WORKSHOPS SESSION 6

Title

A Seat at the Dashboard: Connecting Trainees to Hospital Data for QI Projects

Primary Category

Curriculum

Presenters

Timothy Kreider, MD, PhD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Gauri Shastri, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Alexandra Landau, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Anetta Raysin, DO, Maimonides Medical Center, Theresa De Freitas, MD, Maimonides Medical Center

Education objectives

1. Evaluate existing approaches to QI education in psychiatry residency programs, identifying opportunities to better integrate institutional data and healthcare system priorities into resident project development.

2. Identify institutional data sources beyond traditional clinical dashboards that can inform resident QI initiatives and enhance residents' understanding of systems-based practice.

3. Apply a structured approach to developing resident QI initiatives by identifying relevant data sources, institutional stakeholders, and potential barriers to data acquisition and utilization.

4. Develop actionable strategies to strengthen their residency programs' QI curricula through improved access to institutional data and collaboration with healthcare system leadership.

Abstract

Identifying useful measures for trainee-led projects is a common challenge in a quality improvement curriculum. While it may be easier to connect trainees to existing QI initiatives in the hospital, trainee motivation, engagement, and learning are enhanced if a project’s aim and design are driven by trainee interests. The challenge for the QI course director, then, is connecting trainees to hospital leaders and resources that will support such trainee-initiated projects. In particular, trainees need support to identify sources of data that can be used as measures for QI projects. Left to their own devices, trainees will often create measures like surveys and chart reviews, which require unsustainable effort to generate and are distinct from existing data streams and monitoring processes. As electronic health record systems get more sophisticated and tools in analytics and automation become more accessible, course directors face greater opportunities to leverage existing data sources into the QI curriculum.



This workshop will engage participants in the following considerations: (1) what measures trainees use when developing QI projects; (2) what sources of data are available in a health system; and (3) how a QI course director can connect with such system resources. Contextual differences will be considered, such as type of electronic health record, size and number of clinical sites, and size of training program. In the spirit of continuous quality improvement, all are encouraged to attend regardless of how developed their QI curriculum is towards our aspirational goal of resident-led projects well-integrated with the health system priorities and resources.

Practice Gap

ACGME Common Program Requirements mandate trainee engagement in quality improvement, yet many psychiatry programs still rely on topics chosen through anecdotal workflow frustrations or subjective impressions. At the same time, healthcare systems hold vast data—such as EHR audit reports, safety incident databases, and pharmacy metrics—that may rarely be seen by trainees and educators. Trainees may build projects in silos, disconnected from hospital leadership and institutional priorities. Such disconnect limits project success, weakens training in Systems-Based Practice, and misses a chance to develop residents as real institutional leaders. By embedding structured training into residency curricula, programs can close this gap and drive meaningful improvements in patient care.

Agenda

Introduction: Presentation on curricular approaches to QI education in psychiatry residency programs and how this connects to existing institutional structures and goals (20 minutes)

Small Group Activity 1: Groups will be formed and asked to describe and compare their current QI curricula, guided by a worksheet prompting them to consider what guides resident selection of projects, what measures they use, and what resources may be available in their respective institutions (10 minutes)

Large Group Didactic: Presentation on sources of data that may be available in the health system for residents to use in their QI projects (20 minutes)

Small Group Activity 2: Groups will be given an example of a resident-led QI initiative and asked to brainstorm sources of data and barriers available in their institution for such a project (20 minutes)

Large Group Debrief: Wrap up discussion and concluding remarks (20 minutes)

Scientific Citations

1. Burra T, Peck JR, Waddell AE. Content and process: using continuous quality improvement to teach and evaluate learning outcomes in quality improvement residency education. BMJ Open Qual. 2022 Nov;11(4):e001806. https://doi.org/10.1136/bmjoq-2021-001806. PMID: 36414331

2. Hobbs, J.A., Young, J.Q., Kreider, T.R., Dick, M.H., Hsiao, R.C. (2026). Managing the Culture and Teaching of Patient Safety and Quality Improvement in Psychiatry Residency Training. In: Macaluso, M., Houston, L.J., Kinzie, J.M., Cowley, D.S. (eds) Graduate Medical Education in Psychiatry. Excellence in Medical Education, vol 1. Springer, Cham. https://doi.org/10.1007/978-3-032-14062-3_25

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6. Xiong K, Miller-Kuhlmann RK, Scott BJ, He Z, Dujari S, Gold C, Kvam K. Education Research: Sustained Implementation of Quality Improvement Practices Is Observed in Early Career Physicians Following a Neurology Resident QI Curriculum. Neurol Educ. 2024 Jun 10;3(2):e200137. https://doi.org/10.1212/NE9.0000000000200137. PMID: 39359889

Title

Beyond Substances: Teaching Compassionate Care for Gambling Disorder in Psychiatry Residency

Primary Category

Faculty Development

Presenters

Gerald Busch, MD, MPH, Tripler Army Medical Center, Karim Ghobrial-Sedky, MBBS, Family Health Centers of San Diego, Manassa Hany, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Surita Rao, MBBS, University of Connecticut Health Center

Education objectives

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

1. Apply gambling screening and diagnostic approaches to a clinical case, including assessment of psychiatric comorbidity, financial and relationship harms, and suicide risk.

2. Demonstrate nonjudgmental interviewing and explain evidence-informed treatment options, distinguishing gambling-specific interventions from treatment of co-occurring disorders.

3. Develop a case-based teaching activity and an implementation and evaluation plan for their residency program.

Abstract

Gambling disorder belongs within psychiatric addiction education, yet its recognition requires clinicians to ask about behaviors that patients may be reluctant to disclose. Shame, financial distress, relationship difficulties, and psychiatric comorbidity can obscure the presenting problem. Psychiatric educators need practical ways to prepare residents to identify gambling-related harm, assess safety, and engage patients in treatment without reinforcing stigma.

This workshop will help program directors and faculty teach compassionate assessment and management of gambling disorder in adults. A brief overview will address its classification within substance-related and addictive disorders, current gambling environments, and factors associated with harm. Presenters will distinguish screening from diagnosis and demonstrate how gambling questions can be incorporated into routine psychiatric assessment.

A fictional patient narrative involving online sports betting, concealed debt, and depressive symptoms will anchor the workshop. Participants will discuss the patient's experience and identify opportunities for earlier recognition. Presenters will demonstrate neutral questions about gambling, losses, control, consequences, and readiness for change. Participants will then rehearse interviewing in pairs or triads, with feedback on language,

engagement, and assessment of suicide risk. Discussion will consider cultural context, financial circumstances, and barriers to help-seeking without treating demographic identity as a diagnosis or assuming uniform risk within groups.

An unfolding case will guide small-group treatment planning. Participants will consider gambling-specific cognitive behavioral therapy, motivational interviewing, relapse prevention, family involvement with patient agreement, practical measures to limit gambling access, and community support, including Gamblers Anonymous. Medication discussion will address the evidence and limitations of off-label pharmacotherapy, including naltrexone, and distinguish treatment of gambling disorder from treatment of co-occurring depression, anxiety, or other psychiatric conditions. Presenters will emphasize when specialist consultation is appropriate.

Participants will then adapt a workshop case into a brief residency teaching activity, identifying its learning objective, educational setting, and method of assessing learning. This approach reflects the meeting's emphasis on humanity through attention to patient experience, creativity through narrative and rehearsal, and generativity through faculty preparation of future clinicians and educators.

Participants will leave with selected screening resources, sample interviewing questions, and a case-based teaching plan. A brief exit exercise will assess application of screening, engagement, and treatment principles to a case, alongside the meeting evaluation. The final discussion will address implementation barriers and opportunities to integrate gambling education into existing addiction, outpatient, consultation, or psychotherapy teaching.

Practice Gap

Gambling has expanded beyond casinos and other physical venues to readily accessible online and mobile platforms. Following Murphy v. NCAA (2018), the expansion of state-authorized sports betting, accompanied by television and social media promotion, has further increased opportunities to gamble. This changing landscape underscores an urgent need to prepare psychiatry residents to recognize and address gambling-related harm.

Residents must be prepared to identify gambling behind presentations of financial distress, relationship problems, depression, and suicidal thoughts. Shame and fear of judgment may prevent disclosure unless clinicians ask directly and compassionately. Psychiatric educators need practical teaching approaches that connect recognition with assessment and treatment.

This workshop addresses that educational need through patient narratives, case-based discussion, and interviewing practice. Participants will develop skills for teaching gambling assessment and evidence-informed management and create an activity for integration into residency education.



Agenda

0:00–0:10 | Introduction and Patient Narrative

Review gambling-related harms, educational needs, and the patient's perspective.

0:10–0:25 | Recognition and Assessment

Use an interactive case to distinguish screening from diagnosis and assess comorbidity, financial harm, and suicide risk.

0:25–0:45 | Compassionate Interviewing Practice

Participants rehearse nonjudgmental questions and motivational approaches in pairs or triads, with presenter guidance and feedback.

0:45–1:05 | Collaborative Treatment Planning

Small groups address psychotherapy, medication evidence and limitations, family involvement, practical supports, and referral.

1:05–1:15 | Teaching and Implementation Planning

Adapt a case into a residency teaching activity with a learning objective and evaluation method.

1:15–1:25 | Questions and Discussion

Discuss clinical questions, teaching challenges, and implementation barriers.

1:25–1:30 | Evaluation

Complete a brief case-based exit exercise and the meeting evaluation.

Scientific Citations

1. Moreira D, Azeredo A, Dias P. Risk factors for gambling disorder: a systematic review. Journal of Gambling Studies. 2023;39:483–511. doi:10.1007/s10899-023-10195-1.

2. Wardle H, Degenhardt L, Marionneau V, et al. The Lancet Public Health Commission on gambling. The Lancet Public Health. 2024;9(11):e950–e994. doi:10.1016/S2468-2667(24)00167-1.

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5. National Institute for Health and Care Excellence. Gambling-related harms: identification, assessment and management. NICE guideline NG248. Published January 28, 2025. Guideline.

Title

Beyond Traditional Teaching: Integrating Creativity in Psychiatric Training

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Daniel Gih, BS, MD, University of Nebraska Medical Center College of Medicine, Wayles Haynes, MD, University of New Mexico School of Medicine, Lucy Ogbu-Nwobodo, MD, MS, University of California, San Francisco, Mary Blazek, MD, University of Michigan

Education objectives

1. Describe how creativity can support professional identity formation, resilience, and lifelong learning in psychiatry.

2. Recognize common barriers that limit reflection, creativity, and perspective-taking during training.

3. Practice creativity-based approaches that enhance empathy, communication, and tolerance for clinical uncertainty.

4. Apply at least two creative strategies to patient care, psychotherapy, supervision, or personal professional development.

5. Develop a personalized plan for incorporating creative practices into residency or fellowship training.

Abstract

Psychiatric educators are increasingly asked to engage learners across multiple settings while fostering reflection, empathy, professionalism, and clinical reasoning. Yet many educators rely on traditional teaching approaches despite evidence that active learning and creative pedagogies can enhance engagement, retention, perspective-taking, and learner participation. Faculty often report uncertainty about how to implement creative strategies that are practical, psychologically safe, and aligned with educational objectives.

This highly interactive workshop introduces participants to creativity as a professional competency and a teaching methodology. Participants will explore how creative approaches can strengthen human connection, foster generativity, create educational environments that support diverse perspectives, and nurture the next generation of psychiatrists and educators. Accordingly, participants will experience several arts- and humanities-informed teaching strategies, including metaphor-based reflection, visual thinking techniques, and structured perspective-taking exercises.

Working individually and in small groups, attendees will then redesign an existing teaching activity from their own educational context using creativity-enhancing principles. Participants will leave with practical tools and a personalized action plan for integrating creativity into supervision, classroom teaching, psychotherapy education, and clinical learning environments.

This workshop is appropriate for educators at all career stages and requires no prior experience with creative or arts-based educational methods.

Practice Gap

Psychiatry residents and fellows regularly encounter clinical ambiguity, emotionally complex patient encounters, identity development challenges, and rising risks of burnout and disconnection. Traditional educational approaches may not adequately support reflection, meaning-making, empathy, and professional growth. Creative practices from the arts and humanities can help trainees develop perspective-taking, emotional awareness, psychological flexibility, and resilience while strengthening connections with peers, supervisors, and patients. However, many trainees have limited exposure to practical, evidence-informed creative approaches that can be integrated into clinical learning, supervision, psychotherapy training, and professional development. This workshop offers experiential strategies that residents and fellows can immediately apply to enhance reflection, communication, wellness, and patient-centered care while fostering a stronger sense of belonging within the psychiatric profession.

Agenda

- Introduction and Needs Assessment (10 minutes)
    - Live polling and review of learning objectives
- Activity 1: Metaphor and Meaning Making (15 minutes)
    - Found Object Metaphor Exercise
    - Debrief
- Activity 2: Visual Thinking and Attitudes Toward Creativity (15 minutes)
    - Participants engage in a Visual Thinking Strategies exercise using a work of art.
    - Discussion
- Mini-Didactic: Creativity, Learning, and Equity (10 minutes)
    - Brief review of definitions of creativity and equity and inclusion considerations
- Activity 3: Perspective Taking Through Mirroring (15 minutes)
    - Partner exercise involving observation and mirroring.
    - Reflection

- Design Challenge: Reimagining a Teaching Session (20 minutes)
    - Small groups redesign an existing educational activity using creativity principles.
- Action Planning and Closing Reflection (5 minutes)
    - Participants identify a strategy to implement within 30 days
    - Complete evaluation

Scientific Citations

1. Cerqueira AR, Alves AS, Monteiro-Soares M, Magalhães J. Visual Thinking Strategies in medical education: a systematic review. BMC Med Educ. 2023;23:548.

2. Lazarus MD, Gouda-Vossos A, Ziebell A, Parasnis J, Mujumdar S, Brand G. Mapping educational uncertainty stimuli to support health professions educators in developing learner uncertainty tolerance. Adv Health Sci Educ Theory Pract. 2025;30(1):259-280. PMID: 38869782.

3. Zhang X, Pang HF, Duan Z. Educational efficacy of medical humanities in empathy of medical students and healthcare professionals: a systematic review and meta-analysis. BMC Med Educ. 2023;23(1):925. doi:10.1186/s12909-023-04890-1. PMID: 38057775.

4. Heck AJ, Cross CE, Tatum VY, Chase AJ. Active learning among health professions' educators: perceptions, barriers, and use. Med Sci Educ. 2023;33(3):719-727. PMID: 37501807.

5. Lim J, Krishna LKR, Ong J, et al. A systematic scoping review of group reflection in medical education. BMC Med Educ. 2024;24:393.

Title

Bringing Humanity – if not always harmony – to the disciplinary process

Primary Category

Program Administration and Leadership

Presenters

Ann Schwartz, MD, Emory University School of Medicine, Adrienne Bentman, MD, Institute of Living/Hartford Hosp Psych Program, Deborah Spitz, BA, MD, University of Chicago

Education objectives

1. Describe a structured approach to identifying and managing resident performance concerns from early recognition through resolution.

2. Develop corrective action plans that promote fairness, transparency, resident dignity, and educational growth.

3. Apply practical strategies to navigate common challenges in documentation, communication, implementation, and downstream reporting.

4. Identify approaches to support the broader learning community, including co-residents, faculty, and staff, during corrective action.

Abstract

Managing resident performance concerns and navigating corrective action are among the most challenging responsibilities of residency leadership. Concerns regarding professionalism or clinical performance may emerge after a passing evaluation has been submitted, evolve over time, or become fragmented across rotations, supervisors, and clinical sites. Residents may experience corrective action with fear, shame, confusion, or uncertainty and may have limited insight or different perspectives regarding the concerns being raised. Although institutional policies provide a framework, implementation often involves uncertainty and difficult decisions that can test even experienced program directors.

Within a competency-based framework, advancement reflects demonstrated competence rather than an assumption of satisfactory performance until concerns become severe enough to warrant intervention. We will explore how this framing can help program leaders recognize concerns earlier, communicate uncertainty about performance more clearly, and avoid the difficult position of trying to “turn off” an assumption of competence after it has already been established.

A central theme of the workshop is developing a shared understanding of performance concerns. Faculty, program leadership, and residents frequently begin with different interpretations of events, expectations, and

goals. We will discuss practical communication strategies that promote psychological safety, clarify expectations, foster reflection, and support meaningful remediation.

Following an overview of the corrective action process, participants will review sample evaluation forms, Milestone 2.0-based letters of deficiency and remediation plans. We will introduce structured decision-making guidelines for determining the appropriate level of intervention, including additional support, performance improvement plans, letters of deficiency, probation, and, when necessary, termination. A sample timeline and real-world examples will illustrate how concerns may progress from early identification through escalating levels of intervention.

The workshop will address common challenges including:

1. Addressing concerns involving limited insight, difficulty incorporating feedback, executive dysfunction, professional boundary concerns, psychiatric illness, or substance use disorders.

2. Managing significant concerns when written documentation is limited despite consistent verbal reports from faculty.

3. Implementing remediation plans requiring substantial faculty time, mentorship, coaching, and institutional resources.

4. Ensuring a fair and transparent process while preserving resident dignity and supporting others involved in remediation.

5. Navigating structural challenges, including institutional requirements, competing priorities, and faculty morale.

6. Navigating downstream reporting and disclosure questions, including how terminology, institutional policies, regulatory requirements, and the specific question asked may influence whether and how an action is reported.

Finally, we will examine the collateral effects of corrective action on the broader learning community. Co-residents may experience increased workload, concerns about fairness, or anxiety regarding their own performance, while faculty may experience frustration, compassion fatigue, or uncertainty regarding expectations and documentation. Participants will discuss approaches that preserve confidentiality, promote trust, and support those involved.

Through practical tools, case discussion, and shared experience, participants will leave with strategies for navigating corrective action from early recognition through resolution while supporting learners and the educational community.

Practice Gap

Helping struggling residents succeed is among the most challenging, and most important, responsibilities of residency leadership. While corrective action is intended to support learner development and protect patients, implementing the process fairly and effectively often proves far more complicated than institutional policies suggest. This workshop provides a practical framework that combines procedural guidance with strategies that support fairness, transparency, and educational growth.

Agenda

10 min, CBME and the corrective action process: recognition, escalation, and resolution

15 min, Remediation plan, the performance improvement letter and the vulnerable resident

15 min, Pitfalls and Collateral Damage

20 min, Case Examples and Breakout Groups

30 min, Large Group Discussion, QA and wrap-up

Scientific Citations

1. Czelusta KL, Pershern LS, Appelbaum N. "Managing Resident and Faculty Performance Issues." Graduate Medical Education in Psychiatry: From Basic Processes to True Innovation. Cham: Springer International Publishing, 2022: 291-305.

2. Morreale MK, Balon R, Louie AK, et al. The Vital Importance of Professionalism in Medical Education. Academic Psychiatry 2023; 47:340-343.

3. Godschalx J, van Mook W. Dismissed Psychiatry Residents Who Appeal: Exploring Unprofessional Behavior. Academic Psychiatry 2023; 47: 344-351.

4. Day LB, Butler D, Kuper A, Shah R, Stroud L, Ginsburg S, Tavares W, Brydges R. (Mis) Alignment in resident and advisor co-regulated learning in competency-based training. Medical Education. 2025 May;59(5):519-30.

5. Cheong CW, Quah EL, Chua KZ, Lim WQ, Toh RQ, Chiang CL, Ng CW, Lim EG, Teo YH, Kow CS, Vijayprasanth R. Post graduate remediation programs in medicine: a scoping review. BMC medical education. 2022 Apr 20;22(1):294.

6. Yan Q, Treffalls RN, Li T, Prasla S, Davies MG. Graduate Medical Education “Trainee in difficulty” current remediation practices and outcomes. The American Journal of Surgery. 2022 Aug 1;224(2):796-808.

Title

Expect the Expected: Implementing a preparation curriculum for adverse patient experiences

Primary Category

Curriculum

Presenters

Kristi Kleinschmit, MD, University of Utah School of Medicine, Jennifer O'Donohoe, MD, University of Utah School of Medicine, Katherine "Kat" Amano, MD, University of Utah School of Medicine, Joanna Tomaszewski, MD, University of Utah School of Medicine, Heidi Stahl, MD, Kaiser Permanente Northern California Program (Oakland)

Education objectives

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

1. Describe the rationale for including a resilience and preparation curriculum for psychiatry trainees
2. Recognize the many adverse events that can occur during psychiatry training and the lack of an intentional approach to prepare trainees for them
3. Describe resources and strategies for preparing psychiatry trainees for adverse events
4. Outline a plan for implementing a preparation curriculum in participant's home program

Abstract

The ACGME requires psychiatry training programs to develop work environments and policies to promote well-being and decrease burnout, and to help trainees independently develop a personal and professional well-being plan (4,5). However, burnout continues to be well-recognized in the medical field, with physicians consistently exhibiting higher rates of burnout compared to the general U.S. workforce (3). Residents in training are particularly vulnerable to burnout, and psychiatry trainees specifically contend with potentially predisposing factors such as intense emotional engagement, high rates of violence directed at healthcare staff, and heightened risk of encountering patient suicide (6). Experiencing an adverse event can take a negative emotional toll and cause providers to change practice style or even question career choices (2). Numerous examples for suicide postvention approaches, general resiliency curricula, and preparation to share bad news exist in the literature. For the program directors who want to be intentional and inoculate trainees before a bad outcome occurs, there is little published about how to do so (7, 8) and clear guidelines are lacking to prepare trainees for a myriad of potential adverse outcomes. Training programs then are left in the position of reacting when a trainee has a bad patient outcome instead of supporting a trainee who has already been prepared.



This workshop aims to support educators by providing rationale and direction for how to provide training to prepare residents to anticipate and cope with adverse experiences.

This experiential workshop will first invite participants to reflect on adverse outcomes that they experienced in training. Two programs will then review their curriculum which were spearheaded at each institution by residents in response to an adverse event. The first curriculum, Expect the Expected, was modified by psychiatry residents and fellows, with faculty mentorship, from an existing curriculum for pediatric providers to prepare them for grief and loss within their field (9). The second curriculum, Breaking Silence, Building Resilience (8), was developed by a trainee, with faculty mentorship, to be delivered across all years of psychiatry training. Both curricula involve didactic content regarding adverse patient outcomes and attendings sharing their adverse experiences. Faculty presenters will reflect on their participation in this process. Attendees will next participate in specific exercises used in the curriculum, and practice vulnerability in sharing their adverse experiences. Ultimately, participants will begin to create a curriculum for their individual training program. The workshop will end with participants sharing their impressions and potential barriers for implementation.

Practice Gap

Adverse outcomes in psychiatry occur, with one residency program reporting one-third of their trainees experiencing an adverse event during residency (1), and a meta-analysis reporting almost half of psychiatric trainees experience a patient suicide during training (2). Adverse events, especially a patient suicide, can negatively impact well-being (2) and could further contribute to physician burnout, which is already at higher levels than the general workforce (3). While there are numerous examples of postvention programs to support trainees after a suicide occurs, there are no clear guidelines as to how best prepare psychiatry trainees to cope with adverse outcomes. This workshop attempts to address that gap by reviewing two different approaches at two institutions to prepare trainees for adverse events during training. Participants will be encouraged to begin to develop their own training using this curriculum as a framework.

Agenda

This 90-minute workshop will include large group didactic sessions/discussion and small-group activities.

Minutes 0-5: Begin with a self reflection, followed by a pair/share on an adverse outcome that the participant experienced in training

Minutes 5-20: Introductory didactic on the rationale for explicitly preparing residents for adverse outcomes in psychiatry, and discussion of two programs' approaches, including resident experiences with the content

Minutes 20-40: Small Group One—icebreaker and participation in a sample exercise taken from the resilience curriculum developed by presenters



Minutes 40-50: Large Group Debrief of the experience and discussion of ways to implement resilience curriculum

Minutes 50-70: Small Group Two—In small groups, with the help of a curriculum building tool, participants will work to develop an approach on resilience and adverse events to implement in their program

Minutes 70-85: Large Group Debrief of facilitators and barriers of implementing resilience curricula

Minutes 85-90: Wrap Up and Survey Completion

Scientific Citations

1. Deringer, E., Caligor, E. Supervision and Responses of Psychiatry Residents to Adverse Patient Events. Acad Psychiatry. 2014 38, 761–767. https://doi.org/10.1007/s40596-014-0151-6

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3. Shanafelt TD, et. al. Changes in Burnout and Satisfaction with Work-Life Integration in Physicians and the General US Working Population between 2011 and 2023. Mayo Clinical Proceedings. 2025 100(7), 1142-1158.

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Title

From Clinic to Capitol Hill: Training Tomorrow's Psychiatrist-Advocates

Primary Category

Curriculum

Presenters

Vishal Madaan, MD, American Psychiatric Association, Mark Rapaport, MD, American Psychiatric Association, Marketa Wills, MD, American Psychiatric Association, Kristin Kroeger, BA, American Psychiatric Association

Education objectives

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

1. Analyze the rationale for implementing structured advocacy curriculum in their residency program
2. Apply advocacy principles as a core competency in their residency program
3. Design a framework to identify at least two core skills to effectively advocate in their practice settings

Abstract

Psychiatrists advocate every day, whether helping patients navigate systems, explaining the impact of policy on care, or championing for resources their communities need. Such advocacy occurs at multiple levels, including patient care, addressing institutional needs, or in legislative or public domains. The larger advocacy role becomes increasingly critical as the demand for mental health services continues to outpace our workforce capacity and growth. Despite APA's successful advocacy for funding of increased residency positions over time, closing the workforce gap will require policy solutions related to reimbursement reform, parity enforcement and telehealth regulation. Yet advocacy training continues to be inconsistently taught across psychiatry residencies, with only a small minority of programs offering structured curricula on the topic. With a growing interest in including advocacy as a core competency within the upcoming ACGME revisions, creating structured opportunities and skills development for both faculty and the trainees has become increasingly important.

This workshop will equip training directors with practical strategies to teach advocacy as a core professional skill for psychiatry residents. Participants will explore how to help learners recognize the advocacy they already do, build effective relationships with policymakers and community partners, identify supporters and detractors, and tailor messages to the priorities and language of different audiences.

Using case-based discussion and interactive teaching tools, the workshop will emphasize how to connect advocacy issues to patient care, workforce needs, and financial implications. Attendees will leave with

adaptable teaching approaches, didactic materials, and a framework for helping residents move confidently from clinical insight to effective advocacy action.

Practice Gap

Despite the growing recognition of the importance of advocacy, advocacy training continues to be inconsistently taught across psychiatry residencies, with only a small minority of programs offering structured curricula on the topic.

Agenda

- Introduction and brief description of advocacy constructs and APA initiatives: 15 min
- Audience Poll related to advocacy in residency programs: 5 min
- Small group activity on common advocacy elements seen in residency programs: 10 min
- Discussion of commonly available practical tools including APA Advocacy curriculum: 15 min
- Small group exercise involving practical tools and skill-based learning: 15 min
- Large group discussion related to future engagement for APA-AADPRT advocacy: 15 min
- Interactive Q&A: 15 min

Scientific Citations

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Title

From Gut Feeling to Actionable Feedback: A Competency-Based Approach to Psychotherapy Supervision

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Vitaliy Voytenko, PsyD, Western Michigan University School of Medicine, Donna Sudak, BS, MD, Tower Health -- Phoenixville Hospital General Psychiatry, Anne Ruble, BA, MD, MPH, Johns Hopkins Medical Institutions, Richelle Moen, PhD, University of Minnesota

Education objectives

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

1. Describe core principles of competency-based supervision and their application to psychotherapy training in psychiatry residency.

2. Develop a supervision contract that establishes explicit expectations, roles, responsibilities, competencies, feedback processes, and developmental goals within the context of a psychiatry residency program.

3. Practice providing specific, actionable feedback about psychotherapy process, technique, and the therapeutic relationship.

Abstract

Psychotherapy supervision occupies a critical position in psychiatry residency training. Supervisors are asked to evaluate residents' knowledge of psychotherapy models and techniques, their ability to formulate cases, establish and maintain a therapeutic alliance, recognize and respond to interpersonal processes, monitor the impact of their interventions and countertransference, and reflect on the evolving treatment relationship. Few psychotherapy supervisors have been trained as educators, making psychotherapy supervision particularly vulnerable to vague feedback, variable practices, and unarticulated educational goals.

Competency-based supervision promotes the resident's knowledge, attitude, and skills in a therapeutic modality. Drawing on the work of Falender and Shafranske (e.g., 2004, 2014), this workshop will explore how collaboratively-defined competencies, observable indicators, developmental goals, ongoing assessment, and specific feedback can strengthen psychotherapy supervision in psychiatry residency.

Through brief didactic presentation, supervision vignettes, and small-group exercises, participants will practice making more accurate competency observations in supervision. Participants will then develop specific supervision goals and feedback statements. Participants will also develop a supervision contract tailored to

their training program by reviewing a model competency-based psychotherapy supervision contract and discussing in small groups which elements should be retained, modified, expanded, or omitted for different residency contexts.

Participants will learn a practical framework for structuring psychotherapy supervision around contracting, competencies, observation, formulation, feedback, deliberate practice, and reassessment which could be applied to faculty development to help supervisors from different backgrounds make their clinical reasoning and expectations more transparent so that residents can better understand what they are learning, how they are progressing, and what they need to do next.

Practice Gap

This workshop addresses the gap between knowing psychotherapy and supervising psychotherapy. Too often, supervisors are chosen because they are excellent clinicians, but they may lack a background as educators. Participants will practice translating common supervisory observations—such as a resident's difficulty deciding what to prioritize in a session, or uncertainty about when to shift from facilitation to intervention—into specific, observable competencies. They will practice giving feedback that names what occurred in the session, explains why it matters clinically, and identifies a concrete action step for the resident.

Agenda

- Describing the Supervision Continuum (10 minutes)
    - Brief poll on psychotherapy supervision challenges, followed by a didactic presentation on the shift from knowledge-based learning toward skills, reflective practice, observation, and targeted feedback.
- Feedback Anchors in Supervision (20 minutes)
    - Introduction to competency-based supervision based on Falender and Shafranske. Participants map common supervisory observations onto competency domains.
- Case Exercise: Using Feedback Anchors (20 minutes)
    - Small groups use a psychotherapy vignette to identify supervisory observations and formulate specific, behaviorally anchored, developmentally appropriate feedback and action plan.
- The Supervision Contract: More Than a Form (10 minutes)
    - Review key elements of a competency-based contract, including goals, roles, structure, observation, feedback, evaluation, and adaptation.
- Experiential Exercise: Make the Contract Fit (15 minutes)
    - Participants adapt a model contract to their programs and identify implementation barriers.
- Take-Home Framework (15 minutes)
    - Participants develop three concrete action steps for applying competency-based supervision in their programs.



Scientific Citations

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Title

Holding Space, Building Generativity: Mentoring Trainees Through Difficult Times

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Kari Whatley, MD, University of Texas Austin Dell Medical School, Sasha Jaquez, PhD, University of Texas Austin Dell Medical School, Laurel Wolfe, PsyD, Texas Tech University Health Sciences Center, Stephanie Kopanski, MD, Texas Tech University Health Sciences Center

Education objectives

By the end, participants will be able to:

1. Identify characteristics of effective mentors and mentees.
2. Use a reflective exercise to process your own mentoring experiences (past and present).
3. Apply evidence-based strategies to designing and/or maintaining an effective mentor-mentee relationship.
4. Leave with at least one specific and concrete commitment for their next mentoring interaction.

Abstract

Mentorship is defined as “the influence, guidance, or direction given by a mentor.” Mentorship can be integrated in a variety of ways through structured programs, internal and external mentors, peer mentorship, group mentorship, faculty, etc… While mentorship has been identified as having protective value for trainees, mentorship is not automatically protective as its impact depends on whether mentors feel equipped to support trainees during their most vulnerable moments, and not only during their successful moments. Therefore, confidence and ability to be a strong mentor can become a limiting factor. While many mentors are excellent clinicians, they may have had no formal training or preparation for the conversations that might matter the most to trainees, including responding to a trainee’s disclosure of crisis, burnout, clinical error, or recognizing when support should extend beyond what a mentor alone can offer. Without proper preparation, well-intentioned mentors may default to reassurance, problem-solving, or at worst avoidance which could appear as though discussions around significant difficulty are not welcome in the mentoring relationship.

Identifying and fostering characteristics of effective mentors is important to consider in a program where mentorship is offered, and often expected to be provided, to trainees. Such characteristics of effective mentors include the ability to be honest and trustworthy while also ensuring prioritization of the trainees best interest,

not the program's best interest. Being an active listener is an inherent skill of mental health providers, but having sufficient time to meet and accessibility are also key to an effective mentoring relationship.

Training and educating about the mentee's role in the mentorship relationship is equally important. Characteristics of effective mentees include openness to feedback, active participation by taking initiative and being proactive, bringing honesty and transparency to the relationship, and being open to discussion and feedback with the mentor. Additionally, mentees should be respectful of their mentor's time, which can be achieved by laying out clear goals, coming to meetings with an agenda, and leaving meetings with an action plan. Accountability is important in the mentoring relationship for both the mentee and mentor. Mentees should also engage in self-reflection and self-regulated learning.

Evidence-based strategies for designing and/or maintaining a mentorship program include intentional pairings, clear expectations, set meeting cadence, goal-setting templates, trainings equally focused on both mentors and mentees, flexibility and feedback. Evidence from graduate medical education shows relationships endure when mentor participation is voluntary and when mentors receive explicit preparation for the role including period review of the relationship's fit. Programs that build in mentor training, institutional accountability, and access to a broader network of mentors show significantly higher rates of sustained mentorship over time.

This workshop translates the evidence-based practices into practical guidance for education leaders seeking not only to launch mentoring initiatives, but to sustain them as a durable expression of generativity within training programs. We will also allow for reflection and discussion of successful and unsuccessful mentoring relationships and allow for time to strategize on plans for mentorship within attendee's training programs.

Practice Gap

Psychiatry and psychology training exposes trainees to the emotional weight of working with emotion-provoking cases and in high clinical stakes. Factors contributing to severe burnout in trainees include long working hours and insufficient rest, compounded by the high demands of clinical responsibilities and emotional strain from patient interactions.

Mentorship is one of the few interventions with evidence of protective value. Strong mentors can provide role modeling, guidance, feedback, and emotional support, which can be associated with higher engagement, better coping, improved autonomy and lower burnout and distress among trainees. Mentorship can also buffer stress-related negative outcomes by promoting social connectedness, and potentially identifying the need for early access to support.

Agenda

Introduction & Background (10 minutes): Introduce speakers and discuss the background of the importance of mentorship relationships within training programs, including characteristics of mentors and mentees that lead to positive outcomes in mentorship relationships.



Reflective Practice (5 minutes): Engage in a reflective practice about personal positive/negative mentorship relationships

Small Group Discussion (10 minutes): Discuss in pairs or small groups observations from the reflective practice

Large Group Discussion (15 minutes): Discuss in a large group observations from reflective practice.

Didactic (15 minutes): Discuss evidence-based strategies for maintaining mentorship relationships

Create a Plan (5 minutes): Individually identify evidence-based strategies you can utilize in an ongoing or new mentoring relationship

Small Group Discussion (10 minutes): Discuss in pairs or small groups strategies identified.

Large Group Discussion (10 minutes): Discuss in a large group strategies identified.

Key Takeaways (5 minutes)

Wrap-up/time for evaluation (5 minutes)

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Title

Nuts and Bolts of setting up a CBME Program of Assessment with EPAs… Sharing Solutions for the Pre-Implementation Phase

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Michael Greenspan, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Kristina Jiner, MD, The Ohio State University College of Medicine, Anupriya Schnapp, MD, University of Wisconsin Hospital & Clinics, Bernice Yau, MD, UT Southwestern Medical Center, Mary Hall-Mennes, BA, MD, Case Western Reserve University/University Hospitals of Cleveland Program

Education objectives

1. Review challenges in the pre-implementation (“front-end”) utilization of EPAs within a CBME based Program of Assessment.
2. Discuss solutions for design, distribution and collection of WBAs and other sources of feedback.
3. Apply “pre” implementation considerations to your program.

Abstract

CBME provides an outcome-based framework for assessment programs in Psychiatry Graduate Medical Education (GME) that is aligned with population health and learning science [1]. Supporting CBME, EPA-based WBAs have the potential to: 1) Optimize both formative and summative assessment needs; 2) Foster shared mental models between faculty and learners, and; 3) Support direct observation and structured feedback [2]. Amongst the US Psychiatry GME Programs, there is a wide range of CBME implementation.

There are 13 EPAs within general psychiatry practice [3], with parallel lists being constructed for the sub-specialties (eg Addiction, Geri, CL, etc). In building a CBME focused program of assessment anchored in these 13 EPAs, training programs must consider the design of their WBAs, faculty/learner “buy-in,” the distribution mechanism of assessment forms, and the frequency of assessments. Contextual factors can be incorporated, such as which of the EPAs will typically be observed on which rotations. These “pre” implementation challenges require a thoughtful approach, as they will generate feedback data that ultimately informs learner development and CCC decisions regarding promotion/etc.

A well-designed program of assessment (rooted in a diverse group of well-developed faculty gathering a large number of WBA data points) is a highly effective hedge against bias in assessment programs. Equity considerations are also served by tools that “standardize” direct observation and feedback [4].



In this workshop, we will discuss the challenges of CBME implementation in this "pre" phase and offer guidance for best practices. Both structured and unstructured WBAs will be reviewed, as well as guidance regarding the optimal build of WBA forms. Faculty development is vitally important in early implementation [5]. We will practice using shared mental model development as a way to gain faculty/learner "buy-in," a necessary step in achieving the desired number of WBA. Similarly, the workshop will incorporate performance dimension training, an easy-to-do faculty development aimed at increasing WBA user familiarity and reliability. Finally, practical implementation considerations will be discussed, such as how to incentivize faculty to participate in WBA completion, how and when to perform CBME faculty development, and how to get broad support from all stakeholders.

As educators tasked with preparing our trainees for independent practice, this workshop will demystify the process of EPA implementation. Our hope is that participants leave this workshop with concrete plans for implementing a program of assessment that incorporates the use of WBAs into their own programs.

Practice Gap

Entrustable Professional Activities (EPAs), a core framework within Competency Based Medical Education (CBME), describe central tasks a resident should be able to perform independently by the end of training. There is increasing interest in incorporating EPA evaluations into residency education. EPAs are assessed through workplace-based assessments (WBA), which facilitate direct observation of clinical performance and provide structured feedback. In psychiatry, there are 13 EPAs identified in the American Association of Directors of Psychiatry Residency Training's (AADPRT) EPA toolkit.

The Assessment Committee often receives questions about EPA implementation and the questions fall into two main categories: 1) How does a program begin implementing EPAs and 2) Now that a program has implemented EPAs, how does a program organize, review, and use the results? The Assessment Committee proposes two separate workshops focused on addressing these common questions during EPA implementation; the following abstract pertains to the first, "pre," implementation stage.

Agenda

0-5 minutes: Speaker introductions and review of Learning Objectives

5-15 minutes (10 minutes): Pair/Share with large group report out of current state and experienced challenges in the "pre" implementation stage

15-35 minutes (20 minutes): Review of barriers and proposed solutions to build a Program of Assessment based in CBME principles

35-60 minutes (30 minutes): Small group shared mental model exercise incorporating WBA form construction considerations



65-80 minutes (15 minutes): Facilitated group discussion of practical considerations and challenges. How to "bring home" some of your plans from the workshop.

80-90 minutes (10 minutes): Questions and Wrap-Up (including 5 minutes for evaluation form

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Title

SOAP Happens! What do you do when you don't fill in the Match?

Primary Category

Recruitment and Selection

Presenters

Michael J Peterson, MD, PhD, University of Wisconsin Hospital & Clinics, James Haliburton, EdD, MD, Southern Illinois University School of Medicine, Areesha Satti, MD, Southern Illinois University School of Medicine

Education objectives

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

1. Describe the timeline, steps, and process involved with the SOAP.

2. Develop a strategy for their program to prepare for how to approach SOAP if they do not fill in the Match.

3. Prepare communications to relevant stakeholders (eg- residents, faculty, and leadership) about Match results and SOAP participation to enhance rather than detract from recruitment efforts.

Abstract

Recruitment of residents is one of the most time-consuming and critical tasks for residency programs. Over half of the academic year is consumed with recruitment tasks – application review, interviews and other recruitment events, candidate ranking – culminating in the Match. Although the Match is outside a program's control, it is a high-stakes process. Not filling in the Match can be seen as a public and possibly catastrophic failure. Programs that do not fill can participate in the Supplemental Offer and Acceptance Program (SOAP) to try to fill their remaining open positions with applicants who did not Match.

Over the past decade, applications to psychiatry residency programs from US medical graduates have increased dramatically, resulting in almost no unfilled Match positions and more applicants without a psychiatry Match. From 2020-25, between 4 and 21 PGY1 positions were available after the Match for the SOAP process each year. This caused few psychiatry programs to have experience with SOAP. New psychiatry residency programs starting in the Match and existing programs increasing their complement led to 128 more positions nationally in the 2026 Match, outstripping the increase in psychiatry applications. In 2026, 65 positions in 24 programs went unfilled, a 300% increase from the prior 6 years. As more programs continue be founded and grow, more programs will go unfilled, leading to additional programs participating in SOAP.



The presenters experienced the SOAP process in 2026 and will share their perspectives from the training director and resident perspectives. As SOAP becomes more common in Psychiatry, understanding the SOAP and how to develop a successful strategy that fits a particular program and institution will be a critical skill for Program Directors and their leadership teams. There are many reasons both that a program may not fill, and an applicant may not match. Normalizing this situation removes the shame and stigma and helps both programs and applicants understand that the SOAP can lead to positive outcomes.

A successful SOAP strategy requires understanding the timeline and steps involved. Programs must rapidly muster their team and resources to repeat the application review, selection, interview, and ranking process – in only a few days! Communication with department and institutional leadership, faculty, and residents is critical to set the stage for success and positive morale. At the conclusion of SOAP, programs may sign outstanding candidates filling positions in a mutually beneficial way.

Any time a program doesn't fill, there is an opportunity to learn how to improve and potentially avoid the SOAP in future years. For programs that do SOAP, having a prepared strategy and understanding of the process can reduce the stress and flurry of activity during Match week. Programs that have successfully participated in SOAP know the process can end as a rewarding complement to the Match rather than a walk of shame and failure.

Participants will leave this session with a detailed knowledge of SOAP, building blocks to create a personalized strategy for their program, and methods to effectively communicate about Match and SOAP.

Practice Gap

The Supplemental Offer and Acceptance Program (SOAP) is a structural part of the recruitment and Match process. Although relatively few programs have needed to participate in recent years (e.g. Psychiatry programs have mostly filled), last year showed a significant increase in unfilled positions and programs. This trend is likely to continue as psychiatry applicants decrease from peak numbers, at the same time that new psychiatry programs are launched and existing programs increase their complement. Program directors and teams need to be familiar with SOAP and prepared for possible participation.

Agenda

- 0-10"
    - Introduction and live polling (SOAP participation? Participant reaction to SOAP (word cloud))
- 10-25"
    - Presenters share their experience with SOAP; important steps to consider; creation of a SOAP strategy.
- 25-40"
    - Breakout groups. Discuss creating a strategy for SOAP with available program and GME resources.



- 40-60”
    - Lessons learned: How and what to share about Match and SOAP. Conducting a “post-mortem” on the recruitment season. How to improve for next year.
- 60-75”
    - Break out groups. Reflect on your last recruitment season. Identify areas for improvement? Are you able to create a preliminary strategy for SOAP just in case? What communication tips about Match would you share with a new program director?
- 75-90”
    - Share back from small groups – best tips on improvement and communication.
    - Presenters share last reflections on their SOAP experiences. (Surprises; what was harder/better than expected with SOAP).

Scientific Citations

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Title

The Forensic Thread: Weaving Legal Literacy Across Every Year of Residency

Primary Category

Curriculum

Presenters

David Mancini, BS, MD, University of Maryland/Sheppard Pratt Program, Evan Vitiello, MD, University of North Carolina Hospitals

Education objectives

1. First, presenters will make the case, grounded in curricula and outcome data from their own institutions, that forensic and legal education is essential to developing competent general psychiatrists, not an optional interest reserved for those pursuing forensic subspecialty training. Civil commitment, capacity assessment, confidentiality, duty to warn, and violence risk assessment arise across every clinical setting and every career path.

2. Second, presenters will demonstrate why this education must be longitudinal: sharing distinct curricula and seminar series built for junior residents, senior residents, and consultation-liaison fellows, we illustrate how forensic competencies can be sequenced and reinforced across training years rather than confined to a single rotation or lecture block.

3. Attendees will then apply these principles directly, using a hands-on curriculum-mapping exercise to sketch a longitudinal forensic education plan for their own program, leaving with a concrete starting point rather than a purely theoretical argument for why this work matters.

Abstract

Presenters independently developed forensic psychiatry curricula and seminar series at their respective institutions, targeting different training stages. Rather than sharing a single design, each curriculum reflects locally identified priorities and constraints, while addressing overlapping core competency domains, including introduction to the legal system and the psychiatrist's role within it; civil and criminal competencies; violence and safety risk assessment; confidentiality and privacy; right to treatment and refusal of treatment; and malingering and symptom validity. Each program treated these forensic domains not as a single unit but as recurring content, revisited and deepened at successive training stages as learners' clinical responsibility and complexity increased. Pedagogical approaches varied by site and included case-based small-group discussion, structured readings tied to landmark legal cases, and simulation. Each presenter assessed the impact of their curriculum using outcome measures suited to their own setting and learner group, including pre/post knowledge assessments, self-reported confidence surveys, and qualitative learner feedback.



Across the independently developed curricula, presenters observed measurable gains in learner knowledge and self-reported confidence following participation, alongside favorable qualitative feedback. Junior resident learners most frequently highlighted case-based instruction in civil commitment and capacity assessment as clarifying previously abstract legal concepts, while senior residents and fellows described greater value in practice-based application, including mock testimony, documentation exercises, and capacity evaluation in medically complex patients, content that built directly on earlier foundational exposure rather than introducing forensic concepts for the first time. Presenters observed that residents engaged more readily with forensic material introduced at successive stages of training, consistent with the intent of each curriculum's longitudinal design. Despite differing designs, presenters independently identified a shared barrier: forensic content is often confined to a single rotation or lecture series, without longitudinal reinforcement, and is vulnerable to being deprioritized or forgotten.

These findings support two related conclusions. First, forensic and legal competencies are not a niche interest but a core, generalizable component of psychiatric training that every resident needs regardless of eventual subspecialty. Second, this education is most effective, and most durable, when it is longitudinal: introduced early, revisited at increasing complexity, and reinforced across postgraduate years rather than delivered once. This workshop translates both conclusions into an actionable planning tool: after each presenter briefly shares their curriculum design and outcome data, participants will work in small groups using a shared curriculum-mapping template to inventory existing forensic content in their own programs, sequence core competency domains longitudinally across their curricular calendar, and draft at least one assessable, ACGME-aligned learning objective. Facilitators will circulate to troubleshoot implementation barriers, and the session will close with large-group sharing of curriculum drafts and discussion of how to sustain longitudinal integration over time. Attendees will leave having seen multiple real-world models and with a concrete framework for building forensic education into the full arc of residency training, not just a single point within it.

Practice Gap

In current practice, forensic and legal content is often delivered as a discrete rotation, a single lecture series, or an occasional didactic block, treating forensic knowledge as a niche subspecialty interest rather than a core competency every general psychiatrist needs. Optimal practice recognizes that civil commitment, capacity assessment, confidentiality, duty to warn, and violence risk assessment are recurring, high-stakes clinical decisions residents face with increasing complexity across every year of training and into independent practice. A single isolated exposure cannot build the durable literacy this demands. This gap is compounded by the field's failure to treat forensic education as longitudinal: without deliberate, developmentally sequenced reinforcement across PGY levels, early learning fades, and residents graduate without the confidence or competence to navigate these issues reliably. This workshop addresses both dimensions of the gap, arguing for forensic education as essential and equipping training directors to build it in longitudinally.



Agenda

Min 0–5: Welcome and framing — why forensic and legal competencies are essential, not optional, for every general psychiatrist, and why a single rotation or lecture series cannot build durable literacy.

Min 5–45: Presenter spotlights — each facilitator presents their institution's curriculum design, pedagogical choices, and outcome data (roughly 10 minutes each), spanning junior resident, senior resident, and fellowship perspectives.

Min 45–65: Small-group curriculum-mapping exercise — participants use a shared planning template to inventory existing forensic content at their own program, sequence core competency domains longitudinally across postgraduate years, and draft an ACGME-aligned learning objective, with facilitators circulating to troubleshoot common barriers.

Min 65–75: Large-group share-out — volunteers present draft curriculum outlines for facilitator and peer feedback.

Min 75–85: Facilitated discussion of strategies for sustaining longitudinal integration over time, including cross-year coordination and faculty continuity.

Min 85–90: Wrap-up, resource distribution, and evaluation form completion.

Scientific Citations

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Title

When “Policy” Is Not Neutral: Equity Case Rounds for Psychiatry Residency Leaders and Administrators

Primary Category

Program Administration and Leadership

Presenters

Kai Anderson, BA, MD, Central Michigan University College of Medicine, Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center, Khadijah Booth Watkins, MD, MPH, Massachusetts General Hospital, Ailyn Diaz, MD, Penn State University, Hershey Medical Center, Ravi Shankar, MD, University of Kentucky

Education objectives

1. Explore how seemingly neutral policies can produce inequitable outcomes in residency/fellowship training.

2. Bolster leaders’ ability to recognize bias and disparate impact in policy development and implementation.

3. Develop equitable approaches that balance trainee needs, educational standards, patient care, and institutional responsibilities using the Equity Decision Pause.

4. Examine challenges implementing and adjusting policies using realistic training scenarios: leave, extensions, accommodations, professionalism, and access to leadership opportunities.

Participants will:

a. Recognize inequitable outcomes arising from neutral or inconsistently applied policies.

b. Distinguish equity from uniformity in policy decisions.

c. Apply an equity-informed framework to complex training scenarios.

d. Identify opportunities to improve policies and decision-making within their programs.

e. Examine how transparency, trust, and psychological safety influence policy decisions.

Abstract

This interactive 90-minute workshop is designed for psychiatry residency program directors, associate program directors, program coordinators, administrators, chief residents, faculty supervisors, and GME/DEI leaders. Following brief framing on equity versus equality, power and hierarchy in GME, fear of retaliation, dual roles, and institutional constraints, participants will use small-group “equity case rounds” and a standardized

worksheet to analyze common residency dilemmas. Participants will identify equity, power, and psychological-safety concerns; distinguish immediate safety needs, informal resolution options, formal reporting obligations, and systems-level interventions; and consider how individual decisions may have disparate effects.

Participants will apply principles of equitable decision-making to four complex, realistic residency scenarios addressing common areas of program director responsibility: accommodation, assessment, accountability, and access to opportunity. In small groups, participants will identify the equity tension of each case and reach consensus on a course of action while balancing individual circumstances with educational standards, consistency, confidentiality, and fairness to the larger residency community. Cases will explore subjective judgments of competence, the role of individual circumstances in professionalism concerns, and differential access to mentorship, sponsorship, and advancement opportunities. After groups reach an initial decision, facilitators will introduce new information that complicates each scenario and ask participants to reconsider their conclusions and reasoning. Participants will apply an Equity Decision Pause before finalizing consequential decisions.

Guided group discussion will examine where bias or structural inequity may enter decision-making, when equitable treatment may appropriately differ from identical treatment, and whether proposed actions are transparent, consistent, and defensible. Groups will share key insights during a large-group debrief and identify practical strategies for more equitable assessment, remediation, accommodation, professionalism, and advancement decisions within their own training programs.

In the final application exercise, participants will conduct a “policy stress test” of one home-program process, map current conflict-resolution pathways, identify one gap, and develop an actionable improvement plan. Participants will leave with a reusable Equity Decision Pause, equity case-rounds worksheet, and policy stress-test framework.

Participants will identify an intended practice change, as well as a documented commitment to one program-level action. The workshop aims to strengthen equitable, transparent, and psychologically safe conflict-resolution pathways in psychiatry residency education.

Practice Gap

Residency leaders routinely make high-stakes decisions about recruitment, assessment, remediation, promotion, accommodations, and professionalism. Although policies may appear neutral, their application to individual circumstances can unintentionally reproduce bias or create inequitable outcomes, particularly when power dynamics and institutional norms go unexamined. Yet residency leaders may lack practical, structured approaches for recognizing these risks, assessing the differential impact of consequential decisions, and developing equitable alternatives in psychologically safe settings. This workshop addresses this practice gap through case-based discussion that equips psychiatry residency leaders to critically examine policies and processes, navigate equity dilemmas transparently, and foster psychologically safe learning environments.

Agenda

Time Activity

0–15 minutes Framing: Why equity dilemmas are difficult in residency—hierarchy, dual roles, fear of retaliation, ambiguity, and institutional constraints.

Introduction to the Equity Decision Pause - framing of questions to assess equity

15–50 minutes Small-group discussion of 4 representative cases- each group will review two cases

50–70 minutes Large-group debrief: response options

70–82 minutes Home-program application: participants map current pathways and identify one gap

82–90 minutes Commitments to action, resource sharing, and evaluation

Scientific Citations

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