, MD
Jordyn Feingold, MA
Shreya Nagula, MD
Asher Simon, MD

**Educational Objective**

This workshop has been produced by trainees with two faculty mentors/AADPRT members.

- Understand the process of engaging trainees in developing an effective wellness program
  - Conducting a needs assessment
  - Identifying stress points throughout training
  - Establishing a method of delivery
  - Discussing barriers to buy-in
- Understand the value of positive psychology interventions in residency training

- Discuss the importance of focusing on mental health in wellness, as a distinct entity from mental illness
- Experience a PEERS intervention as a participant and a leader
- Learn how to establish a PEERS program at your home institutions, for your residents as well as for other disciplines and levels of trainees

**Practice Gap**

Adequate ability to achieve a state of well-being (beyond the absence of depression, disease, and other etiologies that limit function) is essential for the sustainable practice of medicine and optimal patient care delivery. Physician burnout begins as early as medical school, increases over the course of training, and affects young physicians at higher rates than their more senior counterparts. Over the last decade, the necessity for emphasizing physician well-being has become increasingly appreciated, and the demand for well-being initiatives is on the rise. The pursuit of well-being has been recognized under the Institute for Healthcare Improvement's Quadruple Aim as an essential part of quality healthcare, we now have an ICD-10 code for burnout in the workplace, and the ACGME is mandating wellness requirements in every accredited training program across the country. While the problem of burnout and pursuit of well-being are being discussed at a national level, solutions have lagged behind. The problem is complex, and largely attributable to systemic failures of medical practice in the 21st century. Solutions must address the system, and simultaneously support the individual operating within this broken system with necessary skills to cope and even thrive through adversity. Within this system that is necessarily lacking in resources, we have found a way to implement an effective, scalable, trainee-driven well-being program that helps trainees maximize their sense of meaning and foster connections among peers and mentors.

**Abstract**

It is well-established that peer support is protective among medical professionals. The Practice Enhancement, Engagement, Resilience, and Support (PEERS) curriculum at the Icahn School of Medicine at Mount Sinai (ISMMS) is a trainee-led longitudinal well-being and resilience curriculum that provides peer-to-peer support, leading to reduced levels of burnout and increased levels of resilience in over 500 trainees in the past 3 years. Developed by trainees who are involved in its dissemination alongside faculty advocates, our program embodies the sentiment of "nothing about us without us," maximizing relevance and buy-in. PEERS teaches critical skills in mindfulness, positive psychology, cognitive behavioral therapy, and other therapeutic modalities, while prioritizing and fostering a sense of community and support among learners. Importantly, skills learned can be employed in real time in clinical settings.

The basic principles inform the name. Practice Enhancement: self-care is not just a moral imperative but a critical clinical skill and prerequisite to sustainable patient-care and optimal patient safety. Engagement: learners can deliberately reflect on their sense of meaning in day-to-day life, maximizing the ability to live by their values and use the best parts of themselves in the medical workplace and personal endeavors. Resilience: mistakes and adversity are inevitable in medicine, and one's ability to bounce forward and grow through challenges can be learned and developed. Highly resilient when they begin medical training, learners can explore

and deliberately cultivate effective mechanisms for dealing with inevitable stress. Support: a strong sense of community can be a powerful antidote to burnout, and no learner should feel alone in their experiences.

Originally designed as a mandatory program for medical students, PEERS is now being customized and expanded for four residency programs (Psychiatry, Pediatrics, OBGYN, Neurology) and PhD graduate students. The PEERS program has been recognized by both the APA (poster won the 2019 Student/Resident Curriculum Development and Education Award) and the ACGME (David C. Leach Award recognizing innovation and improvement in residency programs, advancing humanism in medicine, and increasing efficiency and emphasis on educational outcomes.)

In this workshop we provide a brief overview before engaging all participants in a PEERS-like experience, rejuvenating that connection to others that is a key component of these groups. A facilitation manual will guide participants. Reflecting the ease with which PEERS can be customized for inclusion in curricula and disseminated to different training populations, workshop participants will utilize an operationalized worksheet to begin conceptualizing a program relevant to their institutions. We will review all phases of the process, from needs-assessment, to facilitator recruitment, scheduling, and implementation.

Ultimately, PEERS fills a necessary gap between ACGME requirements, the dangers of burnout, and actual practices within a residency program. We aim to provide program directors with a framework to improve trainee well-being while taking into account institutional culture and utilizing local resources in order to maximize their residents' ability to find meaning and a community within training.

We are excited to share this model and the steps to developing a scalable program with the AADPRT community.

**Agenda**

5 min: Welcome & Introductions
15 min: What is the PEERS program?
40 min: Engage in an abbreviated PEERS session in small groups
15 min: Strategize how to bring PEERS home
10 min: Questions & Discussion
5 min: Evaluation Form

**Scientific Citations**


1. Charlton, J. I. (1998). Nothing About Us Without Us. University of California Press.
2. Dyrbye, LN, Thomas, MR, Massie Jr., FS. et al. (2008). Burnout and suicidal ideation among U.S. medical students. Ann Intern Med, 149, 334-341
3. Muller, D. (2017). "Kathryn." N Engl J Med 376(12): 1101-1103.

4. Lopez-Gomez, I., et al. (2017). "Comparing the acceptability of a positive psychology intervention versus a cognitive behavioural therapy for clinical depression." Clin Psychol Psychother 24(5): 1029-1039.
5. Rathert, C., et al. (2018). "Evidence for the Quadruple Aim: A Systematic Review of the Literature on Physician Burnout and Patient Outcomes." Med Care 56(12): 976-984.
6. Rotenstein, L. S., Ramos, M. A., Torre, M., Segal, J. B., Peluso, M. J., Guille, C., ... & Mata, D. A. (2016). Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: a systematic review and meta-analysis. JAMA, 316(21), 2214-2236.
7. Shanafelt, TD, Hasan, O, Dyrbye, LN et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc, (90), 1600-1613.
8. Wallace, J. E. and J. Lemaire (2007). "On physician well being-you'll get by with a little help from your friends." Soc Sci Med 64(12): 2565-2577.
9. Wallace, J. E., et al. (2009). "Physician wellness: a missing quality indicator." Lancet 374(9702): 1714-1721.
10. Wasson, L. T., et al. (2016). "Association Between Learning Environment Interventions and Medical Student Well-being: A Systematic Review." JAMA 316(21): 2237-2252.
11. West, CP Shanafelt, TD, Kolars, JC. (2011). Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. JAMA, (306)952-960.

## Grabbing the Third Rail: Race and Racism in Clinical Documentation

**Presenters**

J. Corey Williams, MA, MD
Jessica Isom, MD
Matthew Goldenberg, MD
Robert Rohrbaugh, MD

**Educational Objective**

1. List at least three of the most common current practices and rationales around the use of race in clinical documentation.
2. Explain how the current practices of identifying race are connected to a history of scientific racism.
3. Identify at least three ways in which the common use of race in clinical documentation may be problematic and lead to deleterious consequences for patients.
4. Define race as a social construct as opposed to a biological reality.
5. Examine health disparities as a function of institutional racism as opposed to inherent biological differences.
6. Demonstrate an alternative practice that more appropriately places race in its social context as a risk marker of exposure to racism through a guided role play scenario.

**Practice Gap**

Studies indicate that a large proportion of physicians routinely identity the race of the pa-tient (Black, White, Hispanic, Asian, etc.) alongside other variables (e.g. age, sex, medical his-tory) in their oral presentations and clinical documentation, often as one of the first descrip-tive elements of a case. Many clinicians and educators are uncritical of their use of race in clin-ical care. Scholars have cited several problems with this casual practice of identifying race in-cluding: (1) reinforcing the false idea of race as a biological category (as opposed to a social construct), (2) potential activation of biases that may affect clinical care and/or lead to dis-counting of clinical nuances, (3) justification for unwarranted differential treatment, (4) failure to examine racism as opposed to race as an important risk exposure. Critically, clinicians need guidelines and a framework for how and when to discuss and document a patient's race. In this workshop, we encourage participants to critically analyze the use of race in our clinical care as well as whether and how we teach residents to engage race in the clinical setting. Such analysis serves the goals of the ACGME milestones and Common Program Requirements that task programs with preparing residents to recognize disparities and understand the social determinants of health of the populations they serve. To meet the ultimate goal of address-ing these needs and health disparities, programs must attend to the misuse of race in clinical documentation and respond to the benign neglect of racism as a key social determinant of health.

**Abstract**

"An elderly African-American woman with a history of diabetes brought in by her daughter for increased forgetfulness"; "A 24 year-old Caucasian male with a 2-week history of worsening mood"; "An age-appearing Asian woman in no acute physical distress." Physicians, including psychiatrists, frequently employ phrases that bring attention to a patient's race, often in the opening line of oral presentations or clinical documentation. In many cases, this casual identification of a patient's race is a taken-for-granted routine without conscious rationale. In other instances, physicians may believe the race of the patient directly pertinent to the diagnosis or treatment for the patient.

A robust body of literature has demonstrated that racially identifying patient's has important diagnostic and treatment implications, many of which may be deleterious to the patient. A key aspect of misuse of race in clinical documentation and communication is the failure to name and address racism as a social determinate of health. This lack of recognition contributes to the perpetuation of racial health disparities. As a professional community, physicians rarely engage in critical analysis of when and how race is useful to the care of the patient and the potential implications, if any. We will briefly discuss the history of the scientific inventions of race as a biological construct and how this legacy continues to operate in contemporary medical practice. By giving race a misplaced salience in clinical practice, physicians are complicit in perpetuating the myth of distinct biologically-based racial categories. Further-more, invoking racial categories potentially activates bias and negative stereotypes towards racial minority patients.

**Agenda**
0:00 Introduction
0:05 Case Vignettes with Interactive Questions (using audience polling software)
0:35 Small Group Activity: we will provide prompts to discuss issues of patients' race and experiences of racism.
0:20 Brief historical overview of scientific racism
Background on Race, Racism and Health Disparities
0:55 Large Group Debrief of Small Group
1:05 Cultural Formulation Review and Practical Tips (focusing on Race and Discrimination)
1:20 Concluding comments/Questions and Answers
Last 5 minutes: Workshop evaluation

**Scientific Citations**
Smedley, B. D. (2012). The Lived Experience of Race and Its Health Consequences. American Journal of Public Health, 102(5), 933–935. http://doi.org/10.2105/AJPH.2011.300643

Braun L, Fausto-Sterling A, Fullwiley D, Hammonds EM, Nelson A, Quivers W, et al. (2007) Racial Categories in Medical Practice: How Useful Are They? PLoS Med 4(9): e271. https://doi.org/10.1371/journal.pmed.0040271

Acquaviva KD, Mintz M. Perspective: are we teaching racial profiling? The dangers of subjective determinations of race and ethnicity in case presentations. Acad Med. 2010;85:702–705

Jones CP, LaVeist TA, Lillie-Blanton M. "Race" in the epidemiologic literature: an examination of the American Journal of Epidemiology, 1921–1990. Am J Epidemiol. 1991;134:1079–1084.

Pálsson G. How deep is the skin? The geneticization of race and medicine. BioSocieties. 2007;2:257.

## Clinical Skills Evaluation: Data-Informed Strategies to Improve Interrater Reliability Within and Across Programs

**Presenters**
Michael Jibson, MD, PhD
Kaz Nelson, MD
Heather Schultz, MD, MPH

**Educational Objective**
- Attendees will review and discuss a large, multisite database on CSE performance, including data on inter-rater reliability between faculty members and across programs.
- Attendees will review and sample tools available on the AADPRT website to improve inter-rater reliability.

- Attendees will discuss and outline methods to improve inter-rater reliability in their own programs.

**Practice Gap**

Since its implementation in 2006, the Clinical Skills Evaluation (CSE; aka CSV) has been a requirement both for programs and individual residents. Initial training experiences were conducted at AADPRT in 2009, 2010, and 2012, and a variety of training materials have been on the AADPRT website. Since then, a large, multisite study of validity and interrater reliability has been conducted that provides useful information to assist program directors in assessing the reliability of their assessments internally and compared with other training programs. In addition, new training materials are being developed for the AADPRT website. Issues of validity and interrater reliability have not been addressed at AADPRT since a workshop in 2013, leaving a significant group of newer program directors unfamiliar with these issues and how to address them and more experienced directors without current data to inform their evaluation processes.

**Abstract**

Since its implementation in 2006, the Clinical Skills Evaluation (CSE; aka CSV) has been a requirement both for programs and individual residents, with program directors responsible for training faculty to conduct the assessments. In order to assess the validity and interrater reliability of this process in actual practice, a series of studies has looked at (1) 1,183 CSEs conducted in 4 residency programs between 2008 and 2014, (2) interrater reliability data from more than 200 AADPRT members rating multiple interview videos, and (3) 195 CSEs conducted on 51 practicing psychiatrists by experienced and novice evaluators. These data show strong similarities in CSE performance across programs, with a scoring pattern consistent with a valid measure of competency in the skills measured. This pattern was robust across programs despite significant differences in the timing and frequency of the CSEs between programs. These studies also showed distinct patterns of scoring for individual faculty and demonstrated the impact of 3 types of training experience: immediate feedback on scores in large groups observing video interviews, small group discussion of video interviews, and side-by-side training of novice evaluators by experienced colleagues. With these data in mind, a set of training materials for the AADPRT website is being prepared. These data may also be used by individual programs to assess the interrater reliability of their CSE assessments among their own faculty and compared to other programs. The purpose of this workshop is to review these data and tools, and use them to assist attendees to design and implement training for faculty in the conduct of CSEs.

**Agenda**

10 min: Large group review and discussion of validity data.
40 min: Large group review and discussion of interrater reliability and training data.
20 min: Large group review and discussion of AADPRT training tools.
20 min: Small group discussion of implementation issues in individual programs.

**Scientific Citations**

Juul D, Brooks BA, Jozefowicz R, Jibson M, Faulkner L. Clinical skills assessment: the effects of moving certification requirements into neurology, child neurology, and psychiatry residency training. Journal of Graduate Medical Education 2015; 7:98-100.

Jibson MD, Broquet K, Anzia JM, Beresin EV, Hunt JI, Kaye DL, Rao NR, Rostain A, Sexson SB, Summers RF. Clinical skills verification in general psychiatry: recommendations of the ABPN task force on rater training. Academic Psychiatry 2012; 36, 363-68. PMID: 22983466.

Dalack GW, Jibson MD. Clinical skills verification, formative feedback, and psychiatry residency trainees. Academic Psychiatry 2012; 36, 122-25. PMID: 22532202.

Rao NR, Kodali R, Mian A, Ramtekkar U, Kamarajan C, Jibson MD. Psychiatric Residents' Attitudes towards and Experiences with the Clinical Skills Verification Process - A Pilot Study of US and International Medical Graduates. Academic Psychiatry 2012; 36, 316-22. PMID: 22851030.

## Screen Time! Learning to Teach Pediatric Telepsychiatry (PTP) Using a National Curriculum

**Presenters**

Sandra DeJong, MD, MSc
Shabana Khan, MD
Deborah Brooks, MD
Amy Fehrmann, MD

**Educational Objective**

1) Describe a systematic, competency-based approach to PTP education
2) Review key content areas and current resources for PTP education and ways to incorporate them into child fellowship training
3) Learn how to teach PTP using the Collaborative Care setting as a simulated example
4) Develop an individual learning plan for becoming an effective teacher and supervisor of telepsychiatry

**Practice Gap**

The United States currently faces a dire shortage of child and adolescent psychiatrists (CAPs). Although effective treatments are available, a significant percentage of youth with psychiatric disorders do not receive any treatment; for those that do, there is often a significant delay from symptom onset to diagnosis and treatment initiation.

Telepsychiatry, which has been shown to be effective with children and youth, offers a critical opportunity to improve access to pediatric behavioral health.

In a survey of all U.S. ACGME-accredited CAP fellowship programs conducted in April 2019, 100% of respondents felt that it is “somewhat” or “very” important for telepsychiatry to be part of their program; yet 35% reported offering no telepsychiatry experience to their fellows. Of the 65% who reported having “some” or “a lot” of telepsychiatry experience, 60% reported they had no formal didactic curriculum.

Programs identified lack of faculty with expertise in PTP as an important obstacle. Without relevant education, clinical experience, and exposure to technology, psychiatrists may be hesitant to integrate telepsychiatry into their practice.

**Abstract**
This interactive session will begin with an overview of the ongoing effort to develop a national Pediatric Telepsychiatry (PTP) Curriculum. Key content areas, model didactics and assessment tools, and demos of the curriculum will be presented. Participants will then try out and discuss a variety of online resources for PTP education and training, including the joint American Academy of Child and Adolescent Psychiatry (AACAP) and American Psychiatric Association (APA) Telepsychiatry toolkit videos.

Participants will then engage in a simulated training session on “PTP in Collaborative Care.” In this experiential learning exercise, participants will learn how to structure and teach didactic and clinical sessions using existing resources. Testimonials from CAP fellows with experience in telepsychiatry will be shared for discussion. Finally, participants will work in small groups to develop their own individual learning plan for becoming teachers and supervisors of telepsychiatry.

This work is supported by an ABPN Faculty Innovation in Education award to Dr. DeJong.

**Agenda**
0:00 Introduction
0:05 Overview of the Development of a National Pediatric Telepsychiatry Curriculum
0:20 Review of PTP Core Content and Training Resources with Audience Participation
0:35 “Pediatric Telepsychiatry in the Collaborative Care Model” – A simulated example
1:00 Small Group Breakouts: Developing a Learning Plan for Becoming PTP Teachers and Supervisors
1:20 Q&A Discussion

**Scientific Citations**
1 Clinical Update: Telepsychiatry With Children and Adolescents. J Am Acad Child Adolesc Psychiatry. 2017;56(10):875-93.
2 Boydell KM, Hodgins M, and Pignatiello A et al. Using technology to deliver mental health services to children and youth: A scoping review. Can Acad Child Adolesc Psychiatry, 23:2, May 2014
3 Flaum M. Telemental health as a solution to the widening gap between supply and demand for mental health services. In: Myers K, Turvey C, eds. Telemental Health:

Clinical, Technical and Administrative Foundation for Evidence-Based Practice. London: Elsevier Insights; 2013:11-25.
4 DeJong SM et al. (2019). Unpublished data.
5 AACAP-APA Child and Adolescent Telepsychiatry Toolkit. 2019. https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent. Accessed September 3, 2019.

# Educational Workshops Session 3

## Graduate Medical Education Funding Made Less Complex

**Presenters**
Jed Magen

**Educational Objective**
Training Directors will understand:
1) Basics of current Graduate Medical Education funding mechanisms
2) How hospitals and programs may respond to regulatory and other changes that affect funding
3) The state mechanisms currently used across the US to fund residency program positions that they may be a model for other states

**Practice Gap**
1)From discussion and feedback from past workshops, program directors report that they do not have easily accessible or understandable information regarding how hospitals, states and the Federal Government fund graduate medical education and their own programs.
2) Many program directors report that they do not have program budgets and thus do not understand their own costs.
3) Evidence from the Teaching Health Center GME program is consistent with the view that may program directors do not understand how this funding mechanism might be used by their programs to add positions.

**Abstract**
Graduate Medical Education programs rely heavily on Medicare funding. Direct and indirect medical education funding levels continue to decrease based on earlier legislation mandating continued cuts. Caps on hospital residency numbers decrease flexibility to change numbers and other regulations increasingly constrain programs. Health care reform legislation resulted in some changes in GME regulations. This seminar will help program directors to:
1) understand basic mechanisms of GME funding
2) review GME regulatory changes
3) various Federal GME funding recommendations

The following topics will be discussed:

The basics of GME funding
a) direct and indirect GME costs/reimbursement
b) caps on housestaff numbers and years of training
c) workforce issues
d) changes in Medicare payment for services and where does all the money go?

2) Possible responses
a) resident generated revenue
b) other funding sources (state, local)
c) uncompensated residencies
d) outsourcing, consortiums, other novel responses
e) Federally Qualified Health Centers and Teaching Health Center grants

3) Health care reform, past, present

**Agenda**
The objective of this workshop is to help program directors better understand and function in the current very uncertain and complex health care environment that makes maintaining quality in training programs difficult.

**Scientific Citations**
Graduate Medical Education Financing: Sustaining Medical Education in Rural Places
http//depts.washington.edu/uwrhrc/uploads/RTT_Finances_PB.pdf

Accountability and Transparency in Graduate Medical Education Expenditures
Saima I. Chaudhry, MD, MSHS, Sameer Khanijo, MD, Andrew J. Halvorsen, MS, Furman S. McDonald, MD, MPH, Kavita Patel, MD, MSH
American Journal of Medicine. May 2012 Volume 125, Issue 5, pages 517-522

## When the supervisor needs a supervisor: your guide to training supervisors in best practices

**Presenters**
Amber Frank, MD
Aimee Murray
Anne Ruble, MD, MPH
Donna Sudak, MD
David Topor, PhD

**Educational Objective**
By the end of the session, participants will be able to
1) Briefly describe common challenges in psychotherapy supervision faced by residency and fellowship programs.

2) Identify several potential approaches to manage these common challenges.
3) Identify at least one supervisory challenge relevant to their home programs, and develop a preliminary action plan to address it.

**Practice Gap**

Individual supervision of psychotherapy cases is a cornerstone of psychotherapy education for residency and fellowship programs. Program Directors and Directors of Psychotherapy Training are tasked with oversight of their trainees' psychotherapy supervision, including recruiting supervisors, helping address problems in supervision, and providing ongoing faculty development for psychotherapy supervisors. However, training directors may feel less equipped to manage aspects of psychotherapy supervision that fall outside of their personal areas of expertise. This workshop will provide participants with the opportunity to increase their confidence in managing common supervision challenges faced by training directors and faculty supervisors , including recruiting and developing a supervisor pool, managing problems in the supervisor-supervisee dyad, and special issues in psychotherapy supervision, e.g. interdisciplinary collaboration and diversity, equity, and inclusion.

**Abstract**

Despite the importance of the supervisory relationship, there has been little uniformity in its implementation and a paucity of evidence about the most effective supervisory behaviors. Nevertheless, there exists a literature about principles of adult learning that may be applied to supervision to enrich and make the experience more robust. Several recent studies point to supervision as vital to the process of psychotherapy adherence and quality, as well as improvement in patient outcomes.

This workshop is derived from the work of a subgroup of the AADPRT Psychotherapy Committee, which has generated a list of common challenges and core issues in psychotherapy supervision, with the goal of creating a series of practical guides for the membership on these topics. This workshop will review a subset of these common challenges and core issues, and attendees will also discuss specific roadblocks to effective supervision in their program and determine an action plan. Participants will have the opportunity to explore challenges within the supervisor-supervisee dyad as well as systems-level supervision concerns relevant to training directors, such as recruiting and developing your psychotherapy supervisor pool. The workshop will be active in nature, utilizing scenarios and discussion to review key points.

**Agenda**

- Welcome and Introductions - 5 min
- Overview of Challenges in Supervision - 10 min
- Small group scenarios and discussion - 45 min
- Individual program action planning - 10 min
- Large Group Discussion and questions - 15 min
- Evaluations - 5 min

**Scientific Citations**


1. Bambling, MW, King, R, Raue, P, Schweitzer, R, Lambert, M. Clinical supervision: Its influence on client-rated working alliance and clinical symptom reduction in the brief treatment of major depression. Psychotherapy Research 16(3):317-331, 2006.
2. Sholomskas, DE, Syracuse-Siewert, G., Rounsaville, BJ, Ball, SA, Nuro, KE, Carroll, KM. We don't train in vain:A dissemination trial of three strategies of training clinicians in cognitive-behavioural therapy. Journal of Consulting and Clinical Psychology 73: 106-115, 2005
3. Crocker E, Sudak M. Making the Most of Psychotherapy Supervision: A Guide for Psychiatry Residents. Academic Psychiatry. 2017;41(1):35-39. doi:10.1007/s40596-016-0637-5
4. De Golia, GS, Corcoran KM. Supervision in Psychiatric Practice: Practical Approaches across Venues and Providers. American Psychiatric Association Publishing; 2019.
5. Grant J, Schofield MJ, Crawford S. Managing difficulties in supervision: Supervisors perspectives. Journal of Counseling Psychology. 2012;59(4):528-541. doi:10.1037/a0030000.
6. Hutman H, Ellis MV. Supervisee nondisclosure in clinical supervision: Cultural and relational considerations. Training and Education in Professional Psychology. 2019. doi:10.1037/tep0000290.
7. Jacobsen CH, Tanggaard L. Beginning therapists' experiences of what constitutes good and bad psychotherapy supervision: With a special focus on individual differences. Nordic Psychology. 2009;61(4):59-84. doi:10.1027/1901-2276.61.4.59
8. Shanfield SB, Hetherly VV, Matthews KL. Excellent supervision: the residents' perspective. The Journal of Psychotherapy Practice and Research. 2001;10(1):23-27.
9. Watkins CE. Educating Psychotherapy Supervisors. American Journal of Psychotherapy. 2012;66(3):279-307. doi:10.1176/appi.psychotherapy.2012.66.3.279.


## Feedback, mentorship, and change: Finding meaning in the Disciplinary Process

**Presenters**


Adrienne Bentman, MD
Deborah Spitz, MD
Ann Schwartz, MD


**Educational Objective**

1) Identify the time line of the disciplinary process
2) Recognize the key elements of a remediation plan and disciplinary letter
3) Develop tools to address common challenges and missteps in the disciplinary process
4) Identify means to limit collateral damage among residents

**Practice Gap**

Feedback on prior disciplinary workshops suggests that new program directors and even those with some experience are challenged by the complexities of the disciplinary process and need

basic, step-by-step instructions in order to make the process work effectively. This workshop is designed to meet that need while containing the impact of the process on fellow residents.

**Abstract**
For all program directors, the disciplinary process is challenging. Initial faculty assertions of misbehavior or incompetence may evaporate, arrive after submission of a passing evaluation, or become lost in the shuffle among rotations and sites. When confronted, the resident may be scared, misrepresent the issues, or be entirely unaware of the concerns. In spite of guidelines that seem clear, implementing the disciplinary process can leave the program director in a "grey zone" of confusion, surprises and difficult choices which can challenge even the most seasoned among us.

Following a brief overview and outline of the disciplinary process, we will discuss the process of writing letters of deficiency and developing remediation plans. Samples of both will be shared and discussed. The workshop will also address common challenges in the disciplinary process including:

1) Addressing concerns with resident performance including poor insight, difficulty receiving feedback, executive dysfunction, poor boundaries, underlying psychiatric or substance use disorder to name a few.
2) The case of poor performance but limited written documentation (though lots of verbal feedback from faculty in the hallway)
3) Challenges in implementing a plan to address deficiencies (which requires intensive resources, faculty time, mentoring)
4) Problematic structural issues in the Department (low faculty morale, complex institutional requirements)

We will discuss solutions to these problems and share techniques and experiences that have worked! The role of mentorship and coaching will be emphasized as there is something to be gained in the process, often by everyone involved.

In a discussion about pitfalls and collateral damage, we will address the effects of disciplinary actions on other residents in the program and discuss how to manage the challenging and complicated feelings of vulnerability and fear that may arise in the context of remediation or dismissal of a fellow resident.

**Agenda**
5 min, Introduction
5 min, The basics of the disciplinary process (discovery to resolution) (Schwartz)
10 min, Remediation plan and the contents of a disciplinary letter (Spitz)
15 min, Challenges and missteps in the Disciplinary Process (Schwartz)
25 min, Pitfalls and Collateral Damage (Spitz and Bentman)
30 min, Discussion, QA and wrap-up (all)

**Scientific Citations**

Paglia MJ, Frishman. The trainee in difficulty: a viewpoint from the USA. The Obstetrician and Gynecologist 2011: 13:247-251.

Ratan RB, Pica AG, Berkowitz RL. A model for instituting a comprehensive program of remediation for at-risk residents. Obstetrics and Gynecology 2008; 112:1155-1159.

Schwartz AC, Kotwicki RJ, McDonald WM. Developing a modern standard to define and assess professionalism in trainees. Academic Psychiatry 2009: 33:442-450.

## The PGAA Tour: Parenting, Guilt, and Adapting in Academia

**Presenters**

Esther Lee, MD
Sansea Jacobson, MD
Neha Sharma, DO
Isheeta Zalpuri, MD
Robert Kitts, MD

**Educational Objective**

Upon completion of this session, participants will be able to:
1. Understand the impact of parenting challenges upon professional growth, performance, and advancement as an early career psychiatrist.
2. Adopt a more empowered attitude about being or becoming a parent in academia.
3. Demonstrate knowledge of resources, skills, and tools that provide support for parents trying to adapt and thrive in academia.

**Practice Gap**

Physician surveys have revealed that physician mothers are responsible for a disproportionate amount of household duties (1) and childcare (2) compared to their male peers, and that this "second shift" is a contributor to burnout (3). In the general population, motherhood has been associated with greater incidence of burnout, feelings of parental inadequacy, and high levels of anxiety (4). For physicians, there is also significant concern from trainees about the negative impact that having children and taking parental leave might have on their professional reputation and career (5,6). A literature review from 1984-2001 also suggested an increased risk of medical complications, especially adverse late-pregnancy events, with pregnant residents finding the physical demands of training and lack of support to be the most stressful factors (7). While mid-career physicians (11-20 years of experience) were more vulnerable to work-family conflict, the productivity of female faculty members in the later stages of their career (even surpassing that of their male colleagues) is attributed to the decreased burden of family responsibilities at this stage (8).

1- Marital and parental satisfaction of married physicians with children. Warde CM, Moonesinghe K, Allen A, and Gelberg L. J Gen Intern M. 1999 March; 14 (3): 157-165.
2- Effectively mentoring physician-mothers. Lechner BE, Gottlieb AS, Taylor LE. Acad Med. 2009 Dec;84(12):1643-4. doi: 10.1097/ACM.0b013e3181bee79a. PMID: 19940561
3- Marriage, children cause more burnout for female physicians. Bernard R. Medical Economics (BLOG). April 15, 2017. https://www.medicaleconomics.com/medical-economics-blog/marriage-children-cause-more-burnout-female-physicians#_edn5
4- Parental Burnout Crisis in Corporate America – The Incidence of Weary and Work Out Parents in America. BPI Network and PollFish. http://bpinetwork.org/pdf/studies/Parental-Burnout_Report_Final.pdf June 2018
5- Do women residents delay childbearing due to perceived career threats? Willett LL et al. Academic medicine. 2010 April; 85(4).
6- Female trainees believe that having children will negatively impact their careers: results of a quantitative survey of trainees at an academic medical center. Kin C, Yang R., Desai P, Mueller C, and Girod S. BMC Medical Education. 2018; 18:260.
7- Pregnancy during Residency: A Literature Review. Finch S.J. Academic Medicine. 2003 April; 78(4).
8- Balancing motherhood, career, and medicine. Mezu-Chukwu U. JAMA Cardiology. 2017 July; 2(7).

**Abstract**
The transition into parenthood is one of the most life-altering and challenging in any individual's life, yet one for which medical learners and early career psychiatrists are often underprepared. Despite the recently increasing focus on resiliency and burnout, there is a dearth of education and resources on how developing physicians, especially those in academia, can better adapt to this major change. The hidden curriculum of academic parenting is broad and includes the following:
1. The challenges facing new parents in academia (e.g., barriers, impact of leave, career compromise)
2. Internal struggles (e.g., guilt, conflicting priorities, increased pressure for perfection in multiple professional and personal realms)
3. The effect on personal relationships (e.g., depletion of empathy/patience, shifting priorities, reduced time for connection)
4. Effects on professional work (e.g., burnout, impact on productivity/efficiency, chronic sleep deprivation)
This workshop aims to explore this hidden curriculum within the context of the academic realm through discussion and proactive engagement. Created by four academic child & adolescent psychiatrists with diverse parenting backgrounds (e.g., married mother of three, gay father, divorced mother, first-generation American-born parent), this workshop will include an assessment of needs/interest, the establishment of a career development framework/map with resources, and suggested actions and next steps for the future.

**Agenda**
20 minutes: Introductions and ice-breaker

10 minutes: Strength-based exercise identifying the advantages of parenting in academia
45 minutes: The workshop will introduce the following four themes:

1. The challenges of becoming a parent in academia
2. The internal struggles that come with being a parent in academia
3. The effects on personal relationships
4. The effects on professional work

After conducting a needs assessment as a larger group, identifying the challenges presented by parenting in academia, participants will break in smaller groups by theme. With the use of flip charts, handouts, and group think/pair-share, each group will focus on identifying ways, resources and/or tools to target some of the identified challenges for their assigned theme. The goals for each group will be as follows:

1. Conducting an informal needs/interest assessment of parenting challenges and how they are prioritized in the academic setting
2. Working on a career development framework/map and discussing how the aforementioned challenges might be accommodated
3. Generating solutions, resources, and "lessons learned" to help promote adaptation
4. Creating personal, training, and/or institutional goals, action items, and next steps

Each group will then summarize their identified solutions for the larger group and brainstorm ways in which to keep one another accountable for their action plan.

**Scientific Citations**

The inspiration for this topic came when four child & adolescent psychiatrists, including three current fellowship program directors, started a discussion on the impact of parenting upon developing academic careers. As parents of young children in diverse contexts, we still found common concerns regarding the general lack of support, inconsistent institutional policies regarding parental leave, and inflexible expectations for career advancement that exist in our current medical system. After conducting a literature search on this subject, we found that the impact of parenting on an academic career is one that is well-recognized but inadequately addressed as discussed above. The parenting experience is one that is common to a significant proportion of our profession at a time when the importance of physician wellness is being increasingly recognized and prioritized. Our purpose in creating this workshop is to start and carry forward a much-needed dialogue on how to truly obtain a reasonable and compassionate work-life balance in academic psychiatry.

## Addressing the Shortage of Psychiatry Subspecialists: What Residency Educators Can Do

**Presenters**

Anna Kerlek, MD
Carrie Ernst, MD
Rebecca Klisz-Hulbert, MD
Kari Wolf, MD
Art Walaszek, MD

**Educational Objective**

1. Understand and interpret the scope of the shortage of psychiatry subspecialists in the U.S. and the recruitment challenges that psychiatry fellowships face.
2. Describe strategies that general residency programs can implement to help promote subspecialty training and thereby help address the shortage of subspecialists.
3. Identify and generate other strategies for promoting workforce development in psychiatry subspecialties.
4. Select one such strategy to implement in their own residency programs.

**Practice Gap**

While the shortage of psychiatrists in the U.S. is significant, the shortage of psychiatry subspecialists is especially dire. Out of nearly one million physicians in the country, serving a population of 330 million, there are fewer than 10,000 child and adolescent psychiatrists (CAP), roughly 1300 geriatric psychiatrists, and just over 800 addiction psychiatrists. Psychiatry subspecialists are also distributed inequitably, with many areas (especially rural ones) experiencing shortages. For example, 41 states are reported to have "severe" shortages of CAP, defined as 17 or fewer child and adolescent psychiatrists per 100,000 children. 72% of U.S. counties do not have a single CAP. Two states do not have a single geriatric psychiatrist. There are no addiction psychiatrists in four states, and none in 92% of counties.

At the same time, recruitment into fellowships has plateaued or declined. For the 2018-2019 academic year, many fellowship positions went unfilled: an estimated 10% of CAP positions, 28% of addiction psychiatry positions, 39% of forensic psychiatry positions, 42% of consultation-liaison psychiatry positions, and a staggering 57% of geriatric psychiatry positions. The number of CAP fellows has remained flat over time (855 in 2012, 869 in 2018), whereas the number of geriatric psychiatry fellows has declined (67 in 2012, 52 in 2018) – despite the projection that 20% of the U.S. population will be over 65 by 2030.

**Abstract**

More medical students are matching into psychiatry than at any point in the past, and psychiatry programs continue to expand. Despite this increased interest in psychiatry, recruitment into subspecialty fellowships has plateaued. Recruitment into general programs may have an impact on recruitment into fellowships. Historically, international medical graduates (IMGs) have made up a significant proportion of psychiatry fellows (for example, approximately half of geriatric psychiatry fellows). However, as more U.S. medical school graduates have applied to and entered psychiatry residencies, the number of IMGs in residency training has decreased – which may in turn further hamper efforts to recruit into fellowships. Without efforts to promote subspecialty recruitment, it may fall on general residencies to increase the amount of training in subspecialty topics.

This workshop is a joint presentation by the AADPRT Recruitment Committee and the Work Force Task Force. The Work Force Task Force surveyed subspecialty program directors to determine trends in fellowship program establishment, expansion and reduction, as well as

funding, resources and recruitment challenges. Presenters will provide data on the shortage of subspecialists and on recruitment into fellowships, and will then present outcomes of the Work Force Task Force survey of fellowship program directors. Participants will break into small groups for a guided discussion of barriers to subspecialty recruitment. We will discuss strategies that educators in general residency programs can deploy to aid fellowship recruitment and thereby help address the shortage of subspecialists. Finally, participants will consider approaches that they can use in their own programs to increase the number of trainees entering subspecialty training.

**Agenda**

| | |
|---|---|
| 0:00-0:05 | Introduction |
| 0:05-0:20 | Presentation of subspecialty recruitment statistics and results of AADPRT Work Force Task Force survey of fellowship directors |
| 0:20-0:40 | Breakout #1: Facilitated discussion on barriers to subspecialty recruitment |
| 0:40-0:55 | Presentation of strategies for promoting recruitment of fellows |
| 0:55-1:15 | Breakout #2: Facilitated discussion on strategies to promote subspecialty recruitment |
| 1:15-1:30 | Q&A and feedback via Whova |

**Scientific Citations**

Agapoff J, Olson D. Challenges and Perspectives to the Fall in Psychiatry Fellowship Applications. Academic Psychiatry 43: 425-428, 2019.

American Psychiatric Association: Resident Census 2018. https://www.psychiatry.org/residents-medical-students/medical-students/resident-fellow-census, Accessed October 20, 2019.

Balon R. Subspecialty training: time for a change. Academic Psychiatry 41 (4): 558-560, 2017.

University of Michigan Behavioral Health Workforce Research Center: Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce. Ann Arbor, MI: UMSPH; 2018.

Wayeed A, Sadhu J, Kerlek A, Lee P. The Biopsychosocial Model of Program Self-Evaluation: an Innovative and Holistic Approach to Enhance Child and Adolescent Psychiatry Training and Recruitment. Academic Psychiatry 43 (5): 542-546, 2019.

## Resident Scholarly Activity: From Citation to Commendation!

**Presenters**

Rashi Aggarwal, MD
Tanya Keeble, MD
Justin Faden, MD
Amy Burns, MD
Muhammad Zeshan, MBBS

**Educational Objective**
At the end of the workshop, participants will be able to:

1. Identify barriers to productivity in the scholarly activity process during residency training.
2. Describe strategies to enhance scholarly activity for residents
3. Describe concrete steps towards instituting a mentorship program to boost scholarly activity
4. Identify the next step to boost scholarly activity in their own program.

**Practice Gap**
Although resident scholarly activity is encouraged for all psychiatry residents, few guidelines exist for residency training programs with regards to delineating a practical process for assisting residents with accomplishing this goal. In this workshop, we aim to discuss the initiative at two programs, both of which were very successful. We also intend to discuss the generalizability of barriers and insights from other programs and participants via discussion and group participation. In particular, we plan to stress common barriers to the scholarly process, mechanisms for tackling barriers, and suggestions for instituting a more formal process of assigning and guiding guiding mentors, and helping residents and mentors become familiar with the process of taking an idea or case to a scholarly project. We hope that participants gain insights and ideas from this educational and didactic experience to assist in instituting similar initiatives at their respective programs.

**Abstract**
Resident scholarly activity is encouraged for all psychiatry residents as per the 2007 ACGME program requirements. Studies have repeatedly showed that engaging in scholarly projects during training helps residents to interpret the literature, apply evidence to patient care, demonstrate competency in research methods, pursue a career in academic medicine, and ultimately achieve higher academic ranks. It also adds to the program's ranking and enhances its profile by increasing the departmental publications, poster and oral presentation at conferences, and nomination of their residents for regional and national awards.

Despite the overarching benefits, residents find it challenging to pursue scholarly work due a myriad of factors including limited number of formal research training opportunities, increasing pressure on mentors to maintain revenue based clinical activities, trainee attitudes, lack of clarity and consistency among programs about setting scholarly goals and providing protected scholarly/research time. The National Institute of Mental Health has also noted a decline in the number of psychiatrist-researchers as compared to other medical specialties.

In this workshop we highlight two different ways programs have been successful in addressing this gap. The medical center academic program developed a scholarly activity initiative in 2010 in which residents were provided with guidelines on how to identify novel and relevant cases, undertake a literature search, find the most appropriate format for conveying ideas (poster, case report, letter), and start the writing process. Since instituted, this initiative produced significant scholarly activity output, which is evidenced by production of 3 posters and 2

publications from 2008-2010, to 170 posters, 93 publications, and 25 workshops between 2011-2019.

The second, newer community based program was motivated to address scholarly activity gaps after receiving two ACGME citations in this area in 2017, one of which was focused on resident participation in scholarly activity, the other on faculty scholarly activity. They developed an alternative strategy, designed to address the emerging new common program requirement focus on program accomplishments in quality improvement and/or patient safety initiatives, resident engagement in quality improvement activities and faculty support of resident scholarly activity. They developed a resident AI and patient safety and QI curriculum that threads through all 4 years of the categorical program, and includes expectations for scholarly production and dissemination in regional and national settings. This approach has been successful in fully resolving the citation, and garnering an ACGME commendation for taking an active and creative effort in generating participation in scholarly activity in a sustained and supported manner.

The goal of this workshop is to facilitate adoption of the scholarly activity process in other programs by engaging the workshop audience in group discussion, role playing, and various interactive sessions to identify barriers to lack of engagement and productivity. We will delineate specific techniques for tackling these barriers. We will also focus on scholarly activities most attainable for busy residents and departments without significant grant support, including translation of daily clinical activities and quality improvement projects into poster presentations, and publications.

**Agenda**

Introduction and understanding the needs of the audience- 10min
Small Groups to discuss barriers (15min)
Large Group Discussion to discuss barriers (10min)
Role Play (5min)
Solution at an Academic program with many affiliate sites (20min)
Role Play (5min)
Solution at a new community based program (10 min)
Pairing to identify one useful strategy and Large Group Discussion- 15min

**Scientific Citations**


1. Accreditation Council for Graduate Medical Education. ACGME program requirements for graduate medical education in psychiatry. 2007. http://www.acgme.org/acWebsite/down loads/RRC progReq/400 psychiatry 07012007 u 04122008.pdfCaren B, Robert M. Research tracks during psychiatry residency training. Acad Psychiatry 2018
2. Fenton W, James R, Insel T. Psychiatry residency training, the physician-scientist, and the future of psychiatry. Acad Psychiatry. 2004; 28(4):263–6. [PubMed: 15673819] 5.
3. Kupfer DJ, et al. Recruiting and retaining future generations of physician scientistsin mental health. Arch Gen Psychiatry. 2002; 59(7):657–60. [PubMed: 12090819]

4. Josette R, Rachel L, Scott W. Brief Report: Completing a scholarly project during residency training, Perspective of residents who have been successful. J Gen Internal Med 2005;20:366-369

## Putting Entrustable Professional Activities (EPAs) into Action: Implementation Tips and Strategies

**Presenters**
John Q. Young, MD, MPH, PhD
Erick Hung, MD
Colin Stewart, MD
Andrea Weiss, MD
Julie Sadhu, MD

**Educational Objective**
1. Appreciate how the framework of Entrustable Professional Activities (EPAs) complements and enhances a Milestones-based assessment program.
2. Locate the EPA Implementation Toolkit on the AADPRT Website
3. Compare and contrast practical approaches to implementing EPAs

**Practice Gap**
A number of RRCs, the AAMC, and specialty societies in other countries have endorsed EPAs as framework for milestone-based assessment. In 2018, the AADPRT Assessment Committee published their proposed end-of-training EPAs for psychiatry in Academic Medicine. Many programs have expressed interest in the EPA framework but are not sure how to take the next step. This workshop will address this gap.

**Abstract**
With the emergence of the competency- and now milestone-based frameworks for graduate medical education, residency programs must develop new methods for assessment. The AAMC and a number of GME specialties in the U.S. and Canada have embraced Entrustable Professional Activities (EPAs) as a helpful framework with which to build a program of assessment. EPAs focus assessment on residents' performance of the essential work activities in a specialty, and are assessed by determining how much supervision is needed, and how much independence residents have earned, to perform these activities. Psychiatry now has end-of-training EPAs. The main focus of this workshop will focus on implementation of EPAs in psychiatry residency programs. We will introduce the EPA framework, share examples and practical tools for incorporating EPAs into a program of assessment, and help participants identify next steps for their home institutions.

**Agenda**
1. Introduction (LG group discussion, 5 min)
2. Brief orientation to EPAs (Instructional, 10 min)

3. Implementing EPAs: Key Choices (Instructional/Interactive plus Small Group, 15 min)
4. Practical Tools (Demonstration, 10 minutes)
5. Identifying Next Steps (Small Group, 35 minutes)
6. Wrap Up (15 min)

**Scientific Citations**

Young JQ, Hasser C, Hung EK, et al. Developing End-of-Training Entrustable Professional Activities for Psychiatry: Results and Methodological Lessons. Acad Med. 2018;93(7):1048-1054.

## Why (and How) Combined Training? Insights from People Who've Been There to Help People Who Might Like to Go There

**Presenters**

Shannon Suo, MD
Robert McCarron, DO
Sandra Batsel-Thomas, MD
Amy Kim, MD
Sheldon Benjamin, MD

**Educational Objective**

Participants attending the workshop will:

1) Be able to describe the background, history and evolution of combined training programs (internal medicine-psychiatry, family practice-psychiatry, neurology-psychiatry, pediatrics-psychiatry-child psychiatry) and ABPN approved alternative pathway (post-pediatric portal program).
2) Determine benefits and drawbacks to a combined training approach
3) Develop strategies for approaching institutional and external logistics in creating a new combined training program

**Practice Gap**

As physicians dedicated to shaping the future of psychiatry, it is important to consider the growing evidence that patients with psychiatric needs frequently have challenging comorbid medical conditions. Corollaries to this statement include observations (1) that treating patients' behavioral health needs can improve their quality of life while decreasing their expenditures and (2) a psychiatrist may be the only physician a patient with severe mental illness sees. (McCarron et al., 2015).

Though combined training programs have been in existence for over 20 years, common perceptions persist that graduates will pursue one or the other (but not both) specialty and/or that training is lacking. A 2012 survey (Jain et al., 2012) of graduates of combined training programs revealed a high degree of job satisfaction, ability to address complicated interplay between medical and psychiatric illnesses, and tendency to practice in integrated care settings. Given the uncertainty in future of the healthcare system and the evidence that a comprehensive approach to healthcare (including behavioral health considerations) will be

cost-effective, integrated behavioral health models have started to proliferate; combined-trained physicians will be well poised to facilitate, educate and promulgate further alignment of medical and mental health services (Kroenke and Unutzer, 2017).

At present there are 15 internal medicine-psychiatry, 6 family practice-psychiatry, 10 pediatrics-psychiatry-child psychiatry, 5 neurology-psychiatry and 4 post-pediatric portal training programs. Residency training directors for combined programs have witnessed a doubling in the number of applications to combined training programs over the last 5 years, and medical student involvement in organizations dedicated to combined training and practice has grown as well (records from the Association of Medicine and Psychiatry), with some students vowing to pursue sequential training if there is insufficient space in the combined programs. The ABPN has reopened the process for institutions to apply for combined training programs, and new programs are being developed.

Many psychiatrists are unaware of the history and evolution of combined training, and creating a combined training program can seem daunting. The goal of this workshop is to facilitate a discussion about what combined training is and to provide general and specific information to encourage would-be combined training directors. Even if not interested in starting up a combined training program, psychiatry residency training directors may benefit from increased awareness of options (including combined training options) that may be appropriate for medical students who seek career advice.

**Abstract**
There are nearly 30 combined training programs in the country, and new programs coming on line. Combined trained physicians may be in a useful position to help align medical and mental health services to improve patient care, and the majority of combined trained physicians find ways to practice and lead healthcare in both medical and psychiatric disciplines. As educators strive to find ways to incorporate integrated behavioral healthcare curricula in their training programs there may be opportunities to consider the merits of combined training. This workshop will provide information, background, and opportunity to discuss combined training, including logistics, advantages, disadvantages, and possible strategies in starting a new program.

**Agenda**

| | |
|---|---|
| 10 minutes | Introductions, background, history of combined training |
| 20 minutes | Interactive discussion – WHY and WHY NOT combined training |
| 30 minutes | How to start a new combined program |
| | - Ingredients |
| | - Practical considerations |
| | - Starting the program |
| 15 minutes | Mythbusters / Q&A |
| 15 minutes | Develop an Action Plan |

**Scientific Citations**

McCarron RM, Bourgeous JA, Chwastiak LA, et al. Integrated medicine and psychiatry curriculum for psychiatry residency training: A model designed to meet growing mental health workforce needs. Academic Psychiatry 2015; 39(4): 461-465.
Jain G, Dzara K, Gagliardi JP, Xiong G, Resch DS, Summergrad P. Assessing the practices and perceptions of dually-trained physicians: A pilot study. Acad Psychiatry 2012; 36(1): 72-74.
Kroenke K, Unutzer J. Closing the false divide: Sustainable approaches to integrating mental health services into primary care. J Gen Intern Med 2017; 32(4): 404-410.

## Teaching Adolescent SUDs and Co-Occurring Disorders Like an Addictions Expert

**Presenters**

Kelly Blankenship, DO
Sandra DeJong, MD, MSc
Ray Hsiao, MD
Kenneth Zoucha, MD

**Educational Objective**

1. Know how to teach common presentations of complex Co-Occurring Disorders (COD) in adolescent patients in psychiatric residency/fellowship didactics
2. Understand treatment options for adolescent Substance Use Disorders and CODs and how to teach about them to psychiatry residents/fellows
3. Identify ways of teaching the use of combining psychopharmacological and psychosocial interventions to achieve optimal treatment outcome for COD in adolescent patients

**Practice Gap**

The United States in an addiction crisis, and not just among adults. With increasing marijuana legalization, many adolescents feel it is “safe” despite research indicating otherwise. Data from 2016 estimated that 4.3% of all adolescents (ages 12-17 years) have a diagnosable substance use disorder. The same report estimated that 23% of adolescents have a history of lifetime illicit drug use, with 7.9% report using illicit drugs in the previous month (1). Despite increasing substance use disorders (SUDs) in the adolescent population, psychiatrists who feel comfortable diagnosing and treating SUDs and co-occurring disorders in teens are lacking. In addition, psychiatry residency and fellowship training in adolescent addiction is often sparse. In a recent survey of child and adolescent psychiatry fellowships, 63.4% of respondents reported no exposure to inpatient or outpatient specialized addiction training settings in their program (2). With the increased need for trained child and adolescent psychiatrists to diagnose and treat co-occurring substance use disorders in adolescents, improved training and didactics for psychiatry residents and child and adolescent psychiatry fellows in this area is imperative. Teaching the teachers and training the trainers is an important model.

**Abstract**

With the rise of marijuana legalization and the current opioid epidemic plaguing the United States, more and more psychiatrists are encountering adolescent patients with complex co-

occurring disorders. However, many practitioners feel under-prepared to handle such challenging cases based on their residency/fellowship training and their sentiments were recently confirmed in a survey of psychiatry training directors conducted by the American Association of Directors of Psychiatry Residency Training (AADPRT). In an effort to educate current residents/fellow and develop a workforce capable of meeting the needs of the growing number of COD patients, AADPRT has convened a Taskforce on Addictions consisted of experts from various psychiatric organizations including the American Psychiatric Association (APA), American Academy of Addiction Psychiatry (AAAP) and the American Academy of Child and Adolescent Psychiatry (AACAP). The Taskforce is in the process of developing various resources for training residents/fellows on co-occurring disorders and this proposed session is one of the model educational activities aimed at training residents/fellows on management of common co-occurring disorders in adolescent patients. During our session, we will have participants divide into 5 small groups to conduct three case studies of common co-occurring disorders in adolescent patients. Each small group will be facilitated by a member of the AADPRT Taskforce on Addictions, and participants will be given a series of prompts and questions that could be used during didactics to teach residents/fellows to diagnose and treat adolescent patients with co-occurring disorders.

**Agenda**

0:00 Introduction
0:05 Overview of SUDs and Co-Occurring Disorders in Adolescents
0:10 Small Case #1: Major Depressive Disorders and Alcohol Use Disorders in Adolescents
1. Identify Alcohol Use vs. Misuse in adolescents vs. Alcohol Use Disorders
2. Common Laboratory Tests for Adolescent COD patients
3. Treating Alcohol Use Disorders in Adolescents
4. Recognizing Safety and other Risk Management issues
5. Managing Major Depressive Disorder in Adolescents

0:35 Small Group Case #2: Bipolar Disorder and Stimulant/Methamphetamine Use Disorders
1. Recognize early warning signs of Bipolar Disorder in adolescents in the context of Substance Use Disorders
2. Managing Bipolar Disorder and co-morbid substance use in adolescents
3. Managing treatment non-adherence in COD adolescent patients

0:55 Small Group Case #3: Anxiety Disorders and Cannabis Use Disorders
1. Identify Cannabis Use Disorders
2. Managing Cannabis Use Disorders
3. Managing Anxiety Disorders in Adolescent Patients with Cannabis Use Disorder

1:15 Small Group Report Out/Large Group Discussion of Cases and Q&A

**Scientific Citations**

1. Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: results from the 2016 National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm Published September 2017.
2. Welsh JW, Schwartz AC, DeJong SM. Addictions Training in Child and Adolescent

Psychiatry Fellowships. Acad Psychiatry. 2018 Jul 31. doi: 10.1007/s40596-018-0959-6. [Epub ahead of print] PubMed PMID: 30066242.
3. Mark TL, Meinhofer A. The Extent to Which Psychiatrists Diagnose and Treat Substance Use Disorders. Psychiatr Serv. 2018 Mar 1;69(3):250. doi: 10.1176/appi.ps.201700457. Epub 2018 Jan 16. PubMed PMID: 29334879.
4. Schwartz AC, Frank A, Welsh JW, Blankenship K, DeJong SM. Addictions Training in General Psychiatry Training Programs: Current Gaps and Barriers. Acad Psychiatry. 2018 Aug 2. doi: 10.1007/s40596-018-0950-2. [Epub ahead of print] PubMed PMID: 30073538.

## Firearms and Suicide Prevention: Why We Should Ask About Guns and How To Train Residents To Have These Conversations

**Presenters**
Lindsey Pershern, MD
Meagan Whitney, MD
Theresa De Freitas Nicholson, MD

**Educational Objective**
By the end of this workshop, participants will be able to:
Learning Objective 1: Describe the role of firearms in patient suicides.
Learning Objective 2: Demonstrate a basic understanding of firearms, how firearms operate and safe gun storage options.
Learning Objective 3: Develop training experiences in non-threatening, culturally competent ways to discuss firearm access and safety with patients.

**Practice Gap**
Suicides are currently twice as prevalent as homicides in the United States. Additionally, over half of suicides are committed with firearms. A study done in Ohio provided a questionnaire to 422 practicing psychiatrists consisting of barriers, anticipatory guidance on firearms and counseling practices, among other topics. This study found that the majority of responding psychiatrists perceived firearm safety issues to be an important issue for mental health patients. However, only one fourth reported that they had a routine system for identifying patients with firearms and almost half had never thought seriously about discussing firearm safety issues with their patients. Another study performed a questionnaire for psychiatry residency program directors to assess their perceptions and beliefs regarding firearm injury prevention training. The vast majority (79%) of responders reported they had not seriously thought about providing firearm injury prevention training. Given the importance of educating physicians regarding firearm safety, a study was done to search for reviews on firearm safety training programs. This study was able to identify only four programs that met their criteria. In one of the studies cited, practitioners who participated in training discussed gun access and storage significantly more than those who did not. Additionally, residents who participated in training reported feeling more confident when making referrals. This is further evidence that

psychiatric residency programs are inadequately training residents and thereby keeping them from maximizing their roles as mental health professionals. This prevents psychiatrists from being truly effective at preventing patient suicide and keeping patients alive.

**Abstract**

Firearms are a hot-button issue that many trainees do not want to discuss with friends and family, let alone with patients. However, psychiatrists need to learn to discuss firearms and firearm safety with patients and establish this as a part of practice. Despite evidence that counseling from a provider effects a patient's gun safety, in one study nearly half of psychiatrists surveyed never thought seriously about discussing gun safety with patients. Two main barriers to doing so are a lack of specific training in residency in having these conversations and an overall unfamiliarity with firearms. In order to address this practice gap, we developed and implemented a curriculum to train residents on firearm safety counseling. In this workshop, we will:
1. Provide participants with a firm understanding of the significant role firearms play in completed suicides and increase awareness of the need for formalized training of residents using an interactive platform.
2. Demonstrate an education platform on firearm basics including types of firearms, how firearms operate and recommended firearm safety practices.
3. Present our curriculum for resident training aimed at increasing comfort discussing firearms with patients and addressing barriers to these conversations.
4. Demonstrate a role-play exercise to develop non-threatening, culturally competent ways to discuss firearm safety.

Conclusion: This workshop will establish an understanding of the impact firearms have on suicide rates and methods of training in this area. Participants will gain literacy on firearm safety and learn how to better train residents to confidently discuss firearms with patients.

**Agenda**

0:00-0:25- Introduction and self-assessment: We will use a game-based interactive quiz platform to establish the role of firearms in suicide and importance of discussing firearm access and safety with patients
00:25-00:40 - presentation on firearm basics, focusing on developing audience member's literacy with various gun terms, knowledge of how guns operate and understanding of firearm safety including recommended storage options.
00:40-00:50 - Brief review of presenters' experiences with teaching residents about counseling patients on gun safety and review preliminary results of research
00:50-01:10- Role play activity - participants will pair up to role-play scenarios in which a psychiatrist discusses firearms with a patient focusing on developing comfortable, non-threatening and culturally competent ways to assess firearm access and discuss safety practices.
01:10-01:25- Large group discussion including reflection on role-play activity and reactions to educational format
01:25-01:30- Participants will use the Whova app to review the workshop

**Scientific Citations**

1. Price JH, Kinnison A, Dake JA, Thompson AJ, Price JA. Psychiatrists' practices and perceptions regarding anticipatory guidance on firearms. Am J Prev Med. 2007; 33: 370–373.h https://www.ncbi.nlm.nih.gov/pubmed/17950401
2. Price JH , Thompson AJ, Khubchandani Jet al. . Firearm anticipatory guidance training in psychiatric residency programs. Acad Psychiatry . 2010;34(6):417–423. https://www.ncbi.nlm.nih.gov/pubmed/21041464
3. Puttagunta R, Coverdale TR, Coverdale J. What is taught on firearm safety in undergraduate, graduate, and continuing medical education? A review of educational programs. Acad Psychiatry. 2016;40(5):821–824 https://link.springer.com/article/10.1007/s40596-016-0490-6

## The Evolving Composition of the Psychiatry Residency Trainee Workforce: Analysis of matching trends of International Medical Graduates

**Presenters**

Sanya Virani, MD
Souparno Mitra, MD
Robert Cotes, MD
Jessica Kovach, MD
Vishal Madaan, MD

**Educational Objective**

1. At the end of this session participants should be able to:
2. Understand the recent trends of resident recruitment in Psychiatry and the subsequent decline in numbers of matching international medical graduates (IMGs)
3. Gain insight into the impact of declining IMG numbers within the general and subspecialty psychiatric workforce
4. Engage in discussions (especially program directors) about uniform methods of reviewing candidate applications, whether US medical graduates or IMGs
5. Participate in making recommendations for the future of diversified resident recruitment in Psychiatry

**Practice Gap**

Recruitment trends in Psychiatry have been changing over the last decade. Residency programs are experiencing higher application numbers, both from US and International Medical Graduates (IMGs). The increase in residency positions and programs however has been modest and not kept up with the growing applicant pool, with unmatched spots going down from 16% in 1996 to 1% in 2018.1 The ratio of applicants per spot in psychiatry (1.53) is the second highest among all specialties.2

IMGs contribute to a third of the psychiatric workforce3, are often employed in underserved areas and make up a large proportion of the fellowship trainee pool. They come from diverse social and cultural backgrounds but are at a disadvantage when it comes to residency

recruitment, carrying with them the burden of differential training backgrounds and visa sponsorship requirements. It is likely that the increase in applications from US medical graduates has resulted in a downward trend in IMG match rates, with only 123 out of 321 applicants matching in 2018.

The shortage of psychiatrists is estimated to only increase over the next decade, and as the inclusion of IMGs continues to decline, a direct impact could be seen on the numbers of residents entering subspecialty training. Underserved areas could also potentially bear the brunt of this impending shortage.

**Abstract**

Our workshop will focus on aggregate data analysis of the American Psychiatric Association's five year (2014-2018) resident census report4, which panel members have worked on collaboratively to compile. Data for this report was synthesized from the following sources:

1. Graduate Medical Education Survey data available publicly
2. National Resident Matching Program Data
3. Association of American Medical College (AAMC) special data reports

The workshop will begin with the panel engaging participants in an open discussion about their evaluation criteria with respect to resident recruitment, and their perceived challenges with reviewing applications from IMGs. This will be followed by a presentation by Drs. Cotes, Virani and Mitra on the findings of our study, with particular focus on the current geographic and temporal trends of IMG trainee distribution, in topographical and tabular formats. Subsequently, participants will engage in small-group interactive sessions moderated by Dr. Kovach to zone in on the proportion of IMGs in their own programs and share insights about the changing trends over the past five years in light of the data presented. The groups will also elaborate upon their perceptions of special mentoring needs of IMGs if any, after matching into residency programs.

The panel will then regroup the audience to participate in a discussion about the perceived benefits of IMG inclusion in residency programs and broadly, the workforce, keeping in mind elements of cultural competency and diversified recruitment needs. The final wrap up will be preceded by a group activity conducted by Dr. Madaan, to design succinct, inclusive and broadly applicable evaluation criteria to uniformly evaluate applications. A model set of criteria would be proposed by the panel for participants to review and add on to. A brief Q&A session will subsequently close out the workshop leaving participants informed about varied perceptions of the issue of IMG recruitment and an awareness of the impact that these changing trends could have in the following decade.

**Agenda**

0:00- Introduction
0:05- Open discussion: Perceived and real challenges with IMG recruitment
0:15- Presentation of data and analysis results of the study, including APA resident census report

0:25- Small group sessions: Individual experiences with IMG recruitment, perceptions of mentoring needs for IMGs in residency programs
0:35- Open discussion: Benefits of diverse culturally competent IMG recruitment
0:45- Small group activity: Exercise of designing ideal application criteria
1:05- Cumulative presentation of group ideas to develop unified application evaluation model
1:15- Q&A from participants
1:25- Conclusions

**Scientific Citations**

1 Balon, R., Mufti, R., Williams, M., M.D., Riba, M. (1997). Possible Discrimination in Recruitment of Psychiatry Residents? American Journal of Psychiatry, 154 (11), 1608-09. https://doi.org/10.1176/ajp.154.11.1608
2 National Resident Matching Program (2019). Results and Data: 2019 Main Residency Match®. National Resident Matching Program, Washington, DC. 2019.
3 Ahmed, A.A., Hwang, W.T., Thomas, C.R., Deville, C. (2018). International Medical Graduates in the US Physician Workforce and Graduate Medical Education: Current and Historical Trends. Journal of graduate medical education, 10(2), 214–218. doi:10.4300/JGME-D-17-00580.
4 Isom, J., Virani, S. (2019). American Psychiatric Association Resident Census 2012-2017. APA

## Diverse Perspectives and Practical Strategies in URM Psychiatry Recruitment, Retention and Development

**Presenters**

Jaela Barnett, MD
Denese Shervington, MD
Arden Dingle, MD
Danielle Hairston, MD
Sarah Vinson, MD

**Educational Objective**

Educational Objectives:

1. Identify strategies for addressing the ACGME psychiatry core competency of recruitment and retention of a diverse and inclusive workforce of residents, fellows and faculty members.
2. Review the literature regarding the workplace environment and workforce benefits of the inclusion of underrepresented minorities and diversity.
3. Identify barriers limiting underrepresented minorities from pursuing careers in psychiatry
4. Discuss ways in which leaders with experience in education at both predominantly white institutions and historically black college and university medical schools have successfully recruited, retained and developed under-represented minority trainees.

**Practice Gap**

The road to diversifying medicine is complex and continues to evolve. There are various factors that influence individuals to pursue a career in medicine. Within medicine, there has been an increased awareness in mental health. As the field of psychiatry continues to grow with a population that continues to expand and diversify, psychiatrist from minority backgrounds is essential. Yet, there are barriers that limit underrepresented minorities to pursue a career in psychiatry. Those URM who do matriculate into psychiatry residency programs choose and rank programs based on certain criteria. Residency programs themselves base their selection of residents on numerous criteria. This workshop will focus on the recruitment and retainment of URM's in psychiatry

**Abstract**

The need for underrepresented minorities in psychiatry is pronounced. In 2018 there were roughly 330,000,000 people living in the United States. Less than 10 years ago the U.S. population was approximately 308,000,000. The rate of growth has been exponential. According to the U.S. Census Bureau in 2010, Hispanics made up 16.3% of the population, African-American 12.6%, American-Indian 0.9% and Native Hawaiian 0.2%. In 2018, the percentage increased to 18.3% for Hispanics, 13.4% for African-Americans, 1.3% for American Indian, and Native Hawaiian stayed the same at 0.2%. This emphasizes the increasing diversity in the U.S. One can suspect that these numbers will continue to rise. Despite the increase, it is apparent that various problems continue to persist. Health care disparities continue to be prevalent affecting health outcomes and quality of care. It's imperative that the disparities be

addressed as the population becomes more diverse. Specific to the field of psychiatry is the need for more providers from minority backgrounds to aid in decreasing the stigma associated with mental illness within minority communities, increase access to culturally competent mental health care and inform the provision of care to underserved minority communities. This workshop will address actionable strategies for the recruitment, retention and development of underrepresented minorities in psychiatry. African-Americans constitute roughly 6.6% of psychiatry residents yet African-Americans make up 13.2% of the general population. Additionally, an estimated 8.3% of U.S. psychiatry residents are Hispanic but represent 17.1% or more of the U.S. census. After identifying potential causes of this disparity, the presenters will provide the workshop participants with tools to tackle the critical issue of diversity in the field of psychiatry. The presenters have diverse perspectives and experience levels and include two full professors and leaders in psychiatric education who have successfully recruited and developed URMs at PWIs and HBCUs; two URM mid-career psychiatrists with first-hand experience working at HBCUs and PWISs and are current Program Directors at HBCU residency training programs; and a psychiatry resident at a HBCU training program.

**Agenda**

0:03 Introduction & Disclosures

0:07 Dr. Sarah Vinson- Discussion on structural barriers and stigma medical students and residents face pursuing a career in medicine and psychiatry.

0:10 Dr. Jeala Barnett- A URM resident's perspective on factors influencing her choice in residency programs.

0:10 Dr. Arden Dingle – Discussion on educational program development

0:10 Dr. Danielle Hairston - Utilization and Benefit of Pipeline Programs

0:40 Breakout sessions – Participants can choose 1 of 3 breakout groups that will be led by the panelists and include self-assessment, group problem solving, and identification of smart goals.

Break out-topics/groups (groups of 4-5):

- Medical student engagement and recruitment
- Brainstorm ways to increase URM medical student recruitment into the field of psychiatry at your institution.
- Program development
- Discuss ways in which your program or institution can address the ACGME psychiatry core competency of recruitment and retention of a diverse and inclusive workforce of residents, fellows and faculty members.
- Professional development and sponsorship
- Develop a proposal that focuses on ways programs/institutions can foster an environment that supports inclusion and diversity to recruit and retain URM's.

0:10: Questions and discussion

**Scientific Citations**

Pierre, J.M., Mahr, F., Carter, A. et al. Acad Psychiatry (2017) 41: 226.
https://doi.org/10.1007/s40596-016-0499-x

ACGME Program Requirements for Graduate Medical Education in Psychiatry

# Educational Workshops Session 4

## Let's Talk About Sex: Improving Sexuality Education for Trainees

**Presenters**

Cathleen Cerny-Suelzer, MD
Stephen Levine, MD
Victoria Kelly, MD

**Educational Objective**

1. Recognize the gap between patient sexual difficulties and trainee preparation to deal with them 2. Distinguish between the myriad of negative consequences that can result from sexual behavior and psychiatric concepts of sexual disorder 3. Provide residency and fellowship training directors with a coherent curriculum to prepare trainees for the complex dilemmas that often lay hidden behind traditional psychiatric diagnosis

**Practice Gap**

Sexuality is a force in every person's life throughout the lifecycle. While some develop and maintain a relatively problem-free and satisfying sexual life, prevalence data on defined sexual problems is remarkably high. Adolescence, young adulthood, middle age, early older age and advanced age each pose sexual challenges that may cause distress. Regardless of a residents' future area of concentration, sexual issues of their population age group will confront them. The privacy of individual sexual experience forms a barrier that prevents many trainees from responding with comfort, interest, and knowledge to their patients' concerns. Curriculum in sexuality during child and adolescent psychiatry, adult psychiatry and geriatric psychiatry training is limited, inconsistent and omits many of the major life cycle issues that create significant emotional disruptions in individuals, couples, and family lives. The lack of curricular time and perceived lack of teaching expertise limit programs' offerings in this arena. For these reasons, programs may instead focus teaching on only one or two sexual issues, for example, transgender affirmative care, rather than providing a more comprehensive view of sex and the lifecycle. Helping patients with their diverse sexual concerns is beyond the employment of a particular psychiatric ideology. It requires a thoughtful, psychotherapeutic inquiry that appreciates the personal and interpersonal developmental tasks at stake. This workshop aims to improve the standardization of what in existing sexuality curricula.

**Abstract**

The varied assumptions of training directors about the importance of sexuality to understanding human psychology and its role in creating mental distress might be a key to shaping the training curriculum concerning sexual identity, dysfunction, and other concerns. Sex, a universal functional activity for self-discovery, bonding, pleasure, mutual nurturance, and reproduction, which ultimately reflects the capacity to love a partner, is not always given its due by training directors. The number of didactic hours devoted to the topic and the content vary considerably from program to program. An agreed upon, basic sexuality curriculum is lacking. In this workshop, we hope to impress upon training directors the importance of talking about sex with trainees. This workshop will begin with a long list of issues that are relevant to patient's emotional experiences, provide a review of DSM-5 diagnoses and dwell heavily on the recurrent patterns that are not covered by our nosology. These matters, including infertility, infidelity and incompatible sexual interests, often form the background for many presentations of depression, anxiety, and addictions. Consideration of the breadth of sexual problems in any population will be emphasized in order to understand the goals of an improved curriculum. We will then present what is currently being taught and tested on in board examinations. A major goal of this workshop is to prepare trainees for what they will encounter beyond training both

in the heteronormative and sexual minority segments of the population. A template will be offered for the education of advanced residents and fellows. It will move from basic knowledge of three components of sexual identity and the dysfunctions to the more complex sexual dilemmas and conundrums that often lurk behind conventional psychiatric chief complaints. Suggestions for integrating the curricular education with clinical experiences will be provided and we will reinforce the need to teach basic psychotherapy skills in order to organize the treatment of what can be ameliorated in this private domain. Small and large group exercises will enhance learning and engagement.

**Agenda**

• 5 minutes: Speaker introductions and interests in this topic • 10 minutes: Topic introduction - The problems sexuality brings to medical-psychiatric settings • 10 minutes: Literature review of current sexuality education in psychiatry training and review of ABPN focus on this area • 10 minutes: Small group discussion – What is YOUR program teaching about sexuality? Who is teaching it? What topics? How (what methods) is it being taught? 1. General training group 2. Child & Adolescent training group 3. Fellowship training: Geriatric, CL, Forensic, Addiction • 10 minutes: Basic Sexuality Seminar - concepts to be covered for PGY3/4 trainees • 10 minutes: Advanced Sexuality Seminar - concepts to be covered for late PGY3/PGY4/fellow trainees • 15 minutes: Large group exercise – Brainstorm innovative educational methods, address any barriers to effective education, with both trainees and faculty • 5 minutes: Small group exercise - Define your local sexuality experts: Divide into groups by the seven AADPRT regions • 15 minutes: Summary and interactive final discussion

**Scientific Citations**


1. Levine SB, Why Sex Is Important: Background for Helping Patients with Their Sexual Lives., British Journal of Psychiatry Advances (2017), vol. 23(5)300-306; DOI: 10.1192/apt.bp.116.016428 2. Levine SB, Scott D. (2010) Sexual Education of Psychiatric Residents. Academic Psychiatry, 34(5) 349-352. 3. Osborne LM MacLean JV Barzilay EM Meltzer-Brody S, Miller L Yang SN. (2016). Reproductive Psychiatry Residency Training: A Survey of Psychiatric Residency Program Directors. Academic Psychiatry. 2018 Apr;42(2):197-201. doi: 10.1007/s40596-017-0672-x. Epub 2017 Feb 13. 4. Donald CA1, DasGupta S, Metzl JM, Eckstrand KL. Queer Frontiers in Medicine: A Structural Competency Approach Acad Med. 2017 Mar;92(3):345-350. doi: 10.1097/ACM.0000000000001533. 5. Ard KL, Keuroghlian AS. Training in Sexual and Gender Minority Health—Expanding Education to Reach All Clinicians. NEJM 379(25): 2388-2393, 2018. 6. Levine SB. (2019). Psychotherapeutic Approaches to Sexual Problems: An essential guide for mental health professionals. American Psychiatric Association Publications, Washington, D.C.

# Teaching Addictions: You can do it! (We can help)

**Presenters**
Ann Schwartz, MD
Sandra DeJong, MD, MSc
Amber Frank, MD
Scott Oakman, MD, PhD
Ray Hsiao, MD

**Educational Objective**

1) Briefly describe challenges and barriers to teaching about substance abuse and dependence in psychiatry residencies
2) Discuss innovative teaching methods and existing resources for teaching addictions psychiatry
3) Discuss educational needs for training future providers to care for patients with substance use disorders

**Practice Gap**

Despite the high prevalence of substance use disorders in almost all fields of medicine, particularly psychiatry, in which up to half of patients with a mental health diagnosis will be found to meet criteria for a substance use disorder, addiction medicine and addiction psychiatry are woefully under-represented in both undergraduate and graduate medical education programs. Through discussions with educational leaders, we have brought together interested educators to share experiences and resources to assist others in enhancing the teaching of addiction in residency programs. We seek to discuss and develop resources in Addiction Psychiatry to those who wish to apply them their own training programs and improve addiction education to psychiatric trainees.

**Abstract**

Although half of patients with a mental health diagnosis meet criteria for a substance use disorder, addiction psychiatry is woefully under-represented in both undergraduate and graduate medical education programs. There continues to be an insufficient number of subspecialty trained addiction physicians to meet the current national crisis in opiate and other addictions. Given the prevalence and frequent presentation as co-morbidities of psychiatric disorders, additional training in substance use disorders will need to be a core domain of psychiatric residency training to ensure that psychiatric graduates are competent and prepared to treat addictions.

This workshop will utilize educationally-based vignettes to highlight and problem solve common barriers to optimal teaching of addictions in residency programs. Scenarios will review frequently encountered challenges, including programs having limited number of faculty/staff with time to supervise the experiences, limited faculty/staff with expertise, and insufficient clinical sites specializing in addictions/dual diagnosis. During our session, participants will work

in small groups to discuss the various challenges presented in the cases. Each small group discussion will be facilitated by a member of the AADPRT Taskforce on Addictions.

After reconvening as a large group, we will discuss the cases. Workshop presenters will share innovative strategies and initiatives designed to improve the teaching of addiction psychiatry and application to programs' educational needs. In addition, presenters will provide information regarding resources already developed and available to training programs to enhance addictions education, e.g. Project ECHO, free online buprenorphine waiver training, and instructional videos.

**Agenda**

Welcome - 10 minutes - presenters and participants introduce themselves; participants indicate what they hope to gain from attending the workshop

Brief overview of current gaps and barriers in addictions training - 10 minutes (include buprenorphine waiver and the limited faculty time for teaching)

Small Group discussion re: vignettes that present challenges in teaching additions and the group will be asked to discuss strategies to address the lapse - 30 minutes (1 group for 15 minutes and then switch)

Large Group discussion to share ideas about the vignettes and presentations from the presenters – 20 minutes

Discussion about available resources (provide resources on national trainings and conferences) – 10 minutes

Wrap-up and questions – 10 minutes

**Scientific Citations**

Avery J, Zerbo E, Ross S. Improving Psychiatrists' Attitudes Toward Individuals with Psychotic Disorders and Co-Occurring Substance Use Disorders. Acad Psychiatry. 2016;40:520-522

Renner J. How to train residents to identify and treat dual diagnosis patients. Biol Psychiatry. 2004;56:810-816.

Patil D, Andry T. Letter to the Editor: Molding young minds: The importance of Residency Training in Shaping Residents' Attitudes Toward Substance Use Disorders. Am J Addict.2017:26(1):80-82

Schwartz AC, Frank A, Welsh J, Blankenship K, DeJong SM. "Addictions training in general adult psychiatry training programs: Current gaps and barriers." Academic Psychiatry 2018; 42:642-647.

# Professionalism: It ain't what it used to be

**Presenters**
Randon Welton, MD
Suzie Nelson, MD
Kelly Blankenship, DO

**Educational Objective**
By the end of this training attendees will be able to:
1. Discuss professionalism as a developmental task of psychiatry residents
2. Critique competing models of professionalism
3. Define professional conduct and attitudes when faced with conflicting value systems
4. Develop professionalism training experiences for resident using tools that will be provided

**Practice Gap**
As professionalism has been incorporated into the psychiatry milestones, psychiatry residencies have been obligated to develop means of promoting and assessing professionalism among their residents. Unfortunately this ACGME-driven approach has tended to lead to overly reductionistic and simplistic views of professionalism. Often professionalism in residency is boiled down to a series of forbidden behaviors. Residents are led to consider professionalism as an all-or-nothing trait intrinsic to all physicians. A broader view of professionalism would include attitudes and styles of thinking in addition to behavior. It would involve discussions of the many separate, and sometimes competing, facets of professionalism and would describe professionalism more as a spectrum than a black/white dichotomy. A more complex understanding of professionalism would consider the possibility that standards of professionalism may change over time and vary by location and job description.
Residency programs have a limited array of educational strategies and techniques to promote professionalism. The simplest strategies involve hectoring residents to accept lists of unchanging and unchangeable values or to discuss egregious examples of misconduct. Few of the strategies address complex and competing systems of professionalism.

**Abstract**
This workshop challenges the notion that "Being a Professional" is a one-size-fits-all concept. Since professionalism is partly defined by the standards of conduct within the local community, professional standards vary over time and may be partly dependent on the venue in which the psychiatrist works. This workshop will examine the aspects of professionalism that are less observable than behaviors. We will discuss what residencies can do to promote professional attitudes and styles of thinking.

We will start by describing a developmental view of professionalism, which asserts that individuals become more professional as they observe, interpret and mimic the standards of care in the community. This leads naturally to conclusions that professionalism is a malleable quantity and defies simple descriptions. As a large group we discuss various theoretical systems

of professionalism that vary depending on practice. These include the Nostalgic System, the Entrepreneurial System, the Academic System, Social Justice system, and others. Each of these distinct systems meets the needs of a specific niche of psychiatrists.

Attendees will be asked to review the Professional Commitments found in the Medical Professionalism In The New Millennium: A Physicians' Charter which has been promulgated by the American Board of Internal Medicine and other prominent organizations. In small groups they will discuss the relative value of these commitments and be asked to generate a prioritized list of these commitments. Within their groups they will be asked to report and defend their rankings.

When some consensus has been reached within the small groups they will be given a series of scenarios describing residents' conduct and attitudes. They will be asked to evaluate the residents in light of their list of professional commitments. Lessons learned in the small group will be shared with the large group. Finally we will discuss how these exercises could be adapted for their institutions.

This process mimics a professionalism-training seminar used at our institution. This interactive seminar will provide opportunities for small group discussion, large group discussion, and peer based discussion and learning.

**Agenda**

- Introduction of Speakers – 5 minutes
- Models of Professionalism (Didactic)– 10 minutes
- Competing Systems of Professionalism (Didactic) – 15 minutes
- Competing Systems of Professionalism (Large Group Discussion) – 5 minutes
- Reviewing Professional Commitments from Medical Professionalism In The New Millennium: A Physicians' Charter (Didactic) – 10 minutes
- Small Group Discussion of Professional Commitments (15 minutes)
- Small Group Discussion of Professionalism scenrios (20 minutes)
- Applying this workshop to your residency (Large Group Discussion) - 10 minutes

**Scientific Citations**

- ABIM Foundation. American Board of Internal Medicine; ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine; European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. Annals of Internal Medicine, 2002; 136: 243-246.
- Castellani B., Hafferty F.W. (2006) The Complexities of Medical Professionalism. In: Wear D., Aultman J.M. (eds) Professionalism in Medicine. Springer, Boston, MA
- Irby, D.M., Hamstra, S.J. Parting the Clouds: Three Professionalism Frameworks in Medical Education. Academic Medicine, 2016; 91: 1606-1611.
- Paauw, D.S., Papadakis, M., Pfeil, S. (2017) Generational Differences in the Interpretation of Professionalism. In Byyny, R.L., Paauw, D.S., Papadakis, M., Pfeil, S (eds) Medical

Professionalism Best Practices: Professionalism in the Modern Era. Alpha Omega Alpha Honor Medical Society .
- Swing, S.R. The ACGME outcome project: retrospective and prospective. Medical Teacher, 2007; 29: 648-654.

## "Social Media Rounds": Enhancing Resident Competencies in Web 2.0, Social Media and Digital Technologies To Improve Psychiatry Education, Leadership and Patient Care.

**Presenters**
Carlos Salgado, MD
Sohrab Mosaddad, MD
Xenia Aponte, MD
Tamara Zek, MD

**Educational Objective**

1. Appreciate the value and clinical relevance of enhancing trainee and faculty competencies in Web 2.0 and digital media.
2. Develop a greater understanding of the intersection of digital technologies with psychiatry from the view of both patient and clinician.
3. Practice and plan implementation of "Social Media Rounds" as an interactive didactic exercise into the Graduate Medical Education curriculum at one's own institution.
4. Improve familiarity with topics surrounding psychiatry and Web 2.0, such as maintaining a professional online presence, ethical boundaries, Internet addiction, digital health apps, online medical education and more.

**Practice Gap**

Today's children and adolescents live and grow in the digital age, faced with daily challenges that impact their mental health and contribute to interactions with health care and psychiatry. Clinicians and parents often struggle to keep pace with the rapidly changing virtual landscape where our patients exist. Additionally, professional understanding of such technologies as social media, digital health apps and new trends in their use lags behind current technology. As the number of stressors associated with the use of digital technologies grows, there is a growing need for psychiatry trainees to acquire skills, resources and knowledge to discuss the risks of digital media use with patients and their families, to take a pertinent virtual media history and provide guidelines to help parents set limits and support their children. In recent years, the use of Web 2.0- online technologies with interactive user-generated content such as social media, has also gained popularity in medical education. While fields such as emergency medicine and radiology have embraced use of such technologies in Graduate Medical Education (GME), psychiatry has largely lagged behind, potentially due to a lack of integration at the training level.

**Abstract**
The field of psychiatry is uniquely positioned to gain from an enhanced understanding of online technologies due to the proximity of our patient population and often their psychopathologies to the virtual world. This workshop aims to demonstrate that competency in Web 2.0 is a valuable tool for psychiatric Graduate Medical Education to develop professional use standards, guidelines for patients, new diagnostic measures and opportunities for intervention. A set of interactive exercises attempt to immerse the participant with an understanding of key issues such as cyberbullying, sexting, screen time, privacy, gambling, online human trafficking, self-injurious behaviors, social media isolation, public shaming, drug use, gamification of social media, the "dark web", etc. in order to equip future generations of psychiatrists to conduct healthy and informed conversations with parents and their children as they navigate the virtual landscape.

We modeled the workshop after a dynamic series titled "Social Media Rounds" which we have integrated into our own fellowship curriculum. Social Media Rounds or "So Me" Rounds consist of a monthly gathering of trainees, faculty, and program leadership to tackle topics surrounding the new landscape and digital language of our patient population via an experiential and immersive approach, with guidance from assigned exercises. The series is designed to be led by trainees, who are often early adopters of newer online technologies. The exercises are dynamic in that they may change annually as technologies evolve and may be adapted to each program's needs based on geographic, cultural and/or demographic trends. As a secondary goal, this project aims to provide an opportunity for faculty to fill gaps in knowledge, identify clinical challenges and develop strategies to grow the training program's own online presence. As the impact of social media and Web 2.0 grows, psychiatrists are increasingly relied upon to provide guidance to children, families, politicians and even technology firms on healthy use and design practices. Improving trainees' competency in Web 2.0 technologies will also help to alleviate the existing practice gap and improve the therapeutic alliance between patients and psychiatrists, while laying the groundwork for a smooth transition toward a professional online presence, leadership and advocacy for the psychiatrist.

**Agenda**
Minute 0-9 – Introduction
Minute 10-29 – Social Media interactive exercises & discussion groups
Minute 30-49 – Digital Health Apps interactive exercises & discussion groups
Minute 50-69 – Medical Education interactive exercises & discussion groups
Minute 70-84 – Ethics, Privacy & the Law interactive exercises & discussion groups
Minute 85-90 – Participant Review

**Scientific Citations**
Appelbaum PS, Kopelman A. Social media's challenges for psychiatry. World Psychiatry. 2014;13:21–3.
Giordano C, Giordano C. Health professions students' use of social media. J Allied Health. 2011;40(2):78–81.Cheston CC, Flickinger TE, Chisolm MS. Social media use in medical education: a systematic review. Acad Med. 2013;88:893– 901.

Galiatsatos P, Porto-Carreiro F, Hayashi J, Zakaria S. The use of social media to supplement resident medical education - the SMART-ME initiative. Med Educ Online. 2016
Hollinderbaumer A, Hartz T, Uckert F. Education 2.0 – how has social media and Web 2.0 been integrated into medical education? A systematical literature review. In: GMS Z Med Ausblid; 2013.
Jones KB, Sanyer O, Fortenberry K, Van Hala S. Resident education through blogging and other social media platforms. J Grad Med Educ. 2017;9:256.
O'Hagan TS, Roy D, Anton B, Chisolm MS. Social media use in psychiatric graduate medical education: where we are and the places we could go. Acad Psychiatry. 2016;40:131–5.
Peters ME, Uible E, Chisolm MS. A Twitter education: why psychiatrists should tweet. Curr Psychiatry Rep. 2015;17:94.

## Take the pain out of planning: Design a highly effective learning session in 10 minutes

**Presenters**
Kaz Nelson, MD
Jonathan Homans, MD
Lora Wichser, MD

**Educational Objective**
Upon completion of this session, participants will be able to:
Learning Objective 1: Apply the "Minnesota Arc" as a conceptual framework for effective learning.
Learning Objective 2: Learn skills to evaluate learners' receptiveness to learning objectives for any given educational activity.
Learning Objective 3: Efficiently create an effective education session which incorporates evidence-based learning theory.

**Practice Gap**
The consequences of "cognitive overload" in medical training are becoming more apparent. Passive learning strategies involving a traditional hour lecture consisting of multiple PowerPoint slides filled with facts and figures have been demonstrated to be ineffective and potentially contribute to stress and negative health. [1,2] While educators may embrace the theory underlying active learning, many educators struggle with the actual facilitation and structuring of active learning sessions.

**Abstract**
The "Minnesota Arc" is a conceptual framework, originally developed to rapidly teach early learners the skills of interacting with distressed or "difficult" patients. [3] This framework has also been applied in leadership to facilitate interactions with distressed stakeholders. [4] This workshop extends the basic "Minnesota Arc" concept even further to support and equip educators to effectively engage with distressed and potentially cognitively overloaded learners.

The “Interview Arc integrates the science of human cognition and educational theory which allows for quick translation of these concepts to educators of all levels. Application of this framework facilitates highly efficient and effective planning and implementation of learning sessions.

**Agenda**
In this 90 minute workshop, we will conduct a 20 minute needs assessment through small and large group discussion (think/pair/share), 10 minutes of large group discussion summarizing key themes and clarifying learning objectives. We will then show a 2 minute video illustrating a key concept, followed by 10 minutes of presented material. The remaining 45 minutes will be spent in a combination of large and small group work where participants will be able to create a learning session through application of the Minnesota Arc.

**Scientific Citations**
1. Brown, Peter C. Make It Stick : the Science of Successful Learning. Cambridge, Massachusetts: The Belknap Press of Harvard University Press, 2014.
2. Young, JQ, J Van Merrienboer, S Durning, and O Ten Cate. “Cognitive Load Theory: Implications for Medical Education: AMEE Guide No. 86.” Article. Medical Teacher 36 (5): 371–84. https://doi.org/10.3109/0142159X.2014.889290.
3. [Redacted]. The Interview Arc 2.0: A Model for Engaging Learners in the Patient Interview Through Both Virtual Self-Directed Training and Direct Coaching. Association for Academic Psychiatry Annual Meeting, Milwaukee, WI. September 7, 2018.
4. [Redacted]. Teaching Teachers the Interview Arc: A Concise and Elegant Model for Engaging Learners in the Patient Interview. Association for Academic Psychiatry. Denver, CO. September 7, 2017.

## The Self-Compassionate Healer: An interactive curriculum for fostering greater resilience and well-being in medical education

**Presenters**
Kristin Leight, MD
Mary Yaden, MD, MSc
E Cabrina Campbell, MD

**Educational Objective**
- Define self-compassion and review the evidence for its role in clinician/trainee resilience and well-being
- Engage participants in various self-compassion practices, including a brief guided meditation, writing exercise, and other techniques to engender greater self-compassion
- Provide guidance/materials for participants to adapt or recreate this intervention at their home institution

**Practice Gap**

Over the last several years, the number of academic citations that include self-compassion has risen exponentially and currently surpasses over 20,000. While there is a robust literature on positive outcomes associated with self-compassion, we are at the vanguard of implementing and measuring self-compassion interventions in both clinical and psychiatric educational contexts. Our workshop joins a first wave of interventions to focus on self-compassion within medical or psychiatric education. Although mindfulness has been readily assimilated in both therapeutic and educational practices, self-compassion is still a novel personal resource for both patients and clinicians. Our goal is to bridge this practice gap by providing foundational information about self-compassion and to offer active coping strategies for working directly with emotions like shame that arise in the context of burnout by employing self-compassionate techniques.

**Abstract**

Although mindfulness has become ubiquitous throughout clinician wellness initiatives, self-compassion is a rising star of wellness education. While incorporating the foundations of mindfulness, self-compassion moves beyond non-judgmental awareness to provide skills for transforming one's own suffering into compassion and connection. In fact, a recent large-scale study of residents demonstrated that self-compassion had a unique role in predicting burnout above the effects of mindfulness. increasingly, Self-compassion is comprised of three primary components: awareness of when suffering or burnout arises, a recognition that suffering is a shared human experience, and finally a willingness to meet suffering with warmth and kindness instead of resistance or shame. Psychiatric training values cultivating compassion for the suffering of others; however, it rarely teaches the skills of meeting one's own failures or losses with warmth and understanding. Moral injury, an increasingly salient topic in medical education, is especially impacted by self-compassion, and we believe that training in self-compassion equips educators to address this dimension of burnout head-on. In fact, malignant perfectionism remains a prevalent cultural norm within clinical medicine. Our workshop aims to introduce participants to the science of self-compassion through a didactic introduction, as well as to guide them through contemplative practices, writing exercises, and other techniques aimed at developing greater emotional resilience. This workshop will not only offer a language for medical educators looking to talk about loss, failure, and moral-injury but also orient participants to tools to be used within their own curriculum, including handouts, scripts, and scales. Our workshop adapts evidence-based practices in cultivating self-compassion specifically for use in psychiatric residency programs across trainee level.

**Agenda**

Agenda:
0:00 Introduction
0:05 Didactic Presentation: Science of self-compassion
0:20 Discussion: Self-compassion in the psychiatry residency training
0:35 Exercise: Cultivating self-compassion through contemplative practice or journaling
0:50 Discussion: Self-compassion as an antidote to moral injury
1:00 Exercise: Recovering values as a vehicle for self-compassion

1:10 Debriefing self-compassion exercises
1:15 Discussion: Teaching self-compassion for patients and colleagues
1:20 Question and Answer Session

**Scientific Citations**

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. Clinical Psychology Review, 32, 545-552.

Zessin, U., Dickhauser, O., & Garbade, S. (2015). The relationship between self-compassion and well-being: A meta-analysis. Applied Psychology: Health and Well-Being. doi:10.1111/aphw.12051

Kirby, J. N. (2017). Compassion interventions: the programmes, the evidence, and implications for research and practice. Psychology and Psychotherapy: Theory, Research and Practice, 90(3), 432-455.

Finlay?Jones, A., Kane, R., & Rees, C. (2016). Self?Compassion Online: A Pilot Study of an Internet?Based Self?Compassion Cultivation Program for Psychology Trainees. Journal of Clinical Psychology.

Atkinson, D. M., Rodman, J. L., Thuras, P. D., Shiroma, P. R., & Lim, K. O. (2017). Examining Burnout, Depression, and Self-Compassion in Veterans Affairs Mental Health Staff. The Journal of Alternative and Complementary Medicine.

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Measuring relationships between self?compassion, compassion fatigue, burnout and well?being in student counsellors and student cognitive behavioural psychotherapists: a quantitative survey. Counselling and Psychotherapy Research, 16(1), 15-23.PDF

## Optimizing your Leadership Style

**Presenters**

Rachel Russo, MD
Lia Thomas, MD
Heather Schultz, MD, MPH

**Educational Objective**

By the end of this workshop,
Attendees will be able to:

- Compare and contrast leaders and managers
- Discuss maximizing leadership to followership styles in situational leadership

- Describe the core principles of leadership including self-development, core values, communicating purpose, accountability, and organizational culture

Attendees will also develop an individualized action plan for the next step on their leadership path.

**Practice Gap**

While relevant at any point in a career, leadership training is important as physicians may feel unprepared when moving from clinical work to education and administrative work. Our goal is to use this workshop to help attendees learn about leadership styles (objectives 1-3) and come up with a personalized action plan for the next step in their leadership process (objective 4). Several Level 5 elements of the current Psychiatry Milestones speak to residents being able to lead teams.

**Abstract**

Being an effective leader can magnify our impact as educators on the individuals and communities that we serve. One aspect of effective leadership is self-awareness of leadership style, which is a composite of the styles of role models and others in medicine, business and society. Another key aspect is alignment with those aspects of "followership" (or characteristics) of those we lead, as we provide service, advocate and inspire others to lead.

We are often called to be leaders, usually without any formal leadership training, or opportunity to identify our own leadership styles. Education on domains of leadership must be combined with opportunities to reflect and identify personal leadership styles and a longitudinal approach to adjust over time, preferably with team, peer and/or mentor input.

**Agenda**

This 90-minute workshop will use individual reflection and needs assessment followed by small and large group sharing and is appropriate for trainees and all levels of faculty from early to late career.

5 min – Introductions and setting the objectives of the workshop

20 min- Leader vs. Manager explorations: We will present a case and participants will complete a self-reflection worksheet focused on leader and manager roles, educational tasks as they relate to these roles, and their struggles as a leader and manager. They will then pair and share to explore responses and reactions

10 min – Facilitated large group discussion to brainstorm characteristics of high-quality leaders and managers

20 min - Review of leadership styles, theory, social power framework, characteristics of leaders with pair share and then large group discussion of important characteristics for medical educators.

15 min – Action plan worksheet

10 min- Large group discussion/small group reporting on discussions and synthesis of workshop activities, with emphasis on next steps in working within structure of leadership and followership alignment strategies

5 min – Conclusions and questions

5 min – Participant review using WHOVA app

**Scientific Citations**


1. Bennis W. Managing People is like Herding Cats. Provo, UT: Executive Excellence Publishing, 1999.
2. Bjugstad, Thach, Thompson, Morris (2006). A Fresh Look at Followership: A Model for Matching Followership and Leadership Styles. J Behv Applied Management 304-316.
3. Collins-Nakai (2006) Leadership in Medicine. McGill Journal of Medicine 9:68-73.
4. Harolds (2004) Selected Important Characteristics of Enlightened Medical Leaders. J Am Coll Radiol 1: 338-342.
5. Helitzer DL, Newbill SL, Morahan PS, et al. (2014) Perceptions of skill development of participants in three national career development programs for women faculty in academic medicine. Acad Med 89(6):896-903.
6. Houpt, Gilkey, Ehringhaus. Learning to Lead in the Academic Medical Center: A Practical Guide. Switzerland. Springer International Publishing, 2015.
7. Talmon & Beck Dallghan. Mind the Gap: Generational Differences in Medical Education. Gegensatz Press, 2017.
8. Wiseman. Multipliers: How the Best Leaders make Everyone Smarter. New York: HarperCollins Publishers, 2017.
9. Jardine, D et al. The Need for a Leadership Curriculum for Residents. JGME. http://dx.doi.org/10.4300/JGME-07-02-31. Accessed 10/26/19


## Listening to All Voices: Cultural Humility in Psychiatry Resident Supervision

**Presenters**


Raziya Wang, MD
Poh Choo How, MD, PhD
Takesha Cooper, MD, MS
Ryan Harris, MD


**Educational Objective**

1) To introduce residency program directors to cultural humility concepts
2) To prepare residency program directors to implement cultural humility approaches to supervision at their home institutions

**Practice Gap**

The new ACGME accreditation standards for psychiatry residency training programs state that "Residents must demonstrate competence in respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation." Many psychiatry supervisors recognize that cultural and diversity issues may play an important role in the supervisory relationship as well as in resident interactions with patients. Yet, supervisors often feel ill-equipped to address these concerns directly. The complexity of addressing core

psychiatric concepts while recognizing issues of bias or structural determinants can be challenging. Cultural humility offers a structured approach to integrating concepts of culture and diversity within the context of medical education and may facilitate teaching faculty and residents to work effectively with patients from diverse backgrounds.

**Abstract**

The Surgeon General's Supplement to the Report on Mental Health entitled, Mental Health: Culture, Race and Ethnicity underscored significant disparities in mental health care for racial and ethnic minorities and a study by LeCook demonstrated that these disparities increased further for African Americans and Hispanics between 2004 and 2012. Residency training programs have struggled to train psychiatrists to adequately address this issue. Cultural Competency and more recently, Structural Competency, have emerged as approaches to educate psychiatry residents regarding mental health disparities and have been implemented with varying consistency. The term "competency" is often used in medical education and may imply a concrete set of facts that can be mastered by the learner. However, in their 1998 paper, Drs. Tervalon and Murray-Garcia, two pediatricians at the Oakland Children's Hospital, proposed that an approach of cultural humility would better serve diverse patient populations. They describe four components of cultural humility including 1) a lifelong process of self-reflection and self-critique to identify bias on the part of the provider 2) action to redress the power imbalance between patient and provider 3) developing, on a systems level, beneficial partnerships with communities on behalf of individuals and defined populations and 4) advocating and maintaining institutional accountability for the above principles. Cultural Humility approaches are now used in many aspects of medicine as well as in other fields although with some heterogeneity and to varying degrees of success. For the budding psychiatrist, one-to-one supervision with a designated faculty member is a deeply impactful and even "imprinting" process. Therefore, it is paramount that supervisors be comfortable with cultural humility in order to help train the next generation of psychiatrists to have the skills and motivations to address inequity. In this workshop, we will demonstrate the use of experiential methods to teach cultural humility in our own programs, discuss ways to use this approach in supervision, and provide an opportunity for participants to practice a brief experiential exercise.

**Agenda**

Workshop Agenda:

- 5 min ice breaker activity: "health disparity quiz"
- 25 min Introduction to cultural humility concepts
- 15 min partner/small group activity: "cultural identity pie"
- 15 min large group discussion
- 15 min small group activity: supervision scenario role play
- 15 min audience discussion and group generation of plans for their own curricula

**Scientific Citations**

ACGME Program Requirements for Graduate Medical Education in Psychiatry, Editorial Revision: effective July 1, 2019. Accreditation Council for Graduate Medical Education.

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_Psychiatry_2019.pdf?ver=2019-08-26-134127-827

Hook JN, Watkins CE, Davis DE, et al. Cultural Humility in Psychotherapy Supervision. American Journal of Psychotherapy. June 2016; 70(2): 149-166
https://www.researchgate.net/publication/304070808_Cultural_Humility_in_Psychotherapy_Supervision

LeCook B, Trinh M, Li Z, Hou, SS, Progovac AM. Trends in Racial-Ethnic Disparities in Access to Mental Health Care, 2004-2012. Psychiatric Services, 68:1, 9-16, 2017
https://www.ncbi.nlm.nih.gov/pubmed/27476805

Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General. Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, 2001.
https://www.ncbi.nlm.nih.gov/books/NBK44243/

Smedley BD, Stith AY, Nelson AR, editors. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Washington (DC), National Academies Press (US); 2003
https://www.ncbi.nlm.nih.gov/books/NBK220358/

Tervalon M, Murray-Garcia J. Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. Journal of Health Care for the Poor and Underserved. 1998 May; 9(2): 117-125.
https://melanietervalon.com/wp-content/uploads/2013/08/CulturalHumility_Tervalon-and-Murray-Garcia-Article.pdf

## Real Change: Approaching physician trainee well-being through evidence-based individual, structural, and systems-level initiatives

**Presenters**
Aaron Reliford, MD
Sansea Jacobson, MD
Misty Richards, MD
Anne Glowinski, MD
Colin Stewart, MD

**Educational Objective**
1) Describe the benefits and challenges to early identification of burnout and supporting wellbeing of psychiatry trainees.

2) Differentiate individual & organizational drivers to psychiatry trainee burnout and assist participants to identify such drivers at their home institutions

3) Identify and develop targeted interventions to promote trainee wellbeing at the individual trainee level, but beyond it on a departmental & institutional level.

4) Work with participants to identify perceived barriers to making positive change and help participants create an individualized plan to generate sustainable change at the individual and organizational level

**Practice Gap**

Evidence shows increased rates of physician burnout beginning during medical school and continuing through residency and fellowship. This has led to concerning issues of decreased productivity, medical errors, and compromised patient care. Even worse, burnout has been correlated to growing rates of mental illness in physicians. The Accreditation Council for Graduate Medical Education (ACGME) has since prioritized trainee wellness across all training programs, introducing new core program requirements related to physician wellness. Despite best efforts, there remain no gold-standard approaches to how to approach these issues. Furthermore, most existing initiatives are implemented in an untargeted way in the hopes of combating burnout through targeting personal resilience only. Now that there are new ACGME requirements, all programs now must systematically educate trainees and faculty about the warning signs of burnout and mental illness, how to address early warning signs, and how to promote trainee wellness in the midst of intense learning and clinical care. Even fewer programs have worked to identify institutional and local systemic drivers of burnout for targeted change. Enhancing knowledge of differential contributors to burnout and empowering program directors to navigate systems contributors would greatly enhance the effectiveness of such wellbeing initiatives. Consequently, there is a need to examine innovative methods of assessing stress and wellbeing in trainees and model curriculum developed towards delivering high quality resiliency training. Finally, and perhaps most challenging, departmental and institutional cultures must be examined and changed refocusing on the wellbeing of its physicians and trainees.

**Abstract**

There are varying dimensions of physician wellbeing. These are represented in the realms of physician burnout, physician engagement, professional fulfillment/satisfaction, fatigue, emotional health & stress, and quality of life1. More recently, the issue of physician burnout - the syndrome of emotional exhaustion, depersonalization, & decreased sense of personal accomplishment2 - has received renewed attention, particularly in the realm of physician training. This in response to significantly increased rates of burnout in physicians and physicians in training (as much as 50% in medical students, 75% in residents and fellows, and 50% in the physician workforce3,4). Burnout in physicians and physicians in training is associated with negative consequences in patient care (e.g., medical errors, increased mortality rates, longer recovery times, lower patient satisfaction), workforce productivity & costs (e.g., decreased job satisfaction, decreased work effort, higher physician turnover & associated

costs), and directly on the physicians themselves6. Rates of physician suicide are four fold higher than the general population despite the same rates of depression7. The causes of burnout are multi-determined, arising from individual factors and characteristics of the physician or medical culture, and also from problems in the healthcare systems and the working and learning environments5-7. To address burnout, the approach needs to target the driving factors within the individual clinician as well as in the health care system (e.g., residency training, clinical sites, departmental & institutional levels) shown to be significant contributors to this problem1,6.

The ACGME's Clinical Learning Environment Review (CLER) currently outlines an expectation that institutions both educate residents about burnout and measure burnout regularly. Most recent common program requirements have gone further, mandating that programs collaborate with their sponsoring institution and have the same responsibility to address well-being as another aspect of resident competence. They recommend that efforts include work to enhance the meaning of physicianhood, attention to scheduling, and workplace safety focus. Policies and programs must be created to educate and assess burnout, depression and substance abuse, and provide timely means of addressing them when present.

Our goal is to educate training directors on the need to focus on wellbeing and burnout, how to assess for it locally (e.g., beyond the ACGME wellness survey), and to provide a practical framework for creating a meaningful wellbeing curriculum for their trainees. However, most importantly, we endeavor to help our participants evaluate systems drivers that may be contributing to burnout, and how to engage & navigate their department and institution to promote meaningful, sustainable change. In our session, we will elaborate how to engage leadership within health care systems to enhance the trainee wellbeing. Specifically we will briefly review the literature and highlight examples of innovative systems-level approaches to addressing wellbeing at our own home institutions.

**Agenda**

We plan to highlight the wellbeing curricula and structural program changes to address burnout that have been implemented at the NYU, UCLA, Pittsburg, Georgetown, & Washington University CAP fellowships.

1. Introduction to the concept of wellbeing & assessment of wellbeing in Psychiatry training programs (10 min)
2. Participants will learn about how to assess both well-being and stress levels of residents using a variety of evidence based scales. This will be done through an activity in which the participants will followed by completion of the PERMA wellbeing self-assessment tool (5 min)
3. Break-out: Complete, discuss and review the PERMA wellbeing tool, its utility of this augmented assessment for their trainees, individual strategies they have implemented in their programs to address wellbeing locally in their programs. (10 min)

4. Introduction to the drivers of burnout and how to systematically engage their departments and institutions in addressing these in the development of a comprehensive wellbeing program (15 min)
5. Reviewing examples of structural change at 5 training programs designed to enhance the wellbeing of their trainees. Attention will be paid to the necessary steps and challenges to systematically engage the institution and departments for this purpose. Outcome measures of success will also be reviewed (30 min)
6. Break out: Participants will review examples of how their different institutions have attempted to integrate wellness activities and education into their cultures, including the challenges of engaging their departments and institutions to institute meaningful wellbing intiatives. (15 min)
7. Wrap up with discussion of examples from participants (5 min)

**Scientific Citations**


1. Shanafelt TD, Noseworthy J. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. Mayo Clin Proc. 2017;92(1):129-146
2. Maslach C. The measurement of experienced burnout. Journal of Occupational Behavior, 1981; 2:99-113
3. Dyrbye LN et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. Acad Med. 2014;89(3):443-451
4. West CP et al. Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. JAMA 2011;306(9):952-960
5. Botha E, Gwin T. The effectiveness of mindfulness based programs in reducing stress experienced by nurses in adult hospital settings: a systematic review of quantitative evidence protocol. JBI Database System Rev Implement Rep. 2015 Oct;13(10):21-9
6. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences, and solutions J Intern Med. 2018 Jun;283(6):516-529
7. Rothenberger D. Physician Burnout and Well-Being: A Systematic Review and Framework for Action. Dis Colon Rectum. 2017 Jun;60(6):567-576


## Engaging junior faculty and residents: a comprehensive model for effectively supporting scholarship in early academic careers

**Presenters**


Anne Penner, MD
Merlin Ariefdjohan, MPH, PhD
Kimberly Kelsay, MD


**Educational Objective**

Attendees will

1. Understand training gaps for psychiatry trainees and junior faculty engaging in scholarship

2. Appreciate how training programs may engage in this specific scholarship training through mentorship, skill-based trainings, and engaging departmental support
3. Consider a new support model that enables junior psychiatry faculty to be productive academically while concurrently managing their clinical workload
4. Generate next steps for implementation into their academic program accounting for institutional needs, current resources and programmatic experiences

**Practice Gap**

1. Formalized training tracks for specific skills in academic psychiatry have been described, but they continue to be underutilized, and the benefit to junior faculty underrecognized.
2. Junior faculty practicing in academic medicine face the challenge of managing both clinical commitments and the requirement to be productive academically. Concurrently, they may not have the funds to hire their own research staff.
3. A scholarship training program for fellows and junior faculty that incorporates a culture of mentorship, along with the development of research skills through didactics and skill building, has not been described.
4. There has been a lack of emphasis on how to capitalize on the collaboration between residents and junior faculty for completing scholarly work.

**Abstract**

Early career psychiatrists practicing in academic medicine are passionate about education and dissemination of best practices through scholarship. These scholarly products may include evaluating and disseminating training curricula and conducting projects related to quality improvement or program evaluations; all of which should result in professional presentations and/or publication of manuscripts. However, individuals early in their career often find it difficult to engage in meaningful scholarly activities due to demanding clinical commitments, and are therefore at a disadvantage for promotion1,2. Further, many early career psychiatrists lack formal research training. As such, they may not be sufficiently informed on how to formulate and manage a study that can be performed efficiently from start to completion during their appointment. Fellows and junior faculty alike may find resources on campus confusing or costly to maneuver, making them seem unattainable. Meeting scholarship requirements through research and other academic products can be seen as a major stressor of practicing in an academic medicine setting and contributes to problems with retention. Educational and academic work are passions for psychiatrists choosing to be in academic medicine, so creating a formal curriculum for increasing scholarship is a natural fit and a necessary one. Such programs can increase the number of fellows who engage in successful scholarship, create a pipeline into academic programs, and promote junior faculty development3. Our scholarship program focuses on a culture of mentorship, practical skill-based sessions open to all, and broader departmental support through an in-house research support center. Through these efforts, our program saw a more active and productive collaboration between faculty and trainees, an increase in the number of fellows and junior faculty presenting at national meetings, and an increase in the number of newly initiated projects and publications. In this session, we will discuss our initiatives to promote scholarship by outlining the need for specific training in academic medicine, gaps among psychiatrists as

junior faculty, and then provide specific interventions that worked at our institution. For example, we will talk about a multi-faceted approach to mentorship that includes pairing fellows with junior faculty supervisors, project-based mentors, and senior faculty "meta-mentors" on the scholarship committee4-6. We will also discuss the set-up of our in-house research support center including scholarly outcomes and other challenges. In summary, formalized training in academic psychiatry benefits both resident trainees and junior faculty. This type of initiative is feasible, and such a curriculum can be integrated into programs seeking to boost scholarship in their department.

**Agenda**

1. Introduction to the specific training components of our program, a brief review of training tracks for academic psychiatry, and a description of our in-house research support center for junior faculty (25 minutes)
2. Open discussion of gaps in scholarship for junior faculty and trainees, and then pivot to a discussion what has worked in other programs (15 minutes)
3. Outline the successes associated with the in-house research support center and lessons learned associated with the initiative (10 minutes)
4. Break-out session to discuss practical, specific steps that could be employed by programs. Groups will divide based on their program's experience with this type of formalized training. (20 minutes)
5. Return for final discussion as a group and questions (15 minutes)
6. Feedback on workshop using the app (5 minutes)

**Scientific Citations**


1. Jeffe DB, Yan Y, Andriole DA. Competing Risks Analysis of Promotion and Attrition in Academic Medicine: A National Study of U.S. Medical School Graduates. Acad Med. 2019;94(2):227-236.
2. Ries A, Wingard D, Gamst A, Larsen C, Farrell E, Reznik V. Measuring faculty retention and success in academic medicine. Acad Med. 2012;87(8):1046-1051.
3. Penner AE, Lundblad W, Azzam PN, Gopalan P, Jacobson SL, Travis MJ. Assessing Career Outcomes of a Resident Academic Administrator, Clinician Educator Track: A Seven-Year Follow-up. Acad Psychiatry. 2017;41(2):278-281.
4. Ayyala MS, Skarupski K, Bodurtha JN, et al. Mentorship Is Not Enough: Exploring Sponsorship and Its Role in Career Advancement in Academic Medicine. Acad Med. 2019;94(1):94-100.
5. Kashiwagi DT, Varkey P, Cook DA. Mentoring programs for physicians in academic medicine: a systematic review. Acad Med. 2013;88(7):1029-1037.
6. Lis LD, Wood WC, Petkova E, Shatkin J. Mentoring in psychiatric residency programs: a survey of chief residents. Acad Psychiatry. 2009;33(4):307-312.

# Creating a Healthy Program: Shifting the Onus of Residency Wellness from the Individual to the Program

**Presenters**
Julie Wolfe, MD
Heather Murray, MD, MPH
Alyssa Broker, DO
Robert Davies, MD

**Educational Objective**
1. Understand the importance and supporting evidence of wellness initiatives in addressing the issue of resident burnout
2. Locate specific areas which may be contributing to resident burnout in their home institutions
3. Identify possible wellness initiatives and barriers to implementing them within their home institutions

**Practice Gap**
Residency training has the potential to negatively impact trainee mental health which may result in burnout. Although it has been established that wellness behaviors can be helpful in preventing burnout, structural changes and changes in the training culture also need to be addressed. Too often during wellness conversations, the responsibility is placed on the individual. The concern is that "wellness" becomes yet another burden for residents and something they can feel badly about if they are not personally doing something about it. A more effective approach comes from the program itself. Unfortunately, many residency programs face multiple barriers to instituting and maintaining wellness initiatives within their programs. This workshop is intended to describe specific initiatives that have been developed in a large US psychiatric residency program to focus on resident wellness, and to explore solutions to barriers to such initiatives that exist in participants' own programs.

**Abstract**
In this workshop, we will discuss key components of our wellness initiatives, which have been incorporated throughout all four years of residency training, as well as discuss important lessons that have been learned from these initiatives regarding how to maintain interest and engagement by residents, especially during times of high stress or possible burnout. These include the implementation of a quarterly wellness half day policy, empowering residents in creating and leading wellness focused initiatives that address their specific needs and improving communication throughout the residency program. Finally, we will discuss ways for residency programs to make meaningful changes and address barriers to building and maintaining wellness initiatives within their programs. This workshop will be interactive and draw upon participants own experiences either as a resident or a faculty member. Participants will complete a wellness "needs assessment" for their own institution and then brainstorm solutions in larger groups.

**Agenda**
Welcome and introduction: 5 minutes

Didactic presentation of the current state of wellness and burnout in residencies, specific information on initiatives implemented in presenters' residency program, information on the supporting literature: 30 minutes

Small groups facilitated by the presenters to identify areas of focus for wellness initiatives at participants' home institutions through brief needs assessment: 20 minutes

Large group to identify common areas of need and brainstorm possible initiatives that can be brought back and implemented at participants' home institution: 30 minutes

Summary and conclusion: 5 minutes

**Scientific Citations**
Cedfeldt AS, Bower EA, English C, Grady-Weliky TA, Girard DE, Choi D. Personal time off and residents' career satisfaction, attitudes and emotions. Med Educ. 2010;44:977-984

Cedfeldt AS, Bower EA, Grady-Weliky TA, Flores C, Girard DE, Choi D. A comparison between physicians and demographically similar peers in accessing personal health care. Acad Med. 2012;87:327–331

Jennings M, Slavin S. Resident Wellness Matters: Optimizing Resident Education and Wellness Through the Learning Environment. Academic Medicine. September 2015; 90(9): 1246-1250.

Lefebvre D. Resident Physician Wellness: A New Hope. Academic Medicine. May 2012; 87(5): 598-602.

## Workforce Development through Psychiatry Residency Tracks and Expansion

**Presenters**
Deborah Cowley, MD
Rashi Aggarwal, MD
Lindsey Pershern, MD
Kirsten Aaland, MD
Melanie Drake, MD

**Educational Objective**
At the conclusion of this workshop, participants will be able to: 1. Discuss the results of the AADPRT workforce development survey, including their own and other residency directors' perspectives on the challenges and opportunities for expanding psychiatry residency programs and developing residency tracks; 2. Describe issues involved in developing residency tracks,

especially in underserved areas; 3. Discuss ways to advocate to increase awareness of psychiatrist workforce shortages and expand graduate medical education funding.

**Practice Gap**

The United States has a psychiatrist workforce problem. Only one in eight people with a psychiatric disorder see a psychiatrist. Over 75% of counties have a shortage of mental health professionals, especially psychiatrists. Psychiatrists are in particularly short supply in non-urban areas and public mental health settings. While the population of the United States is growing and the demand for mental health care increasing, the existing number of residency slots allows only replacement of the current workforce. Furthermore, the population of psychiatrists is "graying." A 2013 Substance Abuse and Mental Health Services Administration report found that the median age of psychiatrists was 55.7 years, with 46% over the age of 65, and so likely to retire soon. There is a need to train more psychiatrists in order to address these current and projected shortages of psychiatrists, through psychiatry residency expansion and the development of programs or tracks focused on preparing psychiatrists to work in non-urban areas and with underserved populations.

**Abstract**

Given the national shortage of psychiatrists and projected increasing psychiatrist workforce problem, AADPRT has convened a Workforce Development Task Force as a forum to study obstacles to increasing the psychiatrist workforce and the feasibility of potential strategies and solutions. The task force will survey AADPRT members in the fall of 2019 to explore opportunities, challenges, and obstacles to residency and fellowship expansion and the development of new programs and tracks. In this workshop, we will present and discuss the results of this survey regarding core psychiatry residency programs and two examples of ways to increase psychiatrist workforce through the creation of regional residency tracks and through statewide advocacy for GME expansion and the development of a rural and public mental health track.

Participants will learn the results of the survey and will have the opportunity to discuss workforce development challenges and opportunities in their own setting. In the first example of workforce development, the core program residency director involved in development of the track, the track director, and a resident in the track will discuss issues involved in establishing and growing a regional residency track in Idaho aimed at preparing psychiatrists to practice in a non-urban, underserved area, including financial, community engagement, educational, resident recruitment, and program development issues. The second example will discuss coordinated advocacy across programs in Texas to develop a position statement and white paper related to the goals of public mental health education and recruitment in the state and advocacy efforts with the legislature to increase awareness of workforce shortages. This advocacy resulted in expansion of GME funding and positions, including for a Rural and Public Mental Health track at UT-Southwestern, which is under development.

Finally, the workshop will include discussion of ways in which participants can increase psychiatrist workforce in their own programs and institutions.

**Agenda**

- Presentation of the AADPRT Workforce Development Survey compiled responses from psychiatry residency directors (15 minutes)
- Pair and share, followed by large group discussion, reflecting on participants' own responses to survey questions and/or experience with opportunities and challenges regarding program expansion, track development, or other ways to expand psychiatrist and mental health workforce (15 minutes)
- Example: development of a regional residency track (15 minutes)
- Q&A, discussion (5 minutes)
- Example: state-level advocacy for GME expansion (15 minutes)
- Q&A, discussion (5 minutes)
- Individual goal-setting (2 minutes)
- Pair and share regarding goals and next steps (3 minutes)
- Large group discussion of next steps and potential approaches (15 minutes)

**Scientific Citations**

Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve month use of mental health services in the United States: results from the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005; 62:629-640.

Thomas KC, Ellis AR, Konrad TR, Holzer CE, Morrissey JP. County-level estimates of mental health professional shortage in the United States. Psychiatr Serv 2009; 60:1323-1328.

Kupfer JM. The graying of US physicians. Implications for quality and the future supply of physicians. JAMA 2016; 315:341-342.

Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues; SAMSHA 2013; Aging Workforce;11

Cowley DS, Keeble T, Jones J, Layton M, Murray SB, Williams K, Bakker C, Verhulst J. Educating psychiatry residents to practice in smaller communities: a regional residency track model. Academic Psychiatry 2016; 40:846-849.

Reardon CL, Factor RM, Brenner CJ, Singh P, Spurgeon JA. Community psychiatry tracks for residents: a review of four programs. Community Mental Health Journal 2014; 50:10-16.

# Educational Workshops Session 5

## Maintaining a Sense of Wellness Following an Adverse Event: The Development of a Pilot Committee for Resident Safety

**Presenters**

Vanessa Padilla, MD
Cody Bryant, MD
Jessica Healey, MD
Julia Salinas, MD
Omar Munoz, MD

**Educational Objective**

After attending this workshop, the participant will be able to:

1. Identify the impacts of adverse events on resident well-being.
2. Describe challenges and barriers to resident safety when an adverse event occurs.
3. Discuss the creation and development of an institutional protocol to assist psychiatry residents when adverse events occur.
4. Identify the roles and responsibilities of faculty and training directors before, during, and after resident-impacting adverse events.
5. Promote the development of resources that fit the needs of the psychiatry residency program and institution.

**Practice Gap**

Psychiatrists care for patients with a variety of conditions that can affect their insight, judgment, and impulse control. This may lead to a multitude of potential risks that can put the well-being of the psychiatrist in jeopardy. Often encountered adverse events include, among others, risk of physical harm of the psychiatrist by a patient, medical errors, and completed patient suicide. As recent medical graduates, psychiatry residents face additional challenges when dealing with adverse events, such as limited training to predict or avert an adverse event, not being fully aware of the available resources at their new facility to help them recover following an adverse event, and potential self-perception of inadequacy (feeling "not good enough") when seeking help following an adverse event. Psychiatry residents must deal with the emotional and, if any, physical sequelae occurring after an adverse event while continuing to comply with duty hours, often in the midst of financial difficulties and health issues. Training programs are responsible for overseeing and ensuring resident safety, and for providing psychiatry residents adequate training in how to assess and maintain both patient and physician safety.

At our institution, no standardized protocol or committee existed to assist psychiatry residents during and after adverse events. We created a committee designed to educate residents about safety in the workplace, guide the residents to the appropriate available resources, and analyze the data obtained following adverse events.

**Abstract**

Patient suicide and assault by a patient have been described as the most stressful of the adverse events that a psychiatry resident can experience (Kozlowska et al, 1997). A 2014 literature review reported that psychiatry residents experience patient suicide at an alarming rate of 30–60%, while 25–64% are assaulted by a patient at some point during training (Deringer et al, 2014). Physicians often have difficulty coping after work-related traumatic events. A 2018 Dutch study showed that following adverse events, Ob-Gyn physicians find peer-support with colleagues as the best coping mechanism, while others may resort to unhealthy coping strategies such as substance use and medication misuse (Baas et al, 2018). It can often be difficult for physicians to seek support following adverse events for a variety of reasons. These can include, among others, feelings of guilt, shame, loss of confidence/preoccupation about future errors, anxiety, fatigue/sleeping difficulties, fears about confidentiality, and

concerns for impact on their career (Waterman et al, 2007; Lane et al, 2018). In an effort to help and support a physician who falls victim to a severe adverse event, institutional programs must be developed and implemented to promote recovery (Scott et al, 2009).

In 2019, our institution implemented The Severe Adverse Events Committee (SAVE) which is comprised of psychiatry faculty members from each of our three training sites, residents from each training year, and all chief residents. The purpose of the committee is to monitor, respond to, and analyze adverse events involving our psychiatry residents. The protocol provides specific steps on how to contact supervisors, file police/institutional reports, facilitate access to available resources, and receive immediate medical care if necessary. Impacted residents are offered time off from work, assistance with debriefing, and consolidation of necessary but often distressing meetings following the adverse event (i.e. risk management, court hearings, morbidity and mortality conference). The committee is also responsible for conducting bi-annual educational workshops for residents, focusing on topics related to physician/patient safety, crisis intervention, conflict de-escalation techniques, and physician well-being. Resident feedback is gathered to assess the impact of our committee.

This interactive workshop will provide an opportunity for academic leaders to explore the creation of a protocol designed to ensure resident safety and well-being after exposure to an adverse event. We will facilitate an interactive discussion with the audience by working through two scenarios of adverse events and providing an opportunity to create a standardized protocol tailored to their specific residency programs. Through this workshop, we will guide the audience through our process of protocol development, and will invite the audience to self-evaluate and initiate their own plans to actively address resident wellness following adverse events.

**Agenda**

- Welcome and Introduction (5 mins)
- Overview of adverse events and resident safety (10 mins)
- How are we doing it? From creating to implementing a severe adverse events committee (15 mins)
- Resident Perspective (15 mins)
- Small group discussion (30 min):
  (a) Discuss two specific scenarios of adverse events (i.e, patient completed suicide and resident assault by patient) and propose how to address resident safety, while facilitating report, debrief and supportive strategies.
  (b) Tailor and discuss ideas related to your specific residency program.
- Open discussion with audience: Developing an action plan (10 mins)
- Q&A (5 mins)

**Scientific Citations**

- Baas, M.A.M., Scheepstra, K.W.F., Stramrood, C.A.I., Evers, R., Dijksman, L.M., & van Pampus, M.G. (2018). Work-related adverse events leaving their mark: a cross-sectional study among Dutch gynecologists. BMC psychiatry, 18(1), 73.

- Deringer, E., & Caligor, E. (2014). Supervision and responses of psychiatry residents to adverse patient events. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 38(6), 761-7.
- Kozlowska, K., Nunn, K., & Cousens, P. (1997). Adverse experiences in psychiatric training. Part 2. The Australian and New Zealand journal of psychiatry, 31(5), 641-52; discussion 653-4.
- Lane, M.A., Newman, B.M., Taylor, M.Z., O?Neill, M., Ghetti, C., Woltman, R.M., & Waterman, A.D. (2018). Supporting Clinicians After Adverse Events: Development of a Clinician Peer Support Program. Journal of patient safety, 14(3), e56-e60.
- Scott, S.D., Hirschinger, L.E., Cox, K.R., McCoig, M., Brandt, J., & Hall, L.W. (2009). The natural history of recovery for the healthcare provider "second victim" after adverse patient events. Quality & safety in health care, 18(5), 325-30.
- Waterman, A.D., Garbutt, J., Hazel, E., Dunagan, W.C., Levinson, W., Fraser, V.J., & Gallagher, T.H. (2007). The emotional impact of medical errors on practicing physicians in the United States and Canada. Joint Commission journal on quality and patient safety, 33(8), 467-76.

## Teaching Case Formulation, or, How to Make Meaning Central to Treatment

**Presenters**
David Mintz, MD,
Deborah Cabaniss, MD
David Ross, MD, PhD

**Educational Objective**
At the end of this presentation, participants should be able to:
1) Discuss ways that formulating the intersection of meaning and biology enhances all aspects of psychiatric practice
2) Use new techniques for teaching basic formulation skills
3) Utilize new techniques for promoting the integration of psychological formulation into daily practice

**Practice Gap**
At the national level, there is a recognized gap between what we know about the value of patient-centered approaches and their actual implementation, transmitted through the influential Institute of Medicine (IOM) report on the “quality chasm” in American medicine (2001) and instantiated in the Affordable Care Act. Psychiatry has not been immune from pressures which promote an illness-centered model of treatment. Many of the leaders of Academic psychiatry (Cabaniss, et al, 2015; Ross, et al, 2016; Brenner, 2016) recognize that the biopsychosocial and psychodynamic formulation are approaches for ameliorating this practice gap.

**Abstract**
Though our residents generally enter residency with an interest in integrative approaches to the patient, the pressures and efficiencies of modern medical practice may inadvertently

reward more illness-centered approaches. "Formulation," as a disciplined approach to incorporating a psychological (or psychosocial) understanding of the manifestation of the patients' illness, emerged, in part, as an antidote to reductionistic pressures in the medical environment. While changes in the environment of practice have made the integrative task of formulation even more important, they have also necessitated adaptations to how formulation is conceptualized and taught.

In past generations, residents were steeped in psychodynamic approaches that considered patients' complex and conflicting motivations in relation to illness and its care. In the contemporary academic environment, residents must master a number of psychotherapies and vastly more neuroscientific information. These residents often benefit from teaching approaches that do not presume a high degree of psychological-mindedness, but which help the resident to address the questions of the "why" of illness manifestations and of treatment-seeking. Further, in an era when relatively fewer psychiatrists can expect to practice psychodynamic psychotherapy, teaching approaches must also demonstrate the relevance of formulation to domains of practice beyond psychodynamic psychotherapy.

In this workshop, we will explore the value of an integrative formulation that emphasizes the contribution of the patient's subjectivity for multiple domains of psychiatric practice, including psychotherapeutic approaches, pharmacotherapy, and medical leadership. Using examples and simple exercises, we will demonstrate strategies for teaching formulation skills to residents who are not well-versed in more complicated psychological concepts, and for enhancing the skills and capacities of more advance residents. Formulation can be used not just to help guide effective treatment, but also to help patients in self-understanding and self-management. In this workshop, we will explore how to talk to patients in ways that promote patient agency. Further, we will demonstrate techniques to promote the integration of formulation into the everyday practice of our trainees, so that it is not just an academic exercise, but, rather, becomes a foundational approach to patient care.

**Agenda**

0-5 minutes: Welcome, presenters and participants frame their interest in the topic.
5-25 minutes: Dr. Mintz discusses the Overall Diagnosis and integration of formulation into daily practice
25-40 minutes: Dr. Cabaniss address the topic of "Finding the Why"
40-50 minutes: Interactive exercise led by Dr. Cabaniss - "Finding the Why"
50-70 minutes: Interactive exercise led by Dr. Ross: "What to say" - Integrating Meaning and Neuroscience
70-85 minutes: Group discussion
85-90 minutes: Workshop evaluation

**Scientific Citations**

Committee on Quality of Health Care in America, & Institute of Medicine Staff. (2001). Crossing the quality chasm: A new health system for the 21st century. National Academies Press.

Brenner, A. M. (2016). Revisiting the biopsychosocial formulation: neuroscience, social science, and the patient's subjective experience. Academic Psychiatry, 40(5), 740-746.

Cabaniss, D. L., Moga, D. E., & Oquendo, M. A. (2015). Rethinking the biopsychosocial formulation. The Lancet Psychiatry, 2(7), 579-581.

Ross, D. A., van Schalkwyk, G. I., & Rohrbaugh, R. M. (2016). Developing a Novel Approach for Teaching Biopsychosocial Formulation. Academic Psychiatry, 40(3), 540-542.

## Protecting your Trainees and your Program: How to deal with Trainee Unprofessionalism

**Presenters**
Ahmad Hameed, MD
Ken Certa, MD

**Educational Objective**
Educational objectives:
By the end of this seminar the attendees will be able to:

1. Describe steps for evaluating (and documenting) the conduct of trainee professionalism
2. Identify strategies for managing unprofessional trainees
3. List resources that might be available in dealing with issues of professionalism
4. Discuss the emotional, psychological, and administrative impact that unprofessional trainees have on their colleagues and the program

**Practice Gap**
Despite the best efforts of training directors and recruiting committees to select flawless trainees , some trainees will display unprofessional and troubling behavior during their training. These behaviors may initially fall short of gross unprofessional conduct but do raise concerns among staff members and trainees . Residency programs are often ill-prepared to define the line between acceptable, if unusual, behavior and frank misconduct which warrants administrative action or even termination. This 'grey zone' may include misuse of resources or time, sexualized comments and behavior, extreme displays of emotion etc. Training programs can be guided by therapeutic impulses to ignore the behavior or treat the trainees rather than to confront or punish the trainee . This can have an unintended, adverse impact on trainees or staff members who are witnessing the same behavior and having a different personal response. Trainees and staff can divide into pro-trainee and anti-trainee camps in a similar fashion as splitting occurs on inpatient psychiatric units. Few resources exist to help training directors consider and discuss these situations.

**Abstract**
This workshop will describe several cases of trainees who manifested, unexpected unprofessional and troubling behavior during their residency programs. Initially this behavior

might not be egregious enough to warrant immediate administrative action. Often the reports of troubling behavior were second or third hand, undocumented, and minimized or denied by the trainee . Among the cases to be discussed included trainees who:

- Taking extreme advantage of vacation and CME policies
- Taking extreme advantage of generous cafeteria policies
- Behavior detrimental to the profession, institution and the program outside working hours
- Sexual innuendos in the presence of other trainees and medical students
- Hearing and reading what they wanted to hear and read to justify their behavior and actions

We will discuss some of the aspects that make these cases so difficult. There are often delays in reporting concerns but once the first concern is voiced there is a "piling on" of complaints. Other trainees may be reluctant to "tattle" on a peer. Some faculty members may be prone to pathologize or explain away bad behavior and give the trainee third and fourth chances. Those same faculty members may exhibit a desire to be seen as "nice" and protective of the trainees . Decision makers like the Program Director may resist seeing the big picture and base their actions only on what they have personally experienced. Program Directors may also see identifying a failing trainee as a narcissistic injury to them which they resist.
Because of these factors, programs are often slow to react. Responding to these complaints requires the training director to either take on a potentially uncomfortable investigator role or to ignore unsubstantiated but concerning accusations from the staff and trainees. Programs often fail to appreciate the long-term impact that delaying action causes on trainees, their colleagues and the program. These behaviors can result in significant splits among trainees and faculty; between those who are ready to punish and those who deny that there is a problem or want to handle it therapeutically. The importance of thorough documentation will be stressed. Documentation should include signed statements from eyewitnesses as well as all documentation of the discussions and decisions concerning the trainee . We will review the options available to the training directors and review how they can select the most appropriate option.

Attendees will be invited to describe similar cases in their programs and how they resolved them.

**Agenda**

- Introduction of speakers – 5 minutes
- Description of case 1 – 5 minutes
- Large group discussion about appropriate behaviors – 10 minutes
- Description of case 2 – 5 minutes
- Small group discussion about appropriate behaviors – 10 minutes
- Description of case 3 – 5 minutes
- Large group discussion about appropriate behaviors – 10 minutes
- General principles for managing these troubling residents (Didactic) – 10 minutes
- Identification of resources for managing troubling residents (Didactic) – 5 minutes

- Cases from attendees – (Large Group Discussion) - 15 minutes
- Next Steps for residency programs - 10 minutes

**Scientific Citations**

References:
1. Chang, HJ, Lee, YM, Lee YH, Kwon HJ. Causes of resident lapses in professional conduct during the training: A qualitative study on the perspectives of residents. Medical Teacher, 2017; 39:278-284.
2. Fargen KM, Drolet BC, Philibert J. Unprofessional Behaviors Among Tomorrow's Physicians: Review of the Literature With a Focus on Risk Factors, Temporal Trends, and Future Directions. Academic Medicine, 2016; 91: 858-64.

## Community Based Psychiatry Program Development: A Practical Primer

**Presenters**

Tanya Keeble, MD
Elizabeth Ann Cunningham, DO
Kelly Blankenship, DO
Bill Sanders, DO, MS
Areef Kassam, MD

**Educational Objective**

1) Name 3 funding opportunities available for new program development, track development or expansion
2) Understand several effective approaches to developing faculty and resident scholarly culture in community based programs
3) Define one recruitment strategy likely achievable in your specific residency training setting
4) Have the contact details for at least one AADPRT peer that they can lean on for support or advice during the early years of program development

**Practice Gap**

Workforce development is a critical issue in the United States, with many parts of the country without any mental health provider, let alone psychiatrist. By 2030 the supply of psychiatrists is expected to decrease by approximately 27% given the number of psychiatrists entering, leaving, and changing work hours. Demand for psychiatrists is expected to increase by 6% over that timeframe, resulting in an estimated shortage of 21, 150 FTE psychiatrists by 2030. In 2019 AADPRT convened a specific taskforce to focus on this issue. In the 5 years leading up to academic year 18-19 we have seen a national burgeoning of new program development, most notably in the area of community based psychiatry residency training. In the 3 years prior to AY 18-19, we had a 31% increase in the number of newly accredited general psychiatry training programs (AY 2016-17 = 15 new programs, AY2016-17 = 19 new programs, AY 2017-18 = 22 new programs). In AY 18-19 only 9 new categorical programs were ACGME accredited, possibly due to a natural slowing after such a marked rise in new accreditation. Of newly accredited

programs, we have had a consistent increase in the percentage of new programs being community sponsored or based. In AY 2016-17, 10 out of 19 (52%) of the categorical programs were entirely community based programs, and this increased further in AY 2017-18, where 16/22 programs (72%) were community programs and AY 2018-19 6/9 (66%) were community based.

Thus, even with a marked decrease in the total # newly accredited programs in the past AY, the trend for non-university accredited program development continues.

It is clear from our 2017 and 2018 new program workshop polls of attendees, that AADPRT attendees include those who are in the planning stages of psychiatry residency development, are in the initial stages of accreditation or have not yet graduated their first class. There are currently few targeted resources available to guide new program development, with little collaboration around novel funding mechanisms, best practices for development of an educational community outside an academic institution, innovative rotation creation, faculty and resident recruitment and pathways to growth and fellowship development.

This workshop seeks to enable new or potential directors and faculty to learn from the work (and mistakes) of 3 newer community based psychiatry training programs and to develop contacts between programs who are struggling with similar challenges. The three programs presented include: Pine Rest/MSU Psychiatry residency in Grand Rapids Michigan, Providence Psychiatry Residency Program in Spokane, Washington, and Community Health Network Psychiatry Residency Program in Indianapolis, Indiana.

**Abstract**
New Psychiatry Programs are in development across the United States, with much of the growth occurring in community settings, either as track programs accredited by academic medical centers, or through consortium partnerships aimed at developing psychiatry workforce in underserved areas. Collaboration with new program partners is an effective way to develop best practices, understand the unique challenges of smaller, community based medical center programs, and walk through the accreditation process from the initial stages, through continued accreditation and beyond. We present work at three community centered psychiatry residency programs, each with unique attributes, who have worked together to share ideas, and support each other in creating high quality clinician based programs. Each program is in a different stage of development. Pine Rest/Michigan State University Psychiatry Residency in Grand Rapids, MI is the oldest program started and graduated its inaugural class in July 2018. It is an example of a larger community based program which moved quickly to offer fellowship options after starting its categorical program. The second program, Psychiatry Residency Spokane started as a track program of the University of Washington psychiatry residency program over 25 years ago, and developed into a stand-alone affiliated program, accepting its first class in 2015. This program recently began work on development of its first fellowship program, a State funded supported child and adolescent training program. The third program, Community Health Network Psychiatry Residency Program, is a community partnership which achieved ACGME accreditation in 2015 and has a novel funding mechanism.

New, community and small programs share many common strengths and challenges. This workshop will provide time for attendees to engage with peers and obtain concrete support as they develop their own programs. The speakers will share their experiences with the group from the earliest stage of program development, through initial and continued accreditation into fellowship development. The educational strategies will include: initial polling of the audience to gather information about the audience in order to shape the rest of the session to audience needs, didactic presentation, small group planning, and large group brainstorming work. The content will focus on funding structure strategies, development and maintenance of a scholarly culture, program expansion and creation of fellowship programs, and faculty and resident recruitment strategies (strong medical student clerkships and subI's, mentoring structures, fellowship opportunities and exposure to new models of care that address the underserved, including collaborative care and telepsychiatry.

**Agenda**

5 min
Overview of ACGME new psychiatry residency program accreditation in the past 5 years: community to academic program mix, program development (track versus stand alone, academic medical center accreditation versus affiliation.
Tanya Keeble
Didactic

10 min
Let's get to know a little about you, your programs, your main challenges what you hope to get out of attending this workshop
Areef Kassam
Tanya Keeble
Bill Sanders
Ann Cunningham
Poll
Small group discussion

20min
Sponsorship and funding
Bill Sanders
Didactic
Large group discussion

15min
How to right size your program including fellowship development
Kelly Blankenship
Didactic
Large group discussion

20min

Creating an scholarly culture
Tanya Keeble, Ann Cunningham
Didactic
Small group planning activity with large group report back

10min
Faculty and resident recruitment strategies
Tanya Keeble
Areef Kassam
Didactic
Large group brainstorming session

10 mins
Wrap up – did we address the objectives and do you have the contact details for an AADPRT peer
Areef Kassam
Large group discussion

**Scientific Citations**


1. Federal analysis of behavioral health workforce 2018. Accessed 10/23/19https://www.thenationalcouncil.org/capitol-connector/2018/12/new-federal-analysis-of-behavioral-health-care-workforce-released/
2. Behavioral Health Workforce Projections 2016-2030: Psychiatrists. HRSA National Center for Health Workforce Analysis.
3. Deborah S. Cowley, Tanya Keeble, Jeralyn Jones, Matthew Layton, Suzanne B. Murray, Kirsten Williams, Cornelis Bakker, Johan Verhulst. (April 2016). Educating Psychiatry Residents to Practice in Smaller Communities: A Regional Residency Track Model. Academic Psychiatry, Vol 40, number 2. DOI 10.1007/s40596-016-0558-3. PMID 27114242
4. List of Newly Accredited All programs Academic Year 2015-19: acgme.org. Accessed 10/23/19
5. https://www.aamc.org/news-insights/addressing-escalating-psychiatrist-shortage
6. AADPRT Workforce Task Force.


## Competency-Based Behavioral Interviewing: Using a structured interview method to enhance residency and fellowship interviews

**Presenters**
Ashley Walker, MD
Kristy Griffith, MD
Christine Langner, DO

**Educational Objective**

1. Identify the rationales and evidence-base supporting competency-based behavioral interviewing (CBBI) as an alternative or complementary approach to the traditional, less structured interviewing format.
2. Utilize a method to identify which competencies are most relevant to trainee success.
3. Utilize tools and workshop experiences to integrate CBBI into one's own training program.

**Practice Gap**

As the number of applications to psychiatry residencies and fellowships continues to rise, programs are faced with the challenge of how to effectively identify potentially successful applicants from among the large volume of applications received. One important evaluation method is the residency interview. However, faculty are often not trained in how to effectively interview program applicants, and interview methods may vary widely between and even within programs. Furthermore, traditional unstructured interviews may not consistently provide an adequate prediction of applicant success in the training program. The Association of American Medical Colleges (AAMC) has recently promulgated best practice recommendations for conducting residency and fellowship interviews, promoting structured interviews and standardized evaluation methods which aim to gather reliable and valid information (1). This workshop will detail a structured interviewing method called Competency-Based Behavioral Interviewing and will provide participants an interactive experience to train them in how to use this interviewing method for residency recruitment.

**Abstract**

Residency and fellowship recruitment is a complex process in which programs weigh many factors to determine how to rank applicants for the matching process. The formal interview typically weighs heavily in the determination of how to rank applicants, but interviewing methods vary widely among and even within programs. Furthermore, faculty are often not trained in how to effectively interview residency applicants. As the number of applicants to psychiatry residencies and fellowships continues to rise, programs are faced with the challenge of how to compare and rank applicants effectively for optimal fit. The AAMC acknowledges the challenges faced by programs, noting a dearth of resources to guide program faculty in how to conduct effective interviews and how to ensure standardized evaluations of applicants. The AAMC has promulgated best practice recommendations for conducting residency and fellowship interviews, promoting structured interviews and standardized evaluation methods, which aim to gather reliable and valid information. Competency-based behavioral interviewing (CBBI) is a structured interview method that uses job-related behavioral questions to predict applicants' performance in specific competency areas. Paired with standardized evaluation tools, this method may assist programs in better assessing applicant fit for their unique training experiences. This interactive workshop will introduce participants to one program's experience with using CBBI, and will engage participants in tasks including identifying program-specific competency areas, selecting competency-based questions that may predict success in a given training program, practicing using CBBI in small groups, and practicing using a standardized evaluation tool for measuring an applicant's performance in the interview. Participants will

leave the workshop prepared to implement CBBI in their own programs as a complementary or alternative interview method to assist with residency applicant selection for ranking.

**Agenda**

1. 5 min - Introductions and defining the practice gap
2. 10 min - Define CBBI and its evidence-base
3. 5 min - Introduction to identifying competencies
4. 10 min - Practice identifying relevant competencies using 3-3-3 method
5. 10 min - Interview questions, rating scales, and interviewer training
6. 5 min - Interview demonstration
7. 15 min - Practice the CBBI interview (small groups)
8. 5 min - Practice using rating scales
9. 10 min - Sharing what we've learned and how to tailor the process
10. 15 min – Questions, discussion, session evaluation

**Scientific Citations**

1. Best Practices for Conducting Residency Program Interviews. Association of American Medical Colleges. Washington, D.C. 12 September 2016. https://www.aamc.org/download/469536/data/best_practices_residency_program_interviews_09132016.pdf

## Adventures in Active Learning: Active Learning Resources to Fit Any Budget

**Presenters**

Lillian Houston, MD
Cesar Cardenas, Jr., MD

**Educational Objective**

At the end of the workshop, participants should be able to:

1. Describe adult learning theory
2. Describe several available online learning tools (Nearpod, Factile, and Educaplay) and their relative strengths and weaknesses, including associated costs.
3. Design their own classroom activities utilizing both available online resources and offline (board game-based) resources.

**Practice Gap**

The study of andragogy has led to the rise of active learning techniques at multiple levels of education, including medical student and resident education. Studies thus far indicate that active learning greatly enhances long-term retention of material and its integration into clinical practice. However, educators often lack the time and/or finances to locate new teaching resources, making it difficult to embrace new teaching methodology. Workshops presented at educational conferences often highlight the same resources repeatedly, which does not assist attendees already familiar with these resources. This workshop was created to highlight resources that have not been featured at prior conferences. The material was recently presented at the Association for Academic Psychiatry 2019 Annual Meeting and was both well-

attended and well-received, demonstrating the need that educators feel for new material and new concepts in teaching.

**Abstract**
Andragogy is a term popularized by Malcolm Knowles which refers to the methodology of teaching adult learners. Studies in this area have provided changes to teaching methodology across multiple settings, including medical school and residency. The use of active learning methodology has the potential to foster adaptive expertise and to create true lifelong learners. However, locating useful resources can be difficult when instructors have limited protected time and/or budgetary constraints. This workshop will draw from the presenters' experience in locating, appraising, and creating interactive classroom activities to demonstrate the use of online and offline resources that may be new to the audience with an emphasis on accessibility and budget. The group will participate in short demonstrations of 3 online resources (Nearpod, Factile, and Educaplay) and 2 offline resources (Pictionary and Taboo). The group will then reconvene to discuss how the resources and techniques demonstrated can be utilized at their home institutions to create memorable and engaging learning activities. Participants are highly encouraged to bring an electronic device with internet access and to download the Nearpod app prior to attending.

**Agenda**
Introduction of leaders and attendees – 5 minutes

Presentation on the background and practice of andragogy with integrated presentation of Nearpod capabilities/costs – 15 minutes

Presentation of offline activities with discussion of how to choose and develop offline activities – 20 minutes

Presentation of other online resources with discussion of capabilities and costs – 30 minutes

Group discussion/Q&A session – 20 minutes

**Scientific Citations**
Bishop, J. L., & Verleger, M. A. (2013, June). The flipped classroom: A survey of the research. In ASEE national conference proceedings, Atlanta, GA (Vol. 30, No. 9, pp. 1-18).
Bonwell, C. C., & Eison, J. A. (1991). Active Learning: Creating Excitement in the Classroom. ERIC Digest.
Knowles, M. S., Holton III, E. F., & Swanson, R. A. (2012). The adult learner. Routledge.
Mayer, R. E. (2010). Applying the science of learning to medical education. Medical education, 44(6), 543-549.
Merriam, S. B. (2001). Andragogy and self?directed learning: Pillars of adult learning theory. New directions for adult and continuing education, 2001(89), 3-14.
Miller, B. M., Moore Jr, D. E., Stead, W. W., & Balser, J. R. (2010). Beyond Flexner: a new model for continuous learning in the health professions. Academic Medicine, 85(2), 266-272.

Prince, M. (2004). Does active learning work? A review of the research. Journal of engineering education, 93(3), 223-231.

## To Retreat or Not to Retreat: Strategic Use of Resident Retreats as a Wellness Tool with Cues from the Corporate World

**Presenters**
Victoria Kelly, MD
Thomas Roach, DO
Nathan Massengill, MD
Zoellen Murphy, CTAGME
Krisi Williams, MD

**Educational Objective**

1. Identify the role resident retreats have in improving resident wellness, leadership, and cohesion.
2. Review executive coaching strategies from the business field and recognize components that can be incorporated into resident retreats
3. Use a "SWOT matrix" (Strengths, Weaknesses, Opportunities, and Threats) to analyze a mock residency program and develop a sample retreat agenda
4. Identify challenges & potential solutions to resident retreat planning

**Practice Gap**

"Coming together is a beginning. Keeping together is progress. Working together is success." – Henry Ford

The Merriam-Webster dictionary defines a retreat as "a period of group withdrawal for prayer, meditation, study or instruction under a director" [1]. A retreat provides residents a time to bond with their colleagues, which fosters physician and program wellness. This bonding experience helps residents build better working relationships with their peers, which lowers burnout rates [2]. Resident retreats help trainees master the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Psychiatry & Neurology's (ABPN) psychiatry core competency expectations of 'Interpersonal and Communications Skills', 'Professionalism', and 'Systems-Based Practice' [3].

Searching Pubmed for "resident retreat," "wellness" and/or "burnout" yielded only 15 results. Of those, one result found radiology residents to have improved camaraderie after a retreat [4]. Another result found emergency medicine residents had increased team building, resident bonding, and faculty-resident bonding after an "Amazing Race" style retreat [5]. Several more results pertained to pharmacy students and family practice. Although one article discussed using a research retreat to improve career development opportunities for psychiatry residents, it focused on a regional conference rather than the traditional residency retreat [6]. Most notably, no literature was found providing guidance to programs on planning retreats or

psychiatry-specific data on residency retreats. This is especially meaningful, given that 43.9% of psychiatry residents in 2018 noted symptoms of burnout [7].

Chief residents are often sent to “Leadership” trainings, where the most valued skills learned are giving feedback, delegating duties, building teamwork, managing time, making presentations, being on rounds, coping with stress, teaching at the bedside, writing memos, and managing meetings [8]. However, there is a lack of formal training in leadership skills at the program level. A resident retreat is a useful tool for program leadership (director, coordinator, chief resident) to develop or reinforce leadership skills and address the specific and unique needs of the individual program. The ability to function as a physician leader and demonstrate interprofessional skills are addressed in the ACGME Adult Psychiatry milestones of MK6 (Practice of Psychiatry) and SBP1 (Patient Safety and the Health Care Team), PBLI1-2.1A & 2.2A (Development and execution of lifelong learning through constant self-evaluation), and PBLI3 (Teaching) [9].

Formal education and discussion of retreat planning as a wellness tool will empower program directors and chief residents to be more prepared in addressing challenges residents encounter. Having a strategic plan for resident retreats allows for demonstration of managerial skills, fosters interpersonal and professional growth, and addresses burnout all within a bonding experience. Resident retreats also assist in the cultivation of professional development as found within the ACGME milestones PROF2 (Accountability to self, patients, colleagues, and the profession), and ICS1 (Relationship development and conflict management with patients, families, colleagues).

**Abstract**

“In order to understand the world, one has to turn away from it on occasion." – Albert Camus, The Myth of Sisyphus and Other Essays

In the changing climate of healthcare, resident psychiatrists are expected to conquer challenging professional and interpersonal terrains while progressing academically, often without formal training in how to do so. [10]. Poor work-life balance, the changing role of the physician in the healthcare setting, and dealing with conflicts in professional and personal lives, have all been shown to contribute to burnout in physicians. Burnout is a well-known, but not well-defined, problem that has been shown to be particularly high in residents. Now more than ever, trainees need formal guidance on how to prevent burnout and develop professionally while navigating this ever-changing landscape.

Interventions designed to increase well-being and decrease burnout include individual level approaches directed toward enhancing individual well-being as well as systemic interventions aimed at changing workplace factors such as culture, leadership, autonomy, and workflow. These workflow factors include assistance with administrative burdens, increasing physician autonomy) [11]. For residents, factors that contribute to burnout require interventions. These include demands on time, lack of control, work planning, organization, inherently difficult job situations, and interpersonal relationships [12]. In 2015, a national panel of United States

multispecialty residents and fellows specifically recommended resident retreats as a way to increase resident wellness activities [13]. One of the best ways to improve the performance of a medical practice team is to hold a team retreat [14]. A major goal of a retreat is to encourage socialization in an informal setting, allowing barriers to be broken down, and improving teamwork [15]. In medicine, this may indirectly impact patient care due to teamwork factors affecting patient handoff and coverage issues.

Program directors, coordinators / administrators, and chief residents have a unique opportunity to use resident retreats strategically in several ways: as a wellness tool, to evaluate the program's strengths / weaknesses / opportunities / threats, to identify individual professional development needs, to promote bonding, and potentially enact larger departmental change. Incorporating cues from the corporate world provides resident retreats with the general framework that can be adapted to the unique needs of the individual psychiatry residency programs.

To address this need, our interactive workshop will discuss corporate & coaching approaches, potential benefits & impact on residency programs, and ways to enhance the experience. Participants in the workshop will have the opportunity to examine their own program, practice creating an optimal retreat agenda, and discuss challenges & potential solutions for an effective retreat. Upon completion of this workshop, the participant should have an increased knowledgebase and confidence in the ability to strategically plan a resident retreat that will benefit the residents and the program.

**Agenda**

1. 15 minutes – Introduction, Overview, and Why a retreat is important (wellness, milestones & competencies, professional development, and borrowing from the business world)
2. 10 minutes – Breakout – How a retreat could make your program better
3. 15 minutes – Strategic planning and building your retreat - components of agenda, structure, goals like leadership support, program evaluation, teambuilding, and consideration of lasting gains
4. 20 minutes – Breakout – given a standardized scenario, evaluate a mini-SWOT and create a retreat agenda
5. 10 minutes – Breakout – challenges that programs face to making retreats happen successfully
6. 10 minutes – Final discussion points and sample retreat agenda
7. 10 minutes – Wrap up and questions

**Scientific Citations**


1. Definition of Retreat, Merriam-Webster, www.merriam-webster.com/dictionary/retreat.
2. Lee, Huan-Fang, et al. "A Meta-Analysis of the Effects of Coping Strategies on Reducing Nurse Burnout." Applied Nursing Research, vol. 31, 2016, pp. 100–110., doi:10.1016/j.apnr.2016.01.001.?

3. ABPN Board of Directors. ABPN Psychiatry Core Competencies Outline, 22 July 2011, www.abpn.com/wp-content/uploads/2015/02/2011_core_P_MREE.pdf.?
4. Haber MA, Gaviola GC, Mann JR, et al. Reducing Burnout Among Radiology Trainees: A Novel Residency Retreat Curriculum to Improve Camaraderie and Personal Wellness - 3 Strategies for Success. Curr Probl Diagn Radiol. 2019;?
5. Cornelius A, Cornelius BG, Edens MA. Increasing Resident Wellness Through a Novel Retreat Curriculum. Cureus. 2017;9(7):e1524.?
6. Besterman AD, Williams JK, Reus VI, Pato MT, Voglmaier SM, Mathews CA. The Role of Regional Conferences in Research Resident Career Development: The California Psychiatry Research Resident Retreat. Acad Psychiatry. 2017;41(2):272-277.
7. Dyrbye LN, Burke SE, Hardeman RR, et al. Association of Clinical Specialty With Symptoms of Burnout and Career Choice Regret Among US Resident Physicians. JAMA. 2018;320(11):1114–1130. doi:10.1001/jama.2018.12615
8. Lim RF, Schwartz E, Servis M, Cox PD, Lai A, Hales RE. The chief resident in psychiatry: roles and responsibilities. Acad Psychiatry. 2009;33(1):56-9.
9. Thomas, Christopher R. Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurololgy, 6 Nov. 2015, www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf?ver=2015-11-06-120520-753.
10. Thakur A, O'leary B, Cowie W, Soklaridis S. The Development and Validation of a Workplace-Based Leadership Program for Senior Residents in Psychiatry. Acad Psychiatry. 2019;43(1):123-127.
11. “Well-Being and Burnout.” American Psychiatric Association, www.psychiatry.org/wellbeing.
12. Ishak, Waguih William, et al. “Burnout During Residency Training: A Literature Review.” Journal of Graduate Medical Education, vol. 1, no. 2, 2009, pp. 236–242., doi:10.4300/jgme-d-09-00054.1.
13. Daskivich, Timothy J., et al. “Promotion of Wellness and Mental Health Awareness Among Physicians in Training: Perspective of a National, Multispecialty Panel of Residents and Fellows.” Journal of Graduate Medical Education, vol. 7, no. 1, 2015, pp. 143–147., doi:10.4300/jgme-07-01-42.
14. Hills L. How to improve the performance of a good medical practice team: twelve techniques. J Med Pract Manage. 2013;28(6):378-81.
15. Goodale JG. Effective teamwork and productivity conferences. Clin Lab Manage Rev. 1994;8(3):241-5.

# No More Sitting and Staring at Powerpoint! Using Interactive Teaching Techniques to Enhance Meaning-Making in Trainee Didactics

**Presenters**
David Hankins, MD, MS
Julie Penzner, MD
Mark Sullivan, MD
Susan Samuels, MD

**Educational Objective**
By the end of this workshop, participants will be able to:

1. Explain how incorporating active learning techniques into formal didactic sessions is evidence-based and tied to improved learner outcomes
2. Describe at least five active learning techniques that can be incorporated into didactic sessions
3. Anticipate and address barriers to the implementation of active learning techniques
4. Create a new psychiatry didactic session incorporating active learning techniques

**Practice Gap**
When trainees at many medical schools and psychiatry residencies walk into a one-hour didactic session, they know exactly what to expect: sixty minutes of an instructor talking at them, often aided by a set of PowerPoint slides. Lecture-based instruction persists in many settings despite decades of research supporting active learning techniques as means to propel adult learners to higher, more enduring understanding.

Trainees have grown accustomed to passive teaching and learning, and may struggle to even imagine alternative methods. Instructors of didactics for psychiatry trainees have typically trained within the same lecture-driven approach without any formal instruction in pedagogical methods. Lectures are often prepared in advance, and delivered by rote, obviating opportunities for meaning-making for either teacher or learners. Many teachers and learners have identified that the current approach is sub-optimal, but tools to teach and learn differently are not readily available.

Passive presentation formats root learners firmly in the lower two levels of Benjamin Bloom's landmark Taxonomy of Educational Objectives ("knowledge" and to some extent "comprehension") (Bloom 1956), offering no opportunity for learners or teachers to create meaning from the new material by application, analysis, synthesis, or other creative uses. In the context of medical education, research in active learning has focused on problem-based learning and a flipped curriculum model. Both approaches are most readily implemented at the institutional level, in larger, extended courses. But what can one individual teacher, asked to teach a class, do to incorporate active learning techniques into a one-hour session? What can one teacher do if they have rarely or never participated in active learning settings themselves? Finally, how can teachers and learners maximize meaningful contact not just with course

material, but with one another, as we all strive to defend against burnout and promote well-being? Deliberate use of active learning techniques offers opportunity for higher-order learning, as well as for meaningful interpersonal contact between class participants.

**Abstract**
Medical students and psychiatry residents spend considerable time learning key concepts in one-hour didactics taught by teachers who are further along on the training continuum. Frequently, didactic sessions follow a time-worn format: an hour-long lecture with hundreds of factoids of varied importance. Typical didactics are short on learner participation and create little enduring opportunity for learners to use the information meaningfully. Furthermore, most teachers of residency didactics do not have formal educational training, nor have they experienced active learning during their own training. Thus we aim to offer active learning examples that can be readily implemented by novice faculty in psychiatry classes.

Our workshop will review basic educational theory (actively!) and consider evidence supporting the use of active learning to achieve higher-order comprehension. Active learning techniques have been shown to improve retention and ability to activate and apply new material, to increase teacher and learner enjoyment of class, and to improve collaboration. Over-reliance on passive learning misses opportunities for higher-order use of material. We introduce participants to a variety of active learning techniques available for immediate incorporation into didactics, with the goal of increasing learners' interest, enjoyment, and retention. A side benefit is that as learners are more active and engaged, teachers are likely to feel similarly, therefore infusing meaning into teaching, and encouraging real classroom interpersonal contact. The workshop co-leaders, two of whom have formal training as classroom teachers, have implemented active learning techniques in varied settings and in groups of between 3 and 50 medical students and psychiatry residents with success (and some complaining—which they will talk about too!).

Techniques to be modeled include audience response mechanisms for large-group settings, paired and small-group approaches for larger classes (think-pair-share, K-W-L charts, gallery walk, jigsaw method), and options for written responses to the new material. Techniques modeled in this workshop are particularly useful because they can be incorporated into any didactic presentation regardless of institutional policies regarding active learning (e.g. problem-based learning or flipped curriculum). Anecdotally cited barriers to the use of active learning techniques include minimal participant willingness to prepare before class, lack of teacher knowledge of techniques, fear that students will hate it, and lack of time to implement new methods. We will consider these barriers during the workshop.

Our workshop helps close the practice gap by providing participants with specific techniques that they may have never seen used before, but can readily apply to make learning sessions more active. Participants will learn the evidence supporting the use of active learning techniques and will engage with techniques in the workshop itself. Therefore participants will have a chance to see how these new techniques can actually work, to practice their use, to ask questions and address potential challenges, and to decide which of the techniques fit best with

their personal approach to teaching. As we all struggle to "reclaim meaning through teaching," we purport that deliberate use of the active learning strategies practiced in this workshop will confer both educational and psychological benefit to teachers and learners alike.

**Agenda**

0:00 – 0:25 Introductions, presentation of evidence on active learning techniques, and discussion of barriers to incorporating active learning, using interactive modeling of multiple active learning techniques

0:25 – 0:40 Gallery Walk – will reinforce new concepts and model an active learning technique

0:40 – 1:05 Small Group Activity: Reclaiming a Didactic Session – participants will work in small groups to re-create an early psychiatry trainee didactic on a common topic, changing it from one hour of PowerPoint presentation to a more interactive format using techniques discussed in the workshop.

1:05 – 1:20 Each group will share its work with the larger group

1:20 – 1:25 Review of key points and learning objectives

1:25 – 1:30 Participant review

**Scientific Citations**

Bloom, B. S. (1956). Taxonomy of educational objectives: The classification of educational goals. New York: Longmans, Green.

Freeman, S., Eddy, S. L., McDonough, M., Smith, M. K., Okoroafor, N., Jordt, H., & Wenderoth, M. P. (2014). Active learning increases student performance in science, engineering, and mathematics. Proceedings of the National Academy of Sciences, 111(23), 8410-8415.

Markant, D. B., Ruggeri, A., Gureckis, T. M., & Xu, F. (2016). Enhanced memory as a common effect of active learning. Mind, Brain, and Education, 10(3), 142-152.

Muzyk, A. J., White, C. D., Kinghorn, W. A., & Thrall, G. C. (2013). A psychopharmacology course for psychiatry residents utilizing active-learning and residents-as-teachers to develop life-long learning skills. Academic Psychiatry, 37(5), 332-335.

Roediger III, H. L., & Butler, A. C. (2011). The critical role of retrieval practice in long-term retention. Trends in cognitive sciences, 15(1), 20-27.

Taylor, D. C., & Hamdy, H. (2013). Adult learning theories: Implications for learning and teaching in medical education: AMEE Guide No. 83. Medical teacher, 35(11), e1561-e1572.

# Recruitment vs. Selection: Minimizing Systematic Bias During the Match Process

**Presenters**
Christin Drake, MD
Deepti Anbarasan, MD
D Bhatt, MD, PhD
Tyra Bailey, MA

**Educational Objective**
Participants will:

1. Understand the systematic biases inherent to the tools we use to evaluate applicants to our residency programs.
2. Experience their own susceptibility to these biases.
3. Learn about the presenters' experiences implementing a less-biased recruitment process at NYU
4. Consider and discuss strategies to minimize the bias in their own recruitment processes

**Practice Gap**
We are all making great efforts to meet the treatment needs of the diverse populations we serve and the educational needs of our residents. Many departments are rightly focused on recruiting applicants who are members of groups historically underrepresented in psychiatry as a part of their strategy to mitigate barriers to care and race-based structural problems with access and quality. However, many of the tools available to us to evaluate candidates for residency training have been developed in systems that are, themselves, biased against underrepresented groups. Additionally, there is more and more cause to question whether the tools we use to predict applicants' success as residents are reliable even without the concerns around bias. This results in a recruitment and selection process that may work in opposition to our ability to build the diverse residency programs and workforce that we know are needed.

**Abstract**
Out of concern for difficulty faced in recruiting a diverse class of residents one year ago and an ever growing literature showing the systematic biases embedded in the residency selection process, the New York University Psychiatry Residency training office developed and implemented a system for recruitment designed to minimize the impact of bias on our final rank list. We were first convinced through group discussions and independent reflection of our own biases and the risks related to these biases influencing our selection process. We then reviewed the literature and developed a plan to blind our interviewers to all but the personal statement and CV of the applicants they would meet. We oriented a large group of interviewers to the data supporting the new procedure and requested that each interviewer perform their own Implicit Assumption Testing to prepare themselves for the interview.

In this workshop, we will share what we have learned in this process and its impact on the representation of underrepresented students on our rank and match lists. There have been interesting dynamics to observe, technical issues to navigate, and some pitfalls that we hope

will be useful to others. We will also offer the opportunity for attendees to participate in a mock applicant rating exercise that will help them examine their own biases and their impact on how participants assess candidates. Finally, we will ask participants to consider how they might implement similar strategies in their home departments and help anticipate how to address challenges they may face.

**Agenda**
Introduction and Background - 10 minutes

Breakout Session #1 - Exercise in rating composite applicants - 15 minutes

Post-breakout Debrief #1- 10 minutes

Presentation of workshop leaders' recruitment approach - 10 minutes

Details of implementation, pitfalls and lessons learned - 10 minutes

Breakout Session #2 - Exercise rating applicants with bias-minimized materials - 15 minutes

Post-breakout Debrief #2 - 10 minutes

Sharing results of our rank/match and unblinding of ratings given by workshop participants in the session - 10 minutes

**Scientific Citations**
https://www.ncbi.nlm.nih.gov/pubmed/?term=Academic+Medicine.+94(4)%3A562–569%2C+APRIL+2019

https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2607210

https://www.ncbi.nlm.nih.gov/pubmed/29923892

https://www.jgme.org/doi/10.4300/JGME-D-18-00979.3

## Reclaiming Meaning for Everyone: exploring power, privilege, and allyship with psychiatry residents

**Presenters**
Jackie Wang, MD
Isela Pardo, MD
Belinda Bandstra, MD, MA

**Educational Objective**

1. Define privilege and allyship, discuss how these concepts relate to power dynamics within the practice of psychiatry
2. Demonstrate interactive, self-reflective, experiential activities that can be used to explore these concepts with psychiatry trainees
3. Discuss opportunities and challenges to implementing curricula on power, privilege, and allyship at participants' home institutions

**Practice Gap**

Psychiatry residents and the patients they serve are becoming increasingly diverse, but residents are not necessarily receiving training on how to navigate differences between their own identities and those of their patients, which may or may not be familiar to trainees.

The ACGME's accreditation standards for psychiatry residency programs state that residents are required to "demonstrate knowledge of … social-behavioral sciences, as well as the application of this knowledge to patient care." The required knowledge base includes "aspects of American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the resident and the patient, including the dynamics of differences in cultural identity, values and preferences, and power." Many trainees may recognize that differences in cultural identity, values and preferences, and perception of power may exist between them and their patients, but may not feel adequately trained in how to identify, process and address these differences in a clinical setting. The experiential learning they do receive may be ad-hoc based on specific clinical encounters, rather than deliberately planned sessions designed to (1) acknowledge the affective potency that these topics elicit and (2) provide intentional space for self-reflection and group discussion.

**Abstract**

"The cultural elements of the relationship between the resident and the patient, including the dynamics of differences in cultural identity, values and preferences, and power" are important for psychiatry residents to understand not only because of ACGME accreditation standards, but because these elements pervade all clinical encounters between psychiatrists and their patients, whether or not they are explicitly acknowledged and discussed. Privilege, defined as an unearned advantage given by society to all members of a dominant group and resulting from marginalization of another social group, is one important way in which personal identity intersects with power dynamics. Allyship is an active, consistent, and arduous practice of unlearning and reevaluating that those with privilege use to act in solidarity with a marginalized group. These concepts can provide a helpful lens for residents to explore "the dynamics of differences" in power and identity between themselves and their patients, and consider how they might navigate these differences. However, these topics are often affectively charged and can be challenging to confront. Educational sessions about power and identity must therefore be predicated on the tenets of cultural humility, including an emphasis on self-reflection, open discussion, and shared learning in order to engage all learners.

In this workshop, we will demonstrate key activities from a three-session didactic series given to PGY2 residents to introduce them to concepts of power, privilege, and allyship in clinical contexts. These activities are designed explicitly to: feel accessible to an audience with diverse perspectives and experiences regarding these topics; incorporate self-reflection about one's own relevant experiences, both personal and clinical; be experiential and interactive; ground the discussion in specific, real-life clinical scenarios. The presenters will provide reflections on their experience designing and facilitating the didactic series, including challenges encountered and reflections on Reclaiming Meaning Through Teaching. Throughout the workshop, participants will discuss strategies to implement similar sessions into their own training curricula and barriers to implementation.

**Agenda**

Introduction (10 min)

1. Power: individual self-reflection activity about power hierarchy in one's home clinical setting (7 min), followed by small or large group discussion, depending on size of workshop (8 min) and didactic contextualization (5 min)
2. Privilege: media introduction to privilege (3 min), followed by small or large group discussion (7 min)
3. Allyship: pair-share activity of clinical scenarios with complex power dynamics (15 min), didactic introduction to allyship (5 min), followed by large group discussion (10 min)
4. Small group brainstorm opportunities and barriers for implementing curriculum at home institution (7 min)
5. Large group share-out, debrief and questions (8 min)
6. Whova feedback (5 min)

**Scientific Citations**


1. ACGME Program Requirements for Graduate Medical Education in Psychiatry. Effective July 1, 2019: https://www.acgme.org/Specialties/Program-Requirements-and-FAQs-and-Applications/pfcatid/21/Psychiatry.
2. Hansen H, Braslow J, Rohrbaugh R. From cultural to structural competency: training psychiatry residents to act on social determinants of health and institutional racism. JAMA Psychiatry. 2018; 75(2): 117-118.
3. McIntosh P. "White privilege and male privilege: a personal account of coming to see correspondences through work in women's studies." 1988.
4. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved. 1998 May; 9(2): 117-125.
5. Willen S, Bullon A, Good M-J. Opening up a huge can of worms: reflections on a "cultural sensitivity" course for psychiatry residents. Harvard Review of Psychiatry. 2010 July/August; 18(4): 247-253.
6. Wu D et al. The efficacy of an antioppression curriculum for health professionals. Family Medicine. 2019; 51(1): 22-30.

# Being a Peer Reviewer: Why and How?

**Presenters**
Rashi Aggarwal, MD
Adam Brenner, MD
Richard Balon, MD
Ann Tennier, BA, BS

**Educational Objective**
At the end of the workshop, participants will be able to:
1. Recognize the benefits of serving as a reviewer for an academic journal,
2. Appreciate the qualities of a good reviewer,
3. Identify the components of a review,
4. Understand how to effectively use reviewer feedback to improve their manuscripts,
5. Practice assessing the quality of reviews provided by others.

**Practice Gap**
While serving as a reviewer for academic journals is considered an essential part of being an academic faculty and educator, there is usually no formal training on how to be a reviewer. In general, there is no formal feedback system on the quality of reviews provided. There are no mechanisms available to faculty who are interested in learning how to do good reviews or how to improve the quality and effectiveness of their reviews.

**Abstract**
The peer review process is an essential and central aspect of scientific publication. Despite that, there is usually no formal process for training to become a reviewer. In addition, while the importance of peer reviewers is clear to anyone aspiring to publish as well as to the editors of academic journals, the benefits of serving as a peer reviewer can be less clear to potential reviewers. Serving as a reviewer can help academic faculty in several ways including enhancing their own learning, establishing their identity as an academician, and adding substantially to their CV.

While there are no formal qualifications to be a reviewer, good reviewers possess some essential skills which can be developed. Workshop attendees will learn the structure and the components of a review that is helpful to both authors and journal editors. Such a review examines the suitability of the manuscript for the journal by looking at its relevance and quality, including clarity of the study design and of the writing. This task can appear intimidating to many new faculty. In this workshop, we will clarify the steps of a review, assess the typical time commitment, and go over the process of writing the review. We will also discuss how to develop subject matter expertise and how to do effective reviews when at the beginning of your career.

This workshop will be interactive and practical and will be beneficial to both potential and experienced reviewers as well as to potential authors. Interested participants will be able to sign up to be a reviewer for Academic Psychiatry at the end of the session.

**Agenda**

1. Introductions (5min)
2. Benefits of being a peer reviewer: Why should you be a reviewer? (5 min)
3. How to become a reviewer and what does it entail? (10 min)
4. Qualities of a great reviewer (15 min)
5. Using the reviews: Tips for authors (optional) (10min)
6. Practicum-Rate the quality of reviews (10min)
7. Practicum- Try your hand at reviewing (15min)
8. Discussion (20 min)

**Scientific Citations**


1. Bordage G, Caelleigh AS: A tool for reviewers: "Review Criteria for Research Manuscripts." Acad Med 2001; 904–908
2. Jacobson R.M., Fairbrother G., Sheldrick R.C, et al. The role of the peer reviewer. Acad Pediatr., 17 (2017), pp. 105-106
3. Roberts L.W., Coverdale J., Edenharder K. et al. Acad Psychiatry (2004) 28: 81.
4. Roberts, L.W. Acad Psychiatry (2002) 26: 221.
5. Tandon R. How to review a scientific paper. Asian Journal of Psychiatry, 11 (2014), pp. 124-127


## How to become a Journal Club Superstar!

**Presenters**


Lindsey Pershern, MD
Adriane Dela Cruz, MD, PhD


**Educational Objective**

After participating in this workshop, participants will be able to:

1. Identify potential benefits associated with a structured journal club activity
2. Experience a structured journal club activity
3. Discuss new journal club format and compare/contrast to current journal club format/s at home institution
4. Consider application of this journal club format to address their own challenges at home institution

**Practice Gap**

Journal club, a gathering of colleagues to discuss a medical literature article, has been a part of medical education since the time of Osler, and the role of journal club in undergraduate and graduate medical education has been studied for more than 30 years. In theory, journal clubs in

graduate medical education typically serve dual roles of teaching skills in critical appraisal of the literature and keeping residents and faculty up-to-date on key findings. In practice, however, these sessions are often staid presentations in which the journal club leader presents a summary of the article with little discussion amongst journal club attendees. In our residency program, we identified a need to enrich the journal club experience, as few residents enter GME training with strong skills in literature appraisal and residents consistently reported feeling unable to fully engage in the journal club due to the lack of these skills. A small, early study suggested that journal club is not an effective way for psychiatry residents to learn critical appraisal skills [1], at least over a 12 week period in which the journal club format consists of resident-selected articles and a single resident leading the discussion of each article. More recent work has highlighted the importance of utilizing a format that encourages the active participation of multiple residents [2], meeting monthly [3], clearly stating the goals of the journal club [3, 4], and articulation of reasons for article selection for discussion [4], and emphasizing the connection of the article to clinical practice [3, 5]. We are guided also by the incorporation of these topics into resident training requirements in multiple milestone sub-competencies including PBLI1, PROF2, PC3, PC5, MK1, MK3[6]. These changes to journal club allow each resident to consider the importance of the selected articles to their practice.

**Abstract**

Gaining familiarity and comfort with reading the psychiatric literature is a critical skill for all trainees to gain during residency. Additionally, residents need knowledge of foundational findings in the literature to provide evidence-based care and for successful completion of in-training and board exams. Many residents do not gain skills in critical appraisal of the literature in medical school and need to actively learn skills for reading the literature in residency. To address this gap, we have developed a comprehensive journal club curriculum, Journal Club Super Star, recently published as an AADPRT model curriculum. The Journal Club Super Star curriculum provides three documents for each journal club session: the preguide, the article, and the postguide. The preguide contains a list of questions specific to the article to help residents engage with the article and to highlight aspects of the research design. The preguide emphasizes areas in which the authors made critical decisions in either the study design or the presentation of the outcomes. Each preguide contains a "technical point" that poses a specific question about statistics and design. The postguide provides a brief summary of the article, highlighting both the strengths and the weaknesses of the design and analysis, and addressing the "technical point." The discussion in the postguide ensures that consistency among information taught across all groups. Over the course of the PGY2-4 curriculum, residents read and critique the major effectiveness trials (e.g., STAR-D, STEP-BD), traditional randomized controlled trials, neuroimaging and human laboratory studies, large cohort analyses, and other pertinent literature. The PGY1 curriculum focuses on major effectiveness trials and pairs each article from the primary literature with a brief review article focused on research design and statistics. All articles are selected by the course directors to ensure that high quality articles on a variety of topics utilizing different techniques are included in the journal club. This curriculum has been well accepted by residents, with residents evaluating the journal club sessions in the good (3/5) to very good (4/5) range and rating the sessions as equally strong in development of psychiatric knowledge and development of skills in reading the literature. The curriculum also

received high ratings from the AADPRT model curriculum peer reviewers with all domains rated as “excellent” or “outstanding” and with a total score of 36 out of a possible 40 points. In this workshop, we will provide an overview of the Journal Club Super Star Curriculum, including a review of the primary literature articles covered by the curriculum. Workshop attendees will then break into small groups and hold an abbreviated journal club session, utilizing materials from the curriculum. We will then discuss the implementation of these materials in attendees’ home programs. Programs currently using the Journal Club Super Star curriculum are encouraged to attend to discuss their experiences with these materials.

**Agenda**

For a 90 minute workshop, the timeline would be as follows:

0:00-0:20

- Introduction of presenters and participants
- Overview of learning objectives and poll of audience of interest in topic and personal goals of participation
- Introduction to journal club materials and PGY2-4 vs PGY1 curriculum

0:20- 0:55

- Small group journal club session
- Participants will be asked to divide into groups of 10
- Each group will conduct a mock journal club using provided materials

0:55 - 0:75

- Small group reflections
- Participants will reflect on what did and did not work with utilizing the journal club materials
- Participants will be encouraged to compare/contrast presented materials to those used at home institution

0:75-0:90

- Large group discussion and question/answer with session leaders followed by conclusion

**Scientific Citations**


1. Fu et al. (1999) Is a Journal Club Effective for Teaching Critical Appraisal Skills. Academic Psychiatry 23(4): 205-209.
2. Rodriguez and Hawley-Molloy (2017). Revamping Journal Club for the Millenial Learner. Journal of Graduate Medical Education 9(3): 377-378.
3. Deenadayalan et al (2008). How To Run an Effective Journal Club: A Systematic Review. Journal of Evaluation in Clinical Practice 14: 898-911.
4. McLeod et al (2010). Twelve Tips for Conducting a Medical Education Journal Club. Medical Teacher 32(5): 368-370.
5. Hartzell et al (2009). Resident Run Journal Club: A Model Based on the Adult Learning Theory. Medical Teacher 31(4):e156-e161.
6. ACGME and ABPN. The Psychiatry Milestone Project. July 2015