WORKSHOPS SESSION 4

Title

Balancing Safety and Support: A Program Director's Guide to Fitness for Duty

Primary Category

Program Administration and Leadership

Presenters

Jeffrey Khan, MD, Baylor College of Medicine, Keri Stevenson, MD, University of Virginia Health System, Rocksheng Zhong, MD, University of Texas Medical Branch, Galveston, Dana Valdez, MD, University of Texas Austin Dell Medical School

Education objectives

1. Identify common concerns leading to fitness for duty (FFD) evaluations in trainees, and describe the structure, purpose, and limitations of FFD evaluations, including potential bias, systems-level contributors, and legal considerations.

2. Analyze what constitutes "fitness" for a trainee in a supervised training environment versus an independently practicing physician, and explain how supervision, competency milestones, and institutional obligations may shape this distinction.

3. Consider best practices for managing trainees with potential FFD concerns, including documentation strategies, remediation planning, risk mitigation, and collaboration with institutional stakeholders (GME, legal counsel, occupational health, and HR).

Abstract

Program directors are commonly faced with trainees who struggle with their performance. At times, this may be a clear knowledge or skills gap, while at other times, there may be concerns related to the trainee's physical or mental health affecting job performance. This realm often feels more perilous, as program directors often may have experience with coaching or remediation but little to no experience with navigating fitness for duty (FFD), disability, or accommodations in non-clinical settings. This process often generates stress and anguish, as programs may be concerned about whether FFD is the correct way to support the trainee as well as about the potential legal, training, and license ramifications of the process. The involvement of psychiatry faculty in performing these evaluations often raises concerns about confidentiality, bias, and conflicts of interest. Trainees may be concerned about the privacy of information shared throughout the FFD process and the future of their careers. There are additional questions about what it means to be "fit for duty" in a training environment, where clinical supervision is meant to mitigate patient safety risks and there is an expectation of progressive learning and skills development prior to independent practice. This workshop will explore FFD



evaluations from the perspectives of forensic psychiatrists who are also program directors and have insight into both sides of these issues. We will provide background information about FFD evaluations in medical training, the larger context of options for struggling trainees, and an overview of the evaluation process from the forensic perspective. We will also explore FFD processes at various institutions, considering pros and cons of the various approaches, in order to empower attendees to develop processes that balance trainee privacy, support, and rehabilitation along with GME, legal, and HR concerns. Participants will leave with action plans to take back to their home institutions for creating or refining their approach to working with struggling trainees.

Practice Gap

Program directors frequently encounter trainees whose performance deficits stem from underlying physical or mental health concerns rather than simple knowledge or skill deficits. While adept at remediation and coaching, leadership often lacks formal training in navigating fitness for duty (FFD) evaluations, disability accommodations, and their legal and licensure implications. This knowledge gap creates significant institutional stress and role strain. Leaders must balance patient safety, supervisory obligations, and human resources mandates against trainee privacy, career ramifications, and perceived conflicts of interest—especially when internal psychiatry faculty conduct the assessments. Furthermore, programs lack standardized, structured frameworks to distinguish educational developmental needs from medical impairment. Addressing this gap requires equipping program directors with forensic-informed best practices and institutional frameworks to navigate FFD referrals fairly, legally, and transparently while centering trainee support, confidentiality, and rehabilitation alongside patient safety.

Agenda

- Introduction with interactive polls (10 minutes)
- Didactic on FFD concerns and evaluations, including distinctions from disability accommodations and remediation procedures (10 minutes)
- Small group activity with FFD vignette (15 minutes)
- Large group discussion (10 minutes)
- Didactic on known processes and best practices for referring/managing unfit trainees (10 minutes)
- Small group discussion of FFD processes at participant institutions, challenges encountered, and ideas to address barriers to achieving improved procedures/policies (15 minutes)
- Large group discussion & Q&A (15 minutes)
- Evaluation completion (5 minutes)

Scientific Citations

1. ACGME (2026). ACGME Program Requirements for Graduate Medical Education in Psychiatry including FAQs. Available online: https://www.acgme.org/globalassets/pfassets/programrequirements/2026-prs/400_psychiatry_2026.pdf/.



2. Percival, CS, et al. (2026). Remediation in health professions education: a scoping review of reviews. Academic Medicine, 101(7), 858-868.

3. Roberts, R., Jackson, T., Gerdes, R., Deibert, D., Dennett, L., Lytvyak, E., & Straube, S. (2025). Health conditions that impact fitness-to-practice in physicians: a scoping review. International journal for quality in health care : journal of the International Society for Quality in Health Care, 37(4), mzaf108.

4. Williams, B. W., Welindt, D., Hafferty, F. W., Stumps, A., Flanders, P., & Williams, M. V. (2021). Adverse Childhood Experiences in Trainees and Physicians With Professionalism Lapses: Implications for Medical Education and Remediation. Academic medicine : journal of the Association of American Medical Colleges, 96(5), 736–743. https://doi.org/10.1097/ACM.0000000000003532

5. Meeks, LM, et al. (2022). The performance and trajectory of medical students with disabilities: results from a multisite, multicohort study. Academic Medicine, 97(3), 389-395.

WORKSHOPS SESSION 3

Title

“Conducting Patient Safety Event Investigations in Psychiatry Residency Programs”

Primary Category

Learning Environment

Presenters

Silvina Tonarelli, MD, Texas Tech University Health Sciences Center, El Paso, Hiren Umrania, MD, Cone Health Program, Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center, Arden D Dingle, MD, University of Nevada-Reno, Sonia Joutteaux, MD, Texas Tech University Health Sciences Center, El Paso

Education objectives

1. Participants will identify psychiatric clinical events and near misses appropriate for formal or structured patient-safety analysis.

2. Apply a systems-based framework to analyze contributing factors in a psychiatric patient-safety event.

3. Develop feasible systems-level interventions based on findings from a patient-safety investigation.

4. Describe strategies for engaging trainees in patient-safety investigations and communicating investigation findings and resulting actions.

5. Learn to develop and implement approaches to meeting the ACGME requirements for patient-safety education and activities

Abstract

Educational Objectives

1. Participants will identify psychiatric clinical events and near misses appropriate for formal or structured patient-safety analysis.

2. Apply a systems-based framework to analyze contributing factors in a psychiatric patient-safety event.

3. Develop feasible systems-level interventions based on findings from a patient-safety investigation.

4. Describe strategies for engaging trainees in patient-safety investigations and communicating investigation findings and resulting actions.



5. Learn to develop and implement approaches to meeting the ACGME requirements for patient-safety education and activities

Introduction

The Accreditation Council for Graduate Medical Education emphasizes resident and fellow engagement in patient safety and health care quality as an important component of graduate medical education (GME). Residents and fellows should participate in patient-safety activities, including the investigation of safety events, with an emphasis on identifying system vulnerabilities and opportunities for improvement rather than assigning individual blame.

Between 2012 and 2025, the ACGME Clinical Learning Environment Review Program conducted site visits to assess graduate medical education engagement in key cross-cutting areas, including patient safety and health care quality. Findings from these visits identified opportunities for GME programs to strengthen their partnerships with clinical learning environments and more meaningfully involve residents and fellows in patient-safety activities.

The 2025 CLER National Report identified substantial variability in what residents, fellows, and program directors considered a formal patient-safety investigation. Only 42% of residents and fellows reported awareness of the results of patient-safety investigations conducted at their clinical sites. Resident and fellow participation in formal investigations and communication regarding resulting actions remained important opportunities for improvement.

These challenges are particularly relevant to psychiatry. Patient-safety events may involve suicide or suicide attempts, elopement, violence or aggression, medication-related events, failures in observation or monitoring, communication breakdowns during transitions of care, restraint or seclusion, diagnostic delays, and coordination failures across behavioral health and medical systems. Such events frequently involve multiple interacting factors rather than a single identifiable error.

A safety event investigation is a structured process used in healthcare to understand what happened, identify contributing factors, determine opportunities for improvement, and prevent recurrence. The emphasis is on learning and system improvement rather than individual blame

Patient-safety investigation therefore requires moving beyond the question “Who made the mistake?” toward questions such as “What happened?”, “Why did it happen?”, “What system factors contributed?”, and “What can we change to reduce the likelihood of recurrence?”

Psychiatry residency program leaders may lack a practical framework for selecting appropriate cases, engaging residents in investigations, conducting systems-based analyses, and closing the feedback loop after an investigation. This workshop provides participants with practical tools that can be adapted to their own residency programs and also allowed collaboration with their institutions to improve patient care.

Practice Gap

Between 2012-2025, the ACGME Clinical Learning Environment Review Program conducted site visits to assess GME engagement in patient safety and health care quality. Findings from these visits identified opportunities for GME programs to strengthen their partnerships with clinical learning environments and more meaningfully involve residents and fellows in patient-safety activities.

The 2025 CLER National Report identified variability in what trainees and program directors considered a formal patient-safety investigation. Only 42% of trainees reported awareness of the results of patient-safety investigations conducted at their clinical sites. Trainees' participation in formal investigations and communication regarding resulting actions remained important opportunities for improvement. Psychiatry residency program leaders may lack a practical framework for selecting appropriate cases, engaging residents in investigations, conducting systems-based analyses, and closing the feedback loop after an investigation. This workshop provides participants with practical tools that can be adapted to their own residency programs.

Agenda

- Welcome, introductions, and workshop goals (5 min; 5 min total)
- Brief Didactics to Introduce key concepts (5 min; 10 min total)
- Small Breakout Groups 1 (25 min; 35 min total): What should we investigate? The leader will walk participants through real sceneries
- Debrief and introduction to systems analysis (5 min, 40 min total)
- Leg Stretch / Water Break (5 min; 45 min total)
- Small Breakout Groups 2 (25 min; 70 min total): How to act. The leader will guide participants through an exercise focused on conduct a patient-safety analysis
- From analysis to action. Groups will develop potential corrective actions (10 min; 80 min total)
- Take home messages. Questions, Feedback, and Survey Completion (10 min; 90 min total)

Scientific Citations

References

1. Accreditation Council for Graduate Medical Education. CLER National Report of Findings 2025. Chicago, IL: ACGME; 2025. https://www.acgme.org/globalassets/pdfs/cler/clernrof2025.pdf

2. Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements (Residency). Chicago, IL: ACGME. https://www.acgme.org/globalassets/pfassets/programrequirements/2025-reformatted-requirements/cprresidency_2025_reformatted.pdf

3. Le A, Haworth C, Nielsen C, Mathieson K, Sollars C. An Exploration of Psychiatry Residents' Morbidity and Mortality Education Through a Structured Curriculum to Teach Self-Reflection, Accountability, and



Systems-Based Learning. Acad Psychiatry. 2026 Jun;50(3):282-286. doi: 10.1007/s40596-026-02307-x. Epub 2026 Jan 28. PMID: 41606408; PMCID: PMC13219119.

4. Azyabi A, Karwowski W, Hancock P, Wan TTH, Elshennawy A. Assessing Patient Safety Culture in United States Hospitals. Int J Environ Res Public Health. 2022 Feb 18;19(4):2353. doi: 10.3390/ijerph19042353. PMID: 35206542; PMCID: PMC8872500.

5. Lee CL, Kim CH, Frank AA. Speak Up! A Resident-Led Initiative to Increase Safety Event Reporting in Psychiatry. Acad Psychiatry. 2023 Oct;47(5):531-534. doi: 10.1007/s40596-022-01716-y. Epub 2022 Oct 25. PMID: 36284063; PMCID: PMC9595093.

Title

Continuing the Work: Practical Strategies for Teaching Structural Advocacy in a Changing Political Climate

Primary Category

Teaching, Supervision, Pedagogy

Presenters

DeJuan White, MD, Emory University School of Medicine, David Beckmann, MD, MPH, Thomas Jefferson University Hospital, Rahel Bosson, MD, Mass General Brigham/Brigham and Women's Hospital/Harvard Medical School, Joseph Stoklosa, MD, Mass General Brigham/Brigham and Women's Hospital/Harvard Medical School

Education objectives

Through participating in this workshop, attendees will be able to:

1. Explain how structural perspectives on advocacy can deepen psychiatric education by linking social determinants of health, power structures, and patient care within core teaching activities.

2. Apply three practical "carve-in" strategies for teaching structural advocacy within existing curricular structures: journal clubs (PBLI1), case formulation (PC2), and interprofessional dialogue (ICS2).

3. Design facilitation strategies for teaching structural perspectives in ways that preserve psychological safety, educational rigor, and clinical relevance amid changing accreditation and political expectations.

Abstract

Over the past decade, educators have increasingly recognized the importance of expanding teaching on advocacy and bias mitigation from a behavioral and interpersonal lens to a more expansive institutional and structural perspective. This shift had become encoded in standards and guidance such as the Liaison Committee on Medical Education's Standard 7.6 on "Structural Competence, Cultural Competence, and Health Inequities," but many of these guidelines have been softened or removed in the setting of political pressure. This has left many educators wondering where their prior work now fits into the curriculum. While structuralism-specific standards represent one way to advocate for the importance of this content, this "carve-out" educational approach can leave the curriculum dependent on a few educational regulations that are vulnerable to political changes. It can also give the false impression that this content is severable, esoteric, or distinct from the rest of psychiatric care. By contrast, a "carve-in" approach integrates teaching on health equity, structuralism, and advocacy into existing curricular threads, with the dual advantages of greater sustainability and clearer application for learners.

The present workshop offers a framework for doing just that. It begins by providing an overview of the challenges programs are facing as they continue the important work of teaching structuralism, advocacy, and the social determinants of health, including structural racism. Attendees are invited into a space for self-reflection and peer exchange about what is working in their institutions. They are then walked through a three-pronged approach for integrating structural advocacy into milestone-based teaching: social equity journal clubs linked to practice-based learning and improvement, structural formulation exercises linked to patient care, and Open Dialogue-informed exercises linked to interpersonal and communication skills. Together, these strategies show how educators can preserve the human and relational dimensions of this work while embedding it in familiar educational structures. Throughout the workshop, educators are provided with example exercises and small-group reflection spaces where they can grapple with the content and the central question of the benefits and risks of teaching in a dedicated course or clinical rotation versus an integrated perspective.

In the end, attendees are asked to apply this content to their own programs and identify concrete, specific actions they can take to preserve this instruction and link it to other curricular threads. Active learning strategies are emphasized throughout, which highlight the human impact of bias and the importance of a "pedagogy of connection" to support advocacy teaching during these periods of rapid change. This workshop represents an adaptation of the well-received 2025 AADPRT workshop, "It Takes More Than Implicit Bias Training: Using Self-Formulation and Critical Pedagogy to Teach Structural and Spiritual Perspectives on Oppression," now revised for today's new political and regulatory realities. In doing so, it offers educators practical ways to sustain this work while preserving the relational and reflective dimensions of psychiatric education.

Practice Gap

Structural competency and advocacy have become increasingly important in psychiatric education, as reflected in a growing literature and prior AADPRT workshops. However, political pressure and changing accreditation expectations have reduced dedicated curricular space that previously supported teaching on structural competence, cultural humility, and health inequities. As a result, educators may struggle to sustain this work in practical, defensible ways. Although structural advocacy is often taught as a standalone "carve-out" topic in dedicated curricular threads or rotations, its core principles are highly relevant to routine educational activities and patient care. A "carve-in" approach allows educators to integrate structural perspectives into existing teaching moments, reinforcing clinical relevance and avoiding the impression that these topics are abstract, optional, or separable from psychiatric practice. Faculty therefore need practical strategies for embedding structural advocacy into core teaching activities amid changing educational and political expectations, including the removal of dedicated education standards related to these topics.



Agenda

- Introduction (15 Minutes)
  - 10 Minutes: Introductions, objective review, and Poll Everywhere needs assessment
  - 5 Minutes: Mini-didactic on recent accreditation changes and structural advocacy
- Carving Into PBLI: Social Equity Journal Clubs (20 Minutes)
  - 5 Minutes: Review of PBLI-1 milestone and journal clubs focused on the social determinants of health
  - 15 Minutes: Think-pair-share using brief case vignettes to humanize RCTs on housing, insurance, and employment, followed by large-group debrief
- Carving Into PC: Structural Formulation (20 Minutes)
  - 5 Minutes: Review of PC-2 milestone and structural formulation
  - 15 Minutes: Breakout groups exercise on integrating sociostructural perspectives into formulation teaching
- Carving Into ICS: Open Dialogue (20 Minutes)
  - 5 Minutes: Review of ICS-2 milestone and Open Dialogue
  - 15 Minutes: “As If” group exercise using a published medical student first-person narrative, followed by facilitated debrief
- Conclusion (15 Minutes)
  - 10 Minutes: Group Q&A and application, self-reflection worksheet
  - 5 Minutes: Complete evaluations

Scientific Citations

1. Calhoun A, Genao I, Martin A, Windish D. Moving beyond implicit bias in antiracist academic medicine initiatives. Academic Medicine. 2022;97(6):790-792.

2. de Carvalho Filho MA, Hafferty FW. Adopting a pedagogy of connection for medical education. Medical Education. 2025 Jan;59(1):37-45.

3. Dotson S, Ogbu-Nwobodo L, Shtasel D. The importance of an evidence-based structural approach in public and community psychiatry. Psychiatric Annals. 2021;51(6):266-271.

4. Fani N, White D, Marshall-Lee E, Hampton-Anderson J. Antiracist practice in psychiatry. Focus. 2022;20(3):270-276.

5. Greene JA, Glenn JE, Niehuus RM, Jones DS. A Eulogy for Structural Competence? New England Journal of Medicine. 2026 May 28;394(20):1974-6.

6. Hassan IF, Leeds R, Opara IN, Bui TD, Connor SE, Shah S, Iyer S. Structural competency and the medical learning environment—an overdue paradigm shift in medical education. Social Sciences. 2025 Jun 3;14(6):356.



7. Mgbako O, Gonzalez CM, Olagun-Samuel C, Torres C, Richardson S, Williams R, Greene RE, Ortiz R. A Just Appraisal: Co-creating a New Health Equity Framework with Learners through Journal Club to Evaluate the Literature: Mgbako et al. Journal of general internal medicine. 2025 Nov;40(15):3566-71.

8. Rock RM, Ferrel VK, Diaz C, González Corro L, Oki O, Ansah-Samuels E, Gao Q, Kim RS, Hassan I. Design of a Social Justice Curriculum to Expand Critical Consciousness Among Resident Trainees: Rock et al. Journal of General Internal Medicine. 2025 Jan;40(1):185-91.

9. Zhu DT, Lin JC, Woolf SH. Political Interference in US Medical Education: A Growing Threat: Zhu et al. Journal of General Internal Medicine. 2026 May;41(6):1642-6.

Title

Generations in Conversation: Giving and Receiving Feedback in Psychiatric Education

Primary Category

Learning Environment

Presenters

Keith Miller, BA, MD, Mayo School of Graduate Medical Education, Sumru Bilge-Johnson, MD, Northeast Ohio Medical University, Ailyn Diaz, MD, Penn State University, Hershey Medical Center, Carol Bernstein, MD, Albert Einstein College of Medicine/Montefiore Medical Center

Education objectives

1. Compare feedback preferences across generational cohorts and distinguish generational influences from individual learner preferences and established principles of effective feedback.

2. Analyze how generational differences may influence the giving and receiving of feedback in psychiatric training and apply practical strategies to navigate these differences using real-world scenarios.

3. Apply practical strategies for adapting feedback across generations while maintaining clarity, psychological safety, and educational effectiveness.

Abstract

Medical teams are generally multigenerational. Just as Boomers, Gen Xers, and Millennials were starting to figure each other out, Generation Z has joined the wards. Generational differences appear to be the product of social constructs that may lead to depiction of caricatures between generational cohorts. To date, it remains unclear whether, and to what extent, differences in values and expectations may influence teaching, learning, and feedback.

Research into feedback within medical education has expanded substantially over the past several years, but relatively few studies have examined preferred feedback across generations. Among surgeons, learners and faculty appear to prefer direct feedback delivered privately after completion of an activity, regardless of generation. Qualitative studies of medical students and physicians in internal medicine, pediatrics, and surgery have identified some differences in feedback practices and preferences across generational cohorts, while also demonstrating broad agreement regarding established principles of effective feedback.

To our knowledge, no studies have specifically examined the impact of generational differences on feedback within psychiatry training. Given broader discussion about generational differences in communication, workplace expectations, and attitudes toward mental health, this workshop will explore whether generational cohorts among psychiatry trainees and educators differ in how they prefer to give and receive feedback—and,

more importantly, how educators can bridge these differences while maintaining the principles of effective feedback.

Practice Gap

No studies have specifically examined the impact of generational differences on feedback within psychiatry training. Given broader discussion about generational differences in communication, workplace expectations, and attitudes toward mental health, this workshop will explore whether generational cohorts among psychiatry trainees and educators differ in how they prefer to give and receive feedback—and, more importantly, how educators can bridge these differences while maintaining the principles of effective feedback.

Agenda

- Brief didactic: What do we know—and what do we assume—about different generations?
- Large-group discussion: Which generation finds it the hardest to receive feedback?
- Brief didactic: Evidence regarding generational differences in feedback preferences and established principles of effective feedback
- Small group role-play: 2–3 cases involving feedback challenges across generations
- Small- and large-group discussion: Participants identify practical strategies for adapting feedback while maintaining clarity, psychological safety, and educational effectiveness
- Summary: Key takeaways on practical strategies for adapting feedback will be summarized at the end of the session

Scientific Citations

1. Bernstein CA & Bhugra D. 2011. Next generation of psychiatrists: What is needed in training? Asian J Psychiatr. 4:88-91.

2. Pascarella et al. 2023. Preferred Feedback Styles Among Different Groups in an Academic Medical Center. J Surg Res. 288:215-24.

3. Skorey et al. 2026. 'In Our Era…': Feedback Perceptions Across Generational Cohorts. WMJ. 125(1) 54-61.

4. Heuss, S. C., Zimmerli, L., & Schneeberger, A. R. (2022). How do physicians from two generations communicate with each other? Cogent Social Sciences, 8(1), 2095745.

5. National Academies of Sciences, Engineering, and Medicine. 2020. Are Generational Categories Meaningful Distinctions for Workforce Management. Washington, DC: The National Academies Press. https://doi.org/10.17226/25796.

Title

Human in the Loop: Supervising Trainee AI Use to Prevent Deskilling in Psychiatry

Primary Category

Faculty Development

Presenters

Vineeth John, MBA, MD, McGovern Medical School at UTHealth, Stephanie Ding, MD, McGovern Medical School at UTHealth, Seth Kalin, MD, McGovern Medical School at UTHealth, Caesa Nagpal, MD

Education objectives

1. Identify and define the cognitive risks of trainee AI overreliance in psychiatric education, specifically deskilling, never-skilling, mis-skilling, and algorithmic bias.

2. Apply the 5-step DEFT-AI framework (Discussion/Diagnosis, Evidence, Feedback, Teaching, AI engagement recommendation) during clinical supervision to promote critical reasoning.

3. Differentiate between Centaur (task delegation with human evaluation) and Cyborg (tight co-construction) AI interaction styles to establish appropriate task-based supervision boundaries.

4. Utilize heutagogical double-loop learning strategies to foster trainee agency, prompt verification, HIPAA compliance auditing, and self-reflection during AI-assisted psychiatric formulations.

Abstract

Artificial intelligence tools are rapidly entering psychiatric education and clinical practice. Residents increasingly encounter large language models, patient simulators, documentation tools, and predictive algorithms in activities ranging from information synthesis and documentation to differential diagnosis and risk prediction. Although these tools can reduce administrative burden and support data synthesis, uncritical reliance during clinical evaluation, suicide risk assessment, and psychotherapeutic formulation poses distinct educational risks. These risks are especially consequential in psychiatry, where diagnostic reasoning depends on nuanced observation, narrative formulation, and therapeutic alliance.

Cognitive off-loading without active human appraisal creates three related vulnerabilities: deskilling, or loss of developing clinical reasoning skills; never-skilling, or failure to acquire foundational competencies; and mis-skilling, or uncritical adoption of fabricated, inaccurate, or algorithmically biased outputs. Compounding these concerns, technology-fluent residents may adopt AI tools faster than their supervisors, creating an “inversion of expertise” that leaves faculty uncertain how to supervise AI-assisted reasoning while preserving trainee agency and the supervisory relationship.

This interactive workshop equips psychiatric educators with evidence-informed frameworks for human-in-the-loop supervision. Grounded in findings from the AADPRT AI in Psychiatric Education Task Force, the DEFT-AI clinical supervision framework, and adult-learning principles emphasizing trainee agency, the workshop positions AI as an educational copilot that can augment, but should not replace, human clinical judgment, empathy, and diagnostic rigor.

Participants engage in three sequential experiential modules. First, a large-group prompt-critique exercise introduces Centaur and Cyborg modes of human-AI interaction. Participants analyze AI use across clinical scenarios, from routine intake summarization to high-stakes suicide risk formulation, and determine the appropriate degree of delegation, collaboration, and human oversight. Second, small groups role-play a supervisory encounter using the five-step DEFT-AI framework: Diagnosis, Evidence, Feedback, Teaching, and Recommendation for AI Use. Participants debrief a resident who accepted an AI-generated differential without independent verification and practice probing clinical reasoning, identifying potential racial and demographic bias, and applying privacy and institutional-policy safeguards. Third, small groups complete a “Verify, Then Trust” double-loop reflection exercise, guiding trainees to evaluate AI outputs against primary sources while examining how their own assumptions and cognitive biases influenced their use of AI.

Participants leave with supervisory pocket cards, a prompt-critique rubric, and a debriefing script. These resources can be incorporated into existing supervision without additional institutional infrastructure. A post-workshop survey will assess perceived usefulness, confidence in supervising AI-assisted reasoning, and intended application within participants’ programs.

Practice Gap

Generative AI tools, including large language models, custom patient simulators, automated note generators, and triage algorithms, are rapidly permeating psychiatric training. Trainees routinely deploy these tools for clinical documentation, literature synthesis, differential diagnosis, and exam preparation. However, supervisory faculty frequently lack structured pedagogical frameworks and confidence to evaluate these interactions. Uncritical AI reliance threatens core psychiatric competencies, placing learners at risk for deskilling, never-skilling, and adopting demographic or racial biases present in training data. Current GME faculty development rarely addresses the "inversion of expertise," in which trainees possess greater technical familiarity than supervisors. Furthermore, educators lack practical strategies to enforce HIPAA compliance, evaluate AI tool validity, and prevent automated plagiarism without relying on unreliable AI-detection software. As highlighted by recent national task force findings (AADPRT AI in Psychiatric Education), programs urgently require evidence-based strategies to maintain human-in-the-loop clinical reasoning, protect mentor-trainee relationships, and foster self-determined trainee agency in psychiatric education.

Agenda

15 minutes – Interactive Didactic: Overview of AI overreliance in psychiatric training, deskilling risks, inversion of expertise, HIPAA/privacy considerations, and recent national task force recommendations.



15 minutes – Large-Group Prompt Critique: Evaluating resident AI prompts across psychiatric vignettes using the Centaur vs. Cyborg collaboration framework and Bloom's taxonomy-based rubric.

20 minutes – Small-Group Role-Play: Practicing supervisory debriefs using the 5-step DEFT-AI framework with a resident relying on a custom GPT for suicide risk formulation.

15 minutes – Small-Group Exercise: Executing heutagogical "Verify and Trust" double-loop debriefs to interrogate AI output for bias, fabricated content, and primary literature support.

10 minutes – Large-Group Debrief: Facilitated discussion addressing supervisory challenges, ACGME milestone assessment implications, recruitment ethics, and institutional policy considerations.

15 minutes – Wrap-Up & Takeaways: Distribution of DEFT-AI faculty pocket cards, prompt rubrics, and debriefing scripts; workshop evaluation and Q&A.

Scientific Citations

1. Abdulnour RE, Gin B, Boscardin CK. Educational Strategies for Clinical Supervision of Artificial Intelligence Use. N Engl J Med. 2025;393(8):786-797.

2. Torous J, Greenberg W. Large Language Models and Artificial Intelligence in Psychiatry Medical Education: Augmenting But Not Replacing Best Practices. Acad Psychiatry. 2025;49(1):22-24.

3. Cooper A, Rodman A. AI and Medical Education — A 21st-Century Pandora's Box. N Engl J Med. 2023;389(5):385-387.

4. Knopp MI, Warm EJ, Weber D, et al. AI-Enabled Medical Education: Threads of Change, Promising Futures, and Risky Realities Across Four Potential Future Worlds. JMIR Med Educ. 2023;9:e50373.

5. Safranek CW, Sidamon-Eristoff AE, Gilson A, Chartash D. The role of large language models in medical education: applications and implications. JMIR Med Educ. 2023;9:e50945.

6. Landes SJ, Matarazzo BB, Pitcock JA, et al. Impact of implementation facilitation on the REACH VET clinical program for veterans at risk for suicide. Psychiatr Serv. 2024.

7. Grzenda A, Kraguljac NV, McDonald WM, et al. Evaluating the machine learning literature: a primer and user's guide for psychiatrists. Am J Psychiatry. 2021;178(8):715-729.

8. Chen JX, Bowe S, Deng F. Residency Applications in the Era of Generative Artificial Intelligence. J Grad Med Educ. 2024;16(3):254-256.

Title

Leveraging your Executive Function Skills for a Harmonious Life

Primary Category

Faculty Development

Presenters

Mariam Rahmani, MD, Eastern Virginia Medical School, Julia Shekunov, MD, Mayo School of Graduate Medical Education, Anuja Mehta, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program

Education objectives

At the end of this workshop, participants will be able to:

1. Define the core executive function (EF) skills and describe how each can shape daily professional and personal life.

2. Identify their strongest and weakest EF skills through structured self-assessment.

3. Apply at least three concrete strategies (behavioral, environmental and technological) that use their stronger skills to compensate for their weaker skills.

4. Develop an individualized action plan connecting EF awareness to reduced cognitive load, lower stress, and greater wellbeing in their educator role and beyond.

Abstract

Executive function (EF) skills, including working memory, task initiation, planning and prioritizing, task shifting, organization, and stress tolerance are the cognitive foundation of daily adaptive functioning. In academic psychiatry, these skills are taxed constantly. Program directors, core faculty, coordinators, and residents all navigate overlapping clinical, teaching, and administrative demands, often while being asked to accomplish more within shrinking protected time. Mounting cognitive overload is a well-documented driver of stress and burnout across academic medicine. Despite this, EF is rarely a focus of resident and faculty development.

This workshop is designed for all AADPRT attendees, regardless of role or seniority, as everyone who manages competing demands can benefit from understanding the EF skills those demands draw on. The aim is to empower participants to work in greater harmony with their own cognitive strengths and to build practical scaffolding around their vulnerabilities. Participants will complete Dawson and Guare's Executive Skills Questionnaire to identify their strongest and weakest EF skills. In small groups, they will share their reactions and consider whether this information aligns with their past experiences, for example, easily completing tasks that require their strongest skills while feeling overwhelmed by those that rely on weaker ones. A focused

didactic will then review individual EF skills, how they differ from one another, and provide examples of tasks that require those skills.

Participants will receive a set of behavioral, environmental, and technological strategies and resources to compensate for EF vulnerabilities. They will practice at least three of the strategies during the workshop, begin an individualized action plan (for which a template will be provided), and report back on what felt useful and portable to their own setting.

The knowledge and strategies gained in this workshop will help program directors, coordinators, faculty, and residents leverage their strengths for optimal job performance, reduce stress, and increase overall sense of wellbeing. When educators spend less energy managing their own cognitive load, they retain more time and attention for the parts of the work that matter most: teaching, mentoring, and the connections with colleagues and trainees that outlast any single training year.

Practice Gap

Executive function (EF) refers to a complex set of processes necessary for managing the tasks of daily life, including response inhibition, working memory, task initiation, task shifting, task completion, organization, planning and prioritizing, and stress tolerance. Everyone in academic psychiatry–program directors, faculty, program coordinators, trainees, and fellows –relies on these skills to balance competing clinical, educational, and administrative demands, often while being asked to do more with less time and few resources. Rising cognitive load is a recognized contributor to stress and burnout across academic medicine. Yet, EF is rarely addressed during medical training or in faculty development, and most educators have never assessed their own EF profiles. Without this insight, individuals are left to manage escalating demands through effort alone. Knowing one's EF strengths and vulnerabilities allows educators to work more efficiently and with less stress, compensate for weaker areas, and protect the personal bandwidth that sustains wellbeing.

Agenda

- Welcome and brief introductions (5-min)
- Participants will complete a 36-item Executive Skills questionnaire to identify their strongest and weakest executive functioning (EF) skills (10-min; 15-min total)
- In small groups, participants will reflect on their results and whether these findings match their real-life experience across professional and personal tasks (10-min; 25-min total)
- Didactic on what each EF skill entails, with examples relevant to program directors, faculty, coordinators, and residents (15-min; 40-min total)
- A resource sheet of behavioral, environmental, and technological strategies will be shared to improve performance of each EF skill; participants will practice at least 3 targeting their weakest area and begin drafting an individualized action plan. (20-min; 60-min total)

- Participants will be invited to report on the strategies they tried and how they might use them in their daily life in the future (15-min; 75-min total)
- Q&A and session feedback (15-min; 90-min total)

Scientific Citations

1. De Golia SG, Houston LJ, Madaan V, Zalpuri I, Welton R, Bernstein C, Sengupta S, Chaudhry MA, Sudak DM. The Burden of Leadership: a Survey of Burnout Experiences Among Psychiatry Program Directors. Acad Psychiatry. 2023 Apr;47(2):174-180. doi: 10.1007/s40596-022-01675-4. Epub 2022 Jun 27. PMID: 35761064.

2. Young, K. L., Stephens, A. N., & McDonald, H. (2024). Executive function and drivers' ability to self-regulate behaviour when engaging with devices. Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues, 43(31), 25732–25742. https://doi.org/10.1007/s12144-024-06224-w

3. Niebaum JC, Zengilowski A, Katz B, Shah P, Munakata Y. Adaptive habits: understanding executive function and its development. Trends Cogn Sci. 2026 May;30(5):449-463. doi: 10.1016/j.tics.2025.10.016. Epub 2025 Dec 17. PMID: 41412918; PMCID: PMC13135620.

4. Perone S, Simmering VR, Buss AT. A Dynamical Reconceptualization of Executive-Function Development. Perspect Psychol Sci. 2021 Nov;16(6):1198-1208. doi: 10.1177/1745691620966792. Epub 2021 Feb 16. PMID: 33593126; PMCID: PMC8364921.

5. Sen A, Tai XY. Sleep Duration and Executive Function in Adults. Curr Neurol Neurosci Rep. 2023 Nov;23(11):801-813. doi: 10.1007/s11910-023-01309-8. Epub 2023 Nov 14. PMID: 37957525; PMCID: PMC10673787.

6. Yu A, McBeth L, Westcott C, Mueller S, Ozkaynak M, Holliman BD, Maw A, Nicklas J, Jones CD. Overloaded: How task switching, information synthesis, and poor relational trust make interhospital transfers challenging. J Hosp Med. 2025 Dec;20(12):1282-1289. doi: 10.1002/jhm.70084. Epub 2025 May 29. PMID: 40437890.

7. Manji RA, Manji JS, Arora RC. Are maladaptive brain changes the reason for burnout and medical error? J Thorac Cardiovasc Surg. 2021 Oct;162(4):1136-1140. doi: 10.1016/j.jtcvs.2020.06.146. Epub 2020 Jul 25. PMID: 32868063.

8. Mullikin DR, Flanagan RP, Merkebu J, Durning SJ, Soh M. Physiologic measurements of cognitive load in clinical reasoning. Diagnosis (Berl). 2024 Jan 29;11(2):125-131. doi: 10.1515/dx-2023-0143. PMID: 38282337.

Title

Never Too Old: Creative, Case-Based Methods for Teaching Trainees to Care for Older Adults with Substance Use Disorders

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Surita Rao, MBBS, University of Connecticut Health Center, Rehan Aziz, MD, Hackensack Meridian Health-Jersey Shore University Medical Center, Neha Jain, FAPA, MBBS, MD, University of Connecticut Health Center

Education objectives

At the end of this workshop, participants will be able to:

1. Describe the epidemiology of substance use disorders in older adults and the ageism, countertransference, and structural barriers that impede screening and treatment, and locate age-appropriate screening tools and treatment resources.

2. Apply interactive, case-based and experiential teaching methods, including role-play, simulated interviews, small-group cases, and facilitated debrief, to help trainees screen for, assess, and manage substance use disorders in older adults within a patient-centered framework.

3. Adapt these teaching strategies to their own programs and across clinical settings, including inpatient psychiatry, consultation-liaison psychiatry, and outpatient care, and exchange approaches and identify current gaps in how programs teach geriatric substance use.

Abstract

Substance use disorders (SUDs) among older adults are common, rising, and frequently missed, yet the evidence base and nearly all training models derive from younger populations. By 2022, one in 11 adults over 60 had a substance use disorder. Alcohol remains the dominant substance with cannabis use also increasing in the older population.

Late-life SUD risk is amplified by several factors. Older adults are prescribed more medications than any other age group, while slower metabolism and greater brain sensitivity mean smaller exposures produce larger effects. Low detection tools compound the problem, as the CAGE is less reliable in older adults because it does not probe binge drinking. Treatment reach is correspondingly poor. Among adults 65+ with SUD, roughly 24% received treatment for drug use disorders and 16.8% for alcohol use disorders. Ageist assumptions that late-life drinking is benign, entrenched, or not worth confronting sit beneath much of this underdetection, and

trainees receive little explicit guidance on assessing or treating SUDs in later life. Educators, in turn, lack ready-made methods for teaching the content.

This workshop addresses both gaps at once. Designed for program directors, associate program directors, and core faculty in psychiatry and related specialties, it uses audience response, small-group case work with older adults presenting in outpatient and consultation-liaison settings, simulated interviewing, and structured debrief. Methods are deliberately layered so participants experience them as learners before adapting them as teachers. Facilitated report-outs surface countertransference, both positive and negative, and rehearse non-judgmental, age-sensitive screening language, while cross-program discussion maps how geriatric SUD content is currently taught in programs and where it is absent.

Participants will leave with a concrete toolkit, including two ready-to-use cases with facilitator notes, sample non-ageist interview language, and a curated list of age-appropriate screening and treatment resources. Throughout, risk reduction is framed as patient-centered care, and ageism is treated as an explicit, teachable barrier rather than an unspoken one. By centering pedagogy alongside clinical content, the session helps faculty move geriatric substance use to a deliberately taught skill.

Practice Gap

Substance use among older adults is rising sharply, yet most of what trainees learn about assessment and treatment is derived from younger populations. Current past-month cannabis use among adults 65+ climbed from 4.8% to 7.0% between 2021 and 2023, making older adults the second fastest growing group of cannabis users. Alcohol- and opioid-related harms are increasing in this group, too. Older adults face heightened risk from physiologic changes, polypharmacy, and medical and psychiatric comorbidity. Ageism and countertransference, both positive and negative, lead clinicians to under-screen, while standard tools and both addiction and geriatric treatment settings are rarely age-adapted. Few residency programs teach this content systematically, and educators lack ready models. This workshop addresses that gap by equipping educators with creative, transferable methods for teaching geriatric substance use care.

Agenda

We open with a brief, interactive overview of geriatric SUD epidemiology and the attitudinal and structural barriers to care (10 minutes), using audience polling to surface participants' own assumptions.

Participants then work through a small-group case designed to combat ageism in the substance use interview, followed by a facilitated report-out that names positive and negative countertransference and rehearses non-judgmental, age-sensitive screening language (15 minutes).

A focused didactic (15 minutes) equips participants with teachable skills, such as adapting screening tools for older adults, recognizing cannabis- and prescription-related risks amid polypharmacy, applying a risk reducing and age-friendly framework, and, ways to help trainees find age-appropriate treatment resources.

A second, small-group case (20 minutes) extends the work across settings.

A report-out (10 minutes), we ask how represented programs currently teach geriatric SUDs, surfacing shared limitations, gaps, and promising practices across the field.

We close (5 minutes) with facilitated discussion and question- answer session.

Scientific Citations

1. Han BH, Yang KH, Cleland CM, Palamar JJ. Trends in past-month cannabis use among older adults. JAMA Intern Med. 2025;185(7):881-883. doi:10.1001/jamainternmed.2025.1156.

2. Jones KF, Beiting KJ, Ari M, et al. Age-friendly care for older adults with substance use disorder. Lancet Healthy Longev. 2023;4(10):e531-e532. doi:10.1016/S2666-7568(23)00174-5.

3. Joshi P, Duong KT, Trevisan LA, Wilkins KM. Evaluation and management of alcohol use disorder among older adults. Curr Geriatr Rep. 2021;10:82-90. doi:10.1007/s13670-021-00359-5.

4. Kuerbis A, et al. Expanding and adapting prevention and treatment options for older adults who engage in harmful use of substances. Addiction. 2024. doi:10.1111/add.16499.

5. Leton N. The nexus of aging and substance use: a scoping review of therapeutic modalities for geriatric substance use disorders. Cureus. 2024;16(9):e70313. doi:10.7759/cureus.70313.

6. Falise, A. M., Sharma, V., Hoeflich, C. C., Lopez-Quintero, C., & Striley, C. W. (2023). Screening the “invisible population” of older adult patients for prescription pain reliever non-medical use and use disorders. Substance use & misuse, 58(1), 153-159.

7. Lin, Jenny, et al. “Substance Use Disorders in the Geriatric Population: A Review and Synthesis of the Literature of a Growing Problem in a Growing Population.” Current Treatment Options in Psychiatry [Switzerland], vol. 10, no. 3, June 2023, pp. 313–32, https://doi.org/10.1007/s40501-023-00291-9.

8. Weber A, Lynch A, Miskle B, Arndt S, Acion L. Older adult substance use treatment firsttime admissions between 2008 and 2018. The American Journal of Geriatric Psychiatry. 2022;30(10):1055–63

9. Weber, Andrea, et al. “Older Adult Substance Use Treatment First-Time Admissions Between 2008 and 2018.” The American Journal of Geriatric Psychiatry [England], vol. 30, no. 10, October 2022, pp. 1055–63, https://doi.org/10.1016/j.jagp.2022.03.003.

10. Lin, J., Arnovitz, M., Kotbi, N., & Francois, D. (2023). Substance use disorders in the geriatric population: A review and synthesis of the literature of a growing problem in a growing population. Current Treatment Options in Psychiatry, 10, 1–20. https://doi.org/10.1007/s40501-023-00291-9



11. National Institute on Alcohol Abuse and Alcoholism. (n.d.). Aging and alcohol. National Institutes of Health. https://www.niaaa.nih.gov/alcohols-effects-health/aging-and-alcohol . National Institute on Drug Abuse. (2020, July). Substance use in older adults DrugFacts. National Institutes of Health. https://nida.nih.gov/publications/drugfacts/substance-use-in-older-adults-drugfacts

Title

Perfecting the Harmony: Creating a Cohesive Curriculum

Primary Category

Curriculum

Presenters

Dale Peeples, MD, Medical College of Georgia at Augusta University, Remy Sirken, MD, Quinnipiac University Frank H. Netter MD School of Medicine Program, Khyati Kothari, MD, University of Tennessee, Memphis, Simar Kaur, MD, Nassau University Medical Center Program, Arya Soman, MD, Wellspan Health Program

Education objectives

1. Understand theories of curriculum development, organizational approaches, and essential elements of a general psychiatry curriculum.
2. Identify topics that could be used for an AADPRT model curriculum.
3. Understand the process of development and submission of a model curriculum to AADPRT's VTO.
4. Locate, evaluate, and adapt existing curriculum resources in AADPRT's VTO into a residency program.

Abstract

The past decade witnessed remarkable interest in psychiatry as a specialty, resulting in almost a doubling of both positions and programs. With this rapid growth come challenges, new programs are regularly established and must map out curriculum for their trainees. Additionally, ACGME estimates 20% of psychiatry program directors are new to their position, which is typically held for about 6 years. Taking this growth and change together, there is a need to support programs establishing and updating their educational material.

This workshop will discuss approaches to building out curriculum and identify resources available to program leaders as they build or revise their own curriculum. We will begin with an overview of models of curriculum development in medical education, and apply that to needs assessment, development, and implementation of a new curriculum. Members will discuss their experiences in the process of curriculum development, and how they navigated challenges. The audience will then have an opportunity to break into small groups and discuss curriculum needs at their institution, and steps they can take toward curriculum design and implementation.

After considering psychiatry curriculum at the macro level, we will then discuss creating a topic specific curriculum. Consideration will be paid to the audience, timing, length, and modality with an emphasis toward approaches facilitating adult learning. The audience will engage in a similar exercise by identifying a topic they would want to develop into a new curriculum. They will then work through an implementation strategy to develop the idea into a course for trainees.



Finally, identifying and harnessing available existing resources for the curriculum will be discussed. This will provide public options like NNCI, and MedEdPortal, as well as AADPRT specific resources such as the VTO. We will discuss VTO navigation, and utilization of AADPRT model curriculum. We will also discuss the process of submitting a model curriculum to AADPRT to disseminate one's own work and develop peer reviewed scholarly products.

The workshop will close with open discussion from meeting participants.

Practice Gap

The last decade saw remarkable growth in the number of training positions and the number of training programs, increasing from 211 programs in 2015 to 404 programs in 2025. Consequently, the need to consider how to design a curriculum has never been greater. New programs, and new program directors who are revising existing curriculum need support and guidance in curriculum design and access to resources that can support the educational needs of their training program. This workshop will address this gap through discussion and exercising in the process of curriculum design at both a global and topic-focused level. It will also review existing AADPRT resources for curriculum, including the Virtual Training Office (VTO), allowing participants to gain familiarity with navigation and content, and also encourage VTO submissions.

Agenda

Introduction (5 min): Disclosures, learning objectives, and session format.

Didactic Discussion (10 min): Presenters share experiences developing and revising curricula, including challenges and lessons learned.

Group Discussion (14 min): Assess curriculum needs, seminar timing and structure, and program strengths and challenges.

Group Report (4 min)

Didactic Discussion (10 min): Selecting curriculum topics, developing teaching plans, assessing outcomes, and revising subsequent teaching cycles.

Group Discussion (14 min): Identify potential model curriculum topics and consider teaching format, audience, timing in training, and methods for evaluating impact.

Group Report (4 min)

Didactic Discussion (10 min): Review open curriculum resources and implementation strategies, including AADPRT's VTO and model curriculum standards and submission process.

Closing Remarks (4 min): Key takeaways and survey reminder.

Closing Discussion (15 min): General audience discussion and small-group sharing of final observations.



Scientific Citations

1. Accreditation Council for Graduate Medical Education. (2025). Data resource book: Academic year 2024–2025. Accreditation Council for Graduate Medical Education.

2. Dotson, S., Robbins-Welty, G.A., Schwartz, A.C., 2026. The Great Expansion: Are We on the Verge of a Psychiatry Program Bubble?. Academic Psychiatry.. https://doi.org/10.1007/s40596-026-02416-7

3. Mehta, A.S., Hobbs, J.A., Buboltz, M.B., 2024. Call for a National Didactic Curriculum in Psychiatry Training Programs. Academic Psychiatry 48, 522–523.. https://doi.org/10.1007/s40596-024-01950-6

4. Tessier, R., Schreiber, J., Dekosky, A., 2025. Training Psychiatrist-Advocates: Developing a Resident-Led Healthcare Advocacy Curriculum for Psychiatry Residents. Academic Psychiatry 49, 605–606.. https://doi.org/10.1007/s40596-025-02182-y

5. Thomas, Patricia. Curriculum Development for Medical Education, Johns Hopkins University Press, 2022. ProQuest Ebook Central, https://ebookcentral.proquest.com/lib/augustastate/detail.action?docID=29139124.



Title

Psychiatry Subspecialty EPA and Competencies Task Force Updates

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Emily Bray, DO, Jefferson Health Medical Education/Jefferson Einstein Philadelphia Hospital Program, Julie Sadhu, MD, McGaw Medical Center, Northwestern University, William Smith, MD, University of California, San Francisco, srinivas Muvvala, MD, MPH, Andrew Siegel, MA, MD, MS, Perelman School of Medicine University of Pennsylvania

Education objectives

1. Summarize the work the Subspecialty EPA and Competencies Task Force has done, their processes and recommendations for future work.

2. Provide feedback regarding the work of the subspecialty sub- task forces to date and review future directions.

Abstract

In 2025 the AADPRT SC commissioned the CBME Implementation Taskforce to implement recommendations from the original CBME Task Force. Following the presentation of the CBME Implementation Task Force Report at the 2026 Annual meeting, the AADPRT SC President, Dr. Rashi Agarwal commissioned Julie Sadhu, MD and Emily Bray, DO to lead the AADPRT Psychiatry Subspecialty EPA and Competencies Task Force to develop EPAs within the psychiatric subspecialties for end of fellowship training and subspecialty competencies for end of psychiatry residency training. The task force members will provide the membership updates on the work the task force has done this past year and will provide recommendations for the next steps.

Practice Gap

Competency-Based Medical Education (CBME) is now the recommended framework for medical education evolving through the ACGME's adoption of core competencies, milestones, and Entrustable Professional Activities. Despite these advances, widespread adoption and implementation of competency-based medical education has lagged in individual programs. Barriers to implementation include lack of resources, validated assessment tools, faculty development, cost and time, as well as uniformity among program directors and faculty in understanding CBME. Although EPAs exist for psychiatry, none have been developed for the psychiatric subspecialties (child and adolescent psychiatry, addictions, geriatrics, consultation-liaison), which

impedes adoption and implementation of EPAs in these fellowship programs. In addition, competencies for the subspecialties for end of residency training have not been identified or agreed upon.

Agenda

90 minutes total:

10 minutes Introduction/ Overview of process and history of the task force work

40 minutes: EPA Sub Task Forces in Child and Adolescent Psychiatry, Geriatric Psychiatry, Addiction Psychiatry and Consultation-Liaison Psychiatry

30 minutes: Small group discussion

10 minutes: Q & A

Scientific Citations

1. Young JQ, Holmboe ES, Frank JR. Competency-Based Assessment in Psychiatric Education: A Systems Approach. Psychiatr Clin North Am. 2021 Jun;44(2):217-235. doi: 10.1016/j.psc.2020.12.005. Epub 2021 Apr 29. PMID: 34049645.

2. AADPRT CBME Task Force Report. Hung, Hobbs, et al. 2025.

3. AADPRT CBME Implementation Task Force Report. Sadhu, Bray, et al. 2026

Title

Safe Enough to Speak, Challenged Enough to Learn: Building Psychological Safety for Healthy Learning Cultures in Psychiatry Residency

Primary Category

Program Administration and Leadership

Presenters

Vitaliy Voytenko, PsyD, Western Michigan University School of Medicine, Lisa Leininger, PsyD, Western Michigan University School of Medicine, Rebecca White, MD, Western Michigan University School of Medicine, Julia Raffo, DO, Western Michigan University School of Medicine, Sindhu Idicula, MD, Baylor College of Medicine

Education objectives

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

1. Define psychological safety and distinguish it from comfort, permissiveness, and avoidance of accountability.

2. Discuss individual, relational, and systemic factors that undermine psychological safety and healthy learning environments.

3. Describe strategies for addressing distrust and disengagement and rebuilding a culture of psychological safety.

4. Apply practical strategies for fostering psychological safety in supervision, feedback, and competency-based assessment while maintaining appropriate challenge and accountability.

Abstract

What does it take for a resident to say, “I don’t know,” “I made a mistake,” “I’m worried about this patient,” or “I see this differently”—especially when the person listening is also evaluating them? Psychological safety, the shared belief that it is safe to take interpersonal risks within a group, supports learning, speaking up, feedback, teamwork, and patient safety. In psychiatry, where training depends heavily on supervision, self-reflection, tolerance of uncertainty, and development of psychotherapy competencies, psychological safety is particularly important.

Yet psychological safety can be difficult to cultivate in residency. Hierarchy, evaluation, differences in identity and power, fear of appearing incompetent, and prior experiences of criticism or exclusion may lead residents to protect themselves by remaining silent. At the same time, psychological safety is often misunderstood as making training comfortable or shielding learners from difficult feedback. Competency-based education

requires both safety and challenge: enough safety to acknowledge uncertainty and take learning risks, and enough challenge to recognize blind spots, strengthen clinical skills, and progress toward competence.

This workshop uses psychological safety, affective events theory, and social exchange theory to examine how negative experiences and perceived breaches of psychological expectations can erode trust, increase anxiety and disengagement, and shift learners from learning toward self-protection. When concerns remain unspoken, they may surface indirectly through withdrawal, anonymous feedback, or declining engagement, leaving programs struggling to understand and address the underlying problem.

Through modeled scenarios, facilitated discussion, and small-group case practice, participants will examine moments when psychological safety is tested in psychiatry residency: a resident discloses an error, struggles in psychotherapy supervision, disagrees with a faculty member, receives difficult feedback, or raises a concern about the learning environment. Participants will identify the words, behaviors, and supervisory practices that open or close opportunities for learning and practice strategies for responding with curiosity, acknowledging fallibility, inviting questions and dissent, responding productively to mistakes, structuring difficult feedback, and separating developmental challenge from interpersonal threat.

The workshop also considers how psychological safety extends beyond individual supervisory relationships to program norms, faculty development, assessment practices, and mechanisms for responding to resident concerns. Participants will leave with practical language, supervisory strategies, and program-level approaches for creating a culture in which residents can speak openly, seek help, receive candid feedback, and take the interpersonal risks necessary to become excellent psychiatrists.

Practice Gap

Effective psychiatry residency training requires interpersonal risk-taking. Can residents admit uncertainty, disclose mistakes, question a formulation, or say that feedback was confusing? Can they discuss clinical missteps, countertransference, or insecurity in supervision without fearing that these disclosures signal incompetence?

Psychological safety is essential to a healthy learning culture, enabling trainees to speak up, exchange candid feedback, learn from errors, and protect patient safety. Yet supportive faculty and wellness initiatives alone cannot create it. Hierarchy, evaluation, identity and power, prior negative experiences, and leadership practices influence whether trainees take interpersonal risks. Faculty may perceive tension between fostering support and providing candid feedback, assessing competence, and maintaining high standards.

This interactive workshop bridges the gap between valuing psychological safety and knowing how to build it. Through audience reflection, case vignettes, small-group discussion, and skills practice, participants will develop practical strategies for strengthening psychological safety in supervision, assessment, feedback, and overall program culture.



Agenda

- 0:00 Introduction
  - "What learning culture do we want to create in a psychiatry residency?" Reflection on participants' program cultures and goals.
- 0:05 Why Psychological Safety Matters in Psychiatric Training
  - Overview of evidence.
- 0:10 What Shapes a Healthy Learning Culture?
  - Introduction to affective events theory and social exchange theory.
- 0:15 Residents and Faculty: Competing Values in a Culture of Wellness
  - Large-group exploration of competing priorities focusing on common areas of tension in learning
- 0:30 Modeling Psychological Safety
  - Facilitators demonstrate contrasting responses to resident error, uncertainty, disagreement, or feedback.
- 0:40 Debrief
  - Large-group identification of faculty behaviors that affect learning environment.
- 0:45 Small-Group Practice
  - Participants apply didactic information to resident scenarios to identify threats to safety and practice alternative responses
- 1:00 Large-Group Reflection
  - Share strategies and consider how individual behaviors can be translated into program-level practices.
- 1:10 Action Planning
  - Each participant identifies one change to implement in their program.
- 1:15 Questions and Evaluation

Scientific Citations

1. Alden B, Slavin S, Cheong J, Ward J. Past, present, and future of GME well-being: The ACGME Symposium on Physician Well-Being and Affinity Work Groups. Journal of Graduate Medical Education. 2026;18(1):89-91. doi:10.4300/JGME-D-25-01180.1

2. Carrillo I, Skoumalová I, Bruus I, Klemm V, et al. Psychological safety competency training during the clinical internship from the perspective of health care trainee mentors in 11 pan-European countries: Mixed methods observational study. JMIR Medical Education. 2024;10:e64125. doi:10.2196/64125

3. Edmondson AC, Bransby DP. Psychological safety comes of age: Observed themes in an established literature. Annual Review of Organizational Psychology and Organizational Behavior. 2023;10:55-78. doi:10.1146/annurev-orgpsych-120920-055217



4. Hayward NE, McLearn-Montz AJ, Amano K, et al. Speak Up! Simulation Workshop: Teaching graduate medical trainees to recognize and respond to microaggressions in the clinical setting. MedEdPORTAL. 2025;21:11545. doi:10.15766/mep_2374-8265.11545

5. Lerch SP, Huwendiek S, Nendaz M, Klöppel S, Pinilla S. Perceptions of ad hoc entrustment, the need for supervision, and coping strategies in clinical residents: A qualitative study. Academic Medicine. 2025;100(7):844-851. doi:10.1097/ACM.0000000000006019

6. Pang J, Navejar N, Sánchez JP. Mistreatment in residency: Intervening with the REWIND communication tool. MedEdPORTAL. 2022;18:11245. doi:10.15766/mep_2374-8265.11245

Title

Subspecialty Education for The Future: Utilizing Shared Resources, Enhancing The Fourth Year While Increasing Fellowship Recruitment

Primary Category

Curriculum

Presenters

Rebecca Lundquist, MD, TriHealth GME (Non-accredited), Manassa Hany, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Flannery Merideth, BS, MD, UMass Chan -- Baystate Medical Center, Kimberly Hu, MD, MPH, Dartmouth-Hitchcock Medical Center, Erica Garcia-Pittman, MD, University of Texas Austin Dell Medical School

Education objectives

1. At the conclusion of this session, the participant will be able to describe the current and projected psychiatry subspecialist workforce shortage in the U.S.

2. At the conclusion of this session, the participant will be able to identify accessible subspecialty training resources, mentorship networks, and consultation models.

3. At the conclusion of this session, the participant will be able to describe existing solutions and generate novel proposed solutions to the subspecialist shortage.

4. At the conclusion of this session, The participant will be able to outline a locally adaptable plan for redesigning residency, fellowship, or continuing professional development structures to address subspecialty workforce gaps.

Abstract

Methods: This interactive workshop will begin with a brief overview of current psychiatry workforce trends, including the continued growth of general psychiatry training positions alongside projected national shortages in both general and subspecialty psychiatry. Particular attention will be given to perinatal, child and adolescent, geriatric, addiction, and consultation-liaison psychiatry, where limited fellowship participation and uneven geographic distribution contribute to widening access gaps. Facilitators representing multiple subspecialties will frame the discussion around how these shortages affect patient care, resident education, fellowship recruitment, and the scope of practice expected of graduating general psychiatrists. Data from HRSA projections and ACGME program statistics will be used to illustrate the scope of the problem, highlighting the mismatch between growing patient demand and the current pipeline of subspecialty trainees.



Results: Participants will examine existing strategies to address the subspecialty workforce gap, including earlier exposure to subspecialty career pathways, mentorship and consultation networks, shared curricular resources, post-residency training models, and redesign of the PGY-4 year to allow both breadth and depth of experience. Through pair-share discussion and small-group work, participants will identify how subspecialty shortages manifest in their own clinical and educational settings and will develop practical interventions that could be adapted within residency, fellowship, or continuing professional development structures. Each small group will focus on a specific domain of intervention, such as restructuring the fourth year of residency, creating regional fellowship consortia, or developing consultation and mentorship models that extend subspecialty expertise to generalist practitioners. Groups will be asked to outline their proposed intervention, articulate why they believe it could succeed, and identify potential barriers to implementation. Groups will share their proposals with the full audience for further discussion and refinement

Conclusions: Responding to the psychiatry subspecialist shortage requires coordinated action across graduate medical education, fellowship recruitment, and support for practicing generalists. By bringing together generalists and subspecialists, this workshop will move beyond describing the workforce problem toward generating actionable, locally adaptable solutions that participants can begin to implement in their programs. Participants will leave with concrete ideas for strengthening subspecialty exposure, expanding shared educational resources, supporting generalist psychiatrists in broader scopes of care, and reimagining the fourth year of residency as a key opportunity to prepare the future psychiatric workforce. The workshop will also foster new cross-institutional connections among educators who share a commitment to addressing these workforce challenges, laying the groundwork for ongoing collaboration and resource sharing beyond the session itself.

Practice Gap

As we work to address the shortage of psychiatrists in the US, we must also turn our attention to the subspecialist workforce, where shortages are even more dire than in the generalist workforce, especially in perinatal, child and adolescent, geriatric, addiction, and consultation-liaison psychiatry. These shortages require attention in multiple spheres, including increasing the number of fellows in these subspecialty programs and examining needed changes to the training of generalists, who will need to be prepared to practice in areas traditionally managed by subspecialists. Few forums exist for generalist and subspecialty educators to collaboratively design solutions. This workshop will seek to generate ideas for increasing interest in subspecialties among psychiatry residents as well as to support the training of generalist psychiatrists as they expand their clinical toolkits. Participants will leave with actionable strategies adaptable to their own institutional and regional contexts.



Agenda

- Didactic – Overview of the subspecialist shortage and what this means for our patients – 15 min
- Pair-share – Prompt: "In what ways do you notice the subspecialist shortage in your practice and/or program?" - share with group – 2-3 people called on – 15 min
- Didactic – Examples of solutions from each subspecialty represented, including– strategies to encourage fellowship training, nationally available resources for each subspecialty, post-residency trainings separate from fellowship, redesigning the 4th year of residency, offering supports and mentorship to practicing psychiatrists, etc. – 20 min
- Small group – Pick something to redesign – residency, fellowship, post-residency training — sketch it out. What would it look like, why do you think it might succeed? What are the barriers to implementation? Share with group – 2-3 people called on – 25 min
- Concluding remarks – key takeaways, next steps - 15 min

Scientific Citations

1. Accreditation Council for Graduate Medical Education. (2025). ACGME Data Resource Book: Academic Year 2024–2025. ACGME Chicago, IL.

2. Aggarwal, R., Balon, R., Beresin, E. V., Coverdale, J., Morreale, M. K., Guerrero, A. P. S., Louie, A. K., & Brenner, A. M. (2022). Addressing Psychiatry Workforce Needs: Where Are We Now? Academic Psychiatry, 46(4), 407–409. https://doi.org/10.1007/s40596-022-01690-5 .

3. Aggarwal R, Brenner AM, Balon R, Guerrero APS, Beresin EV, Coverdale J, Morreale MK, Louie AK. Is It Time to Rethink Psychiatry Residency Training? Part II: Training All Psychiatry Residents to be General Psychiatrists. Acad Psychiatry. 2023 Aug;47(4):335-339. doi: 10.1007/s40596-023-01841-2. PMID: 37589887.

4. Beach, S. R., Ernst, C. L., Lavakumar, M., Greenstein, S. P., Fipps, D. C., Soeprono, T. M., Heinrich, T. W., & Schwartz, A. C. (2023). A 10-Year Follow-up Survey of Psychiatry Resident Education in Consultation-Liaison Psychiatry. Journal of the Academy of Consultation-Liaison Psychiatry, 64(3), 199–208. https://doi.org/10.1016/j.jaclp.2022.12.003

5. Becker, M. A., Bradley, M. V., Montalvo, C., Nash, S. S., Shah, S. B., Tobin, M., & Desan, P. H. (2021). Factors Affecting Psychiatry Resident Decision to Pursue Consultation-Liaison Psychiatry or Other Subspecialty Fellowship Training. Journal of the Academy of Consultation-Liaison Psychiatry, 62(1), 38–45. https://doi.org/10.1016/j.psym.2020.05.009

6. Health Resources and Services Administration. (2025). Health Workforce Projections: Behavioral health occupations, 2023–2038. U.S. Department of Health and Human Services, National Center for Health Workforce Analysis



7. McBain, R. K., Kofner, A., Stein, B. D., & Cantone, R. E. (2022). Growth and distribution of the child and adolescent psychiatry workforce, 2010–2020. Pediatrics, 150(6), e2022057788. https://doi.org/10.1542/peds.2022-057788

8. National Association of State Alcohol and Drug Abuse Directors. (2025). The Substance Use Workforce Crisis: Drivers, Challenges, and Promising Strategies. NASADAD Issue Brief

9. Pheister, M., Cowley, D., Sanders, W., Keeble, T., Lu, F., Pershern, L., Wolf, K., Walaszek, A., & Aggarwal, R. (2021). Growing the Psychiatry Workforce Through Expansion or Creation of Residencies and Fellowships: the Results of a Survey by the AADPRT Workforce Task Force. Academic Psychiatry, 46(4), 421–427. https://doi.org/10.1007/s40596-021-01509-9

Title

Using the Annual ACGME Report to Your (Web) AD-vantage

Primary Category

Program Administration and Leadership

Presenters

Megan Zappitelli, MD, Prisma Health/University of South Carolina School of Medicine - Greenville, Robert Simon, MD, University of Kentucky, Rachele Yadon, MD, University of Kentucky, Raphaela Fontana, DO, Prisma Health/University of South Carolina School of Medicine - Greenville, Norah Silver, MD, Prisma Health/University of South Carolina School of Medicine - Greenville

Education objectives

At the conclusion of this workshop, participants will be able to:

1. Understand the process and content of the ACGME annual reporting (WebADS) process

2. Identify strategies and tools for leveraging the WebADS process to highlight the strengths of and to respond to challenges within their program

3. Generate an action plan to decrease the burden of the ACGME annual reporting (WebADS) process

Abstract

The Accreditation Council for Graduate Medical Education (ACGME) requests annual reports through the Accreditation Data System [ADS], informally referred to as “WebADS.” The TD is responsible for the submission of these reports each fall, and this process can be daunting, particularly for new TDs, or for programs who have gone through many recent changes. There are many topics included in the annual reports such as an accounting of trainee and faculty scholarly activity, clinical schedule information (i.e. block diagrams), program overview information including program major changes, and responses to citations. The information presented in WebADS is an opportunity for training directors to highlight the strengths of their program and to directly address areas of concern that are seen in the ACGME survey results. Preparation of the content in WebADS can be time-consuming, daunting, and is a high-stakes responsibility held by the TD.

The presenters are current TDs, and the content is additionally informed by a designated institutional officer (DIO) who, although unable to attend, will provide expertise. This workshop was presented in 2025 and 2026, and due to consistent positive feedback which included requests to repeat this workshop annually, the presenters of this workshop will update this workshop, building on previous year’s learnings.

The presenters will first provide an overview of the ACGME Accreditation timeline and then will break down the elements of the WebADS annual report to provide tips and strategies for using the WebADS process in an



effective way throughout the year. An overview of the review committee meeting process, site visits and the accreditation process will be provided. The presentation will review the limited available literature associated with the ACGME survey and then expand on creating tools including Annual Performance Evaluations (APEs), structured Program Evaluation Committee (PEC) meetings, and internal surveys that can be used to provide data and content to prepare for the WebADS yearly report. Presenters will review cases where the WebADS process has been as a tool to assist in responding to an unfavorable ACGME survey into receiving ACGME continued accreditation with commendation, all within one academic year. This year, we will include more specific examples of how a special review, led by the GME office, has helped with ACGME reporting.

Participants will divide into breakout groups to share strategies that they have incorporated to help them with their own WebADS reports as well as ways that they have used the annual reporting system to help support their programs. In a subsequent breakout, participants will work together to create an action plan around which strategies they would like to incorporate for managing and organizing their future WebADS reports in their home institutions. Participants will complete a year-long timeline to organize ACGME-related tasks and ways to use the presented tools throughout the year to help with the WebADS process. Finally, participants will share strategies with the larger group and will leave the session empowered to leverage the annual WebADS reporting system to their program's AD-vantage.

Practice Gap

Psychiatric training directors (TDs) are faced with the daunting task of submitting an annual report to the Accreditation Council for Graduate Medical Education (ACGME) through the Accreditation Data System [ADS], informally referred to as "WebADS." This report includes a program overview, faculty/trainee scholarly activity, major program changes, and responses to previous citations or areas of concern. This report, along with the yearly ACGME Program Survey, is one of the main tools that the ACGME uses to determine program status and to identify areas of program non-compliance. Despite the importance of this report, many TDs lack strategies for completing this annual report outside of what is available in the ACGME online resources. There is currently no literature that outlines strategies for WebADS completion, and our workshop hopes to bridge this gap to empower TDs to use WebADS to best reflect their training program.

Agenda

0-5 minutes – Introduction and Learning Objectives

5-10 minutes – Presentation of the ACGME annual report timeline and WebADS process and limited literature

10-15 minutes – Detailed breakdown of each WebADS category

15-30 minutes – Presentation of case examples, success stories, special review case examples, and proposed strategies that can be used to generate content and data in preparation for the annual WebADS report



30-40 – Breakout groups: participants will identify and discuss strategies that they have to manage WebADS reports as well as ways that they have used the annual reporting system to help support their programs

40-65 – Breakout groups: participants will work together to create an action plan and timeline around which strategies that they would like to incorporate for managing and organizing their future WebADS reports in their home institutions

65-75 – Breakout groups share back to the large group.

75-90 – Question, answer, and wrap-up session

Scientific Citations

1. Artino AR Jr, Malloy K, Miller RS, Kirk LM, Brigham TP. A Redesign of the ACGME Resident/Fellow Survey Through Expert Reviews and Cognitive Interviews. J Grad Med Educ. 2023 Feb;15(1):67-73. doi: 10.4300/JGME-D-22-00437.1. PMID: 36817519; PMCID: PMC9934830.

2. Caniano DA, Martinez SA, Nace C, Hogan SO. Reasons for Data-Prompted Site Visits: Field Staff Findings and Review Committee Decisions. J Grad Med Educ. 2021 Jun;13(3):447-454. doi: 10.4300/JGME-D-21-00435.1. Epub 2021 Jun 14. PMID: 34178287; PMCID: PMC8207924.

3. Dougherty PJ. CORR® Curriculum-Orthopaedic Education: How to Handle a Bad ACGME Survey. Clin Orthop Relat Res. 2024 Mar 1;482(3):434-435. doi: 10.1097/CORR.0000000000002988. Epub 2024 Jan 24. PMID: 38265258; PMCID: PMC10871740.

4. Fahy BN, Todd SR, Paukert JL, Johnson ML, Bass BL. How accurate is the Accreditation Council for Graduate Medical Education (ACGME) Resident survey? Comparison between ACGME and in-house GME survey. J Surg Educ. 2010 Nov-Dec;67(6):387-92. doi: 10.1016/j.jsurg.2010.06.003. Epub 2010 Nov 5. PMID: 21156296.

5. Hoffert MM, Pfeiffer L, Hepke M, Brink W, Newman J, Passalacqua KD, Baker-Genaw K. Gathering Trainee Feedback to Improve Programs With Low Annual ACGME Survey Content Area Compliance: A Pilot Study. Acad Med. 2024 Apr 1;99(4):419-423. doi: 10.1097/ACM.0000000000005464. Epub 2023 Sep 25. PMID: 37748087.

6. Knox J, Fortenberry KT, Qeadan F, Tingey B, Holman A, Stoesser K, Van Hala S. Implementing an Anonymous Closed-Loop Feedback Process and Associations With ACGME Annual Survey Scores in a Family Medicine Residency. Fam Med. 2021 Nov;53(10):878-881. doi: 10.22454/FamMed.2021.714773. PMID: 34780655.

7. Rose SH, Long TR. Accreditation Council for Graduate Medical Education (ACGME) annual anesthesiology residency and fellowship program review: a "report card" model for continuous improvement. BMC Med Educ. 2010 Feb 8;10:13. doi: 10.1186/1472-6920-10-13. PMID: 20141641; PMCID: PMC283022