Workshop Session #4

Title
Coaching in Residency: An Essential Component within CBME

Primary Category
Assessment – learner (summative, formative, programmatic) or program

Presenters
Sallie DeGolia, MD, MPH, Stanford University School of Medicine
Anita Kishore, MD, Stanford University School of Medicine
Alissa Rogol, JD, MD, Stanford University School of Medicine
Sam Saenz, MD, Stanford University School of Medicine

Educational Objectives
Participants will be able to:
1. Recognize how a coaching program fits into Competency-based Medical Education
2. Identify the goals, benefits and elements of a psychiatry coaching program
3. Appreciate the challenges of implementing a coaching program and ways to address them
4. Strategize how to implement such a program into your own residency structure

Abstract
A well-conceived coaching program can represent part of a carefully designed competency-based assessment program. Coaching is becoming more recognized within medical training (Theeboom, Beersma, van Vianen 2013) as an important component of skill and professional development with particular focus on deliberate practice. By positioning itself in a work-based setting, coaching is more responsive than mentoring as a way to meet the needs of adult learners through observing, engaging in reflective, bidirectional feedback, and actively resetting goals. Through this process, coaching can engage learners as co-producers of their own education and competency, leading to the development of lifelong learners who can self-regulate their own learning (Konings et al 2016). Furthermore, with longitudinal coaching, a psychologically-safe space can be developed and has been shown to be particularly effective in reducing the pervasive imposter syndrome among medical learners by increasing self-enhancing attributions and strong self-efficacy beliefs while decreasing the tendency to cover up errors and fear of negative evaluation (LaDonna et al 2018; Zanchetta et al. 2020). Coaching has also enhanced faculty wellness through feeling a sense of belonging and being valued in multiple communities, offers the opportunity to develop multidimensional learning and skill development, and enhanced their professional identity formation – particularly as educators (Selling et al. 2023). In short, coaching impacts all learners – trainees and faculty alike.

The goal of Stanford Psychiatry's coaching program is to facilitate a continuous improvement cycle where the coach and resident partner. Through an empowering and learner-focused approach, coaching will build capacity instead of dependency, and move all learners towards mastery, while fostering an inclusive environment of belonging-- devoid of shaming or "othering" for those who may not be as skilled. Within our context, coaching has been particularly important as we increase diversity in our program and department and emerge from a global pandemic which has created undo strain on residents and impacted community cohesion.

To meet the demands of CBME and ensure all residents are ready for independent practice and perform at the top of their abilities as well as engage faculty to become better educators, we have developed a coaching program that encompasses direct observation, goal setting, formative feedback, and mentoring within the work setting.

We will provide a brief overview of coaching – a definition, how it fits into CBME, the evidence and how it works. We will also differentiate coaching from other roles such as supervision, mentorship, teaching, advocacy, and therapy. This will be followed by small group breakouts for programs to identify how such a program might be integrated into their residency structure. Finally, we will present Stanford's Coaching Program and discuss options for funding such a program and how to manage specific challenges that have arisen. We will end with a general Q&A session and wrap up with asking each participant to write down a specific action plan that they would like to implement on returning to their program.

Practice Gap

With the shift to competency-based training emphasizing performance outcomes over time, program directors and clinical faculty seek to optimally assess residents' readiness for independent practice. Though Direct observation represents the ideal assessment method (Holmboe 2015, Iobst et al. 2010) with effective, bidirectional formative feedback as a necessary intervention to improve performance, it has been challenging to implement because of a lack of faculty time and/or skill as well as potential stress for the learner (Fromme, Karani and Downing 2009). In addition, lack of financial compensation for time spent observing trainees, faculty scheduling challenges, competing demands, and difficulty incorporating direct observation into an existing structure creates significant barriers to implementing direct observation (Madan, Conn, Dubo, Voore and Wiesenfeld 2012).

Agenda

5min | Welcome & Introductions | Interactive | SDG
5min | What is coaching to YOU | Interactive | AR
15 min | What is Coaching? | Mini-Lecture | SDG
20min | Coaching into your residency | Small Group Breakouts | AK

15 min | Stanford's Coaching Program | Mini-Lecture | SDG
20 min | Q&A/Explore barriers | Interactive | ALL
10 min | Goal setting | Interactive | All

Scientific Citations

• Fromme, Karani and Downing Direct observation in medical education: a review of the literature and evidence for validity.Mt Sinai J Med. 2009 Aug;76(4):365-71.

• Holmboe ES: Realizing the promise of competency-based medical education.Acad Med. 2015 Apr;90(4):411-3.

• Iobst WF, Sherbino J, Ten Cate O, Richardson DL, Dath D, Swing SR, Harris P, Mungroo R, Holmboe ES, Frank JR, International CBME Collaborators: Competency-based medical education in postgraduate medical education, Medical Teacher 32(8):651-656, 2010, DOI: 10.3109/0142159X.2010.500709

• Konings KD, van Berlo J, Koopmans R, et al. Using a smartphone app and coaching group sessions to promote residents' reflection in the workplace.Acad Med 2016;91(3):365–70.)

• LaDonna KA, Ginsburg S, Watling C. Rising to the level of your incompetence": what physicians' self-assessment of their performance reveals about the imposter syndrome in medicine. Acad Med 2018;93(5):763–8.)]

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• Selling SK, Rooholamini SN, Grow HM, McPhillips H, Hoang K, Blankenburg R, and Rassbach C. The effects of coaching pediatric residents on faculty coaches' relationships, learning, and professional identity formation. Academic Medicine. 98(3):376 – 383, March 2023

• Theeboom T, Beersma B, van Vianen AEM: Does coaching work? A meta-analysis on the effects of coaching on individual level outcomes in an organizational context, The Journal of Positive Psychology (2013)

• Zanchetta M, Junker S, Wolf AM, Traut-Mattausch E: "Overcoming the Fear That Haunts Your Success" - The Effectiveness of Interventions for Reducing the Impostor Phenomenon.Front Psychol. 11:405, 2020

Title
Crispy to Cool: Using Emotional Intelligence to Combat Burnout in Leadership

Primary Category
Wellness, Burnout, Resilience

Presenters
Jessica Obeysekare, MD, Prisma Health- Upstate/University of South Carolina School of Medicine Greenville (Greer) Program
Megan Zappitelli, MD, Prisma Health/University of South Carolina School of Medicine - Greenville

Educational Objectives
At the conclusion of this session, the participant will:
1. Reflect upon the literature regarding the prevalence of burnout in psychiatry leadership and the relationship between burnout and emotional intelligence.
2. Complete a self-assessment regarding emotional intelligence.
3. Learn about skills that foster emotional intelligence.
4. Apply learned skills in a team-based simulated scenario.
5. Consider ways to promote the growth of emotional intelligence skills in their home institution.

Abstract
As physicians navigate the complexities and demands of modern medicine, physician burnout continues to be an increasing problem in the United States (1). The impact of burnout on the physician workforce is substantial (2). Burnout among program directors and assistant/associate training directors, while not as alarming as rates of burnout among physicians-in-training, is commonly associated with the desire to resign and a struggle to find meaning in the highly demanding position of Training Director or Associate Training Director (3).

During this session, the presenters will introduce participants to using improved Emotional Intelligence (EQ) skills as a potential strategy for combating burnout and for inspiring meaning in their training leadership role. Emotional Intelligence (EQ) is the ability to have insight about yourself as well as others and the ability to manage your behavior and relationships. Developing these skills has positive effects on how relationships and connections are built through enhancing positive communication, effectively managing conflicts, and reducing burnout, and could be a helpful tool in reducing burnout and in nurturing resilience in training directors and associate training directors.

The association between EQ and burnout has been studied previously, with most research affirming an inverse association between the two (4). Despite this, EQ has not been considered a vital component in the medical training of physicians. Given that the complex role of training directors and associate training director necessitates building relationships, solving crises, securing jobs for residents and maintaining well-being of trainees (4) in addition to all the other administrative responsibilities in this role, enhancing EQ could predictably support professional development for psychiatric training leadership. There is evidence that leading with EQ ensures relationship and rapport building, positive communication, effective conflict management, and a reduction in burnout (5).

In this workshop we will explore the research between EQ and burnout and will describe examples of EQ-building skills. The participants will then divide into small groups for small group reflective activities to self-assess and then to apply EQ skills. Finally, participants will discuss ways that these skills could be incorporated into their home institutions to help support leaders in psychiatric residency training.

Practice Gap

Despite physician burnout growing at an alarming rate, there are limited effective interventions to blunt this trend. Concerns about burnout led the Accreditation Council for Graduate Medical Education (ACGME) to require residency Program Directors to develop policies and procedures to encourage optimal resident and faculty well-being; however, the ACGME does not address the health and wellness of Program Directors other than ensuring access to education and screening materials as faculty members (3). Emotional Intelligence (EQ) is the ability to have insight about yourself as well as others and the ability to manage your behavior and relationships. While it is likely that training directors have inherent or developed high EQ, intentional growth of these skills could be considered as a helpful tool in reducing burnout and nurturing a long and meaningful career for leaders in psychiatric training.

Agenda

0-3 minutes: Introduction
3-13 minutes: Brief overview of the literature demonstrating the prevalence of burnout in psychiatry leadership
13-25 minutes: Discuss Core Emotional Intelligence (EQ) Skills for Personal Growth
25-40 minutes: Complete a self-assessment regarding emotional intelligence
40-60 minutes: Introduce and practice EQ skills in a small group
60-75 minutes: Large group discussion reflecting on this experience.
75-80 minutes: Postcards: Please reflect and write what you would like to remember about your emotional intelligence skills after attending this workshop? Write your own address and we will send it back to you in 3 months.
80-85 minutes: Questions

85-90 minutes: Evaluation

Scientific Citations

1. Ortega MV, Hidrue MK, Lehrhoff SR, Ellis DB, Sisodia RC, Curry WT, Del Carmen MG, Wasfy JH. Patterns in Physician Burnout in a Stable-Linked Cohort. JAMA Netw Open. 2023 Oct 2;6(10):e2336745. doi: 10.1001/jamanetworkopen.2023.36745. PMID: 37801314; PMCID: PMC10559175.Park C, Lee YJ, Hong M, Jung CH, Synn Y, Kwack YS, Ryu JS, Park TW, Lee SA, Bahn GH. A Multicenter Study Investigating Empathy and Burnout Characteristics in Medical Residents with Various Specialties. J Korean Med Sci. 2016 Apr;31(4):590-7. doi: 10.3346/jkms.2016.31.4.590. Epub 2016 Mar 2. PMID: 27051244; PMCID: PMC4810343.

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6. Accreditation Council for Graduate Medical Education (ACGME). ACGME Common Program Requirements (Residency) [Internet]. 2020 Accessed at https://www.acgme.org/globalassets/pfassets/programrequirements/400_psychiatry_2022_tcc.pdf

7. Shrivastava S, Martinez J, Coletti DJ, Fornari A. Interprofessional Leadership Development: Role of Emotional Intelligence and Communication Skills Training. MedEdPORTAL. 2022 May 13;18:11247. doi: 10.15766/mep_2374-8265.11247. PMID: 35634034; PMCID: PMC9098732.

AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Empowering Change in Psychotherapy: Innovative Psychodynamic Teaching Strategies for PGY3 & 4 Residents

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Richard Summers, MD, Perelman School of Medicine University of Pennsylvania
Scott Campbell, MD, Perelman School of Medicine University of Pennsylvania
Marla Wald, MD, Duke University Medical Center
Judith Lewis, MD, University of Vermont Medical Center

Educational Objectives
1. Identify three challenges to teaching psychodynamic thinking and deepening resident skills in the PGY3 and PGY4 years of the psychiatry residency in an evolving medical education landscape.
2. Recognize the six mechanisms of change present in psychodynamic therapy and describe basic skills for engaging and leveraging these mechanisms.
3. Become familiar with materials participants can bring back to their home programs on teaching mechanisms of change useful for resident training and fostering the development of future psychotherapy educators.

Abstract
This workshop will help training directors enhance psychodynamic training in the PGY3 and 4 years of their programs by experiencing the value of learning about the six evidence-based change processes that occur in psychodynamic therapy. By adopting a common-sense, jargon-free approach, we aim to modernize psychodynamic education, making it more accessible, engaging, and relevant for a wide range of clinical settings.

We discuss current challenges to psychodynamic training, the need for inclusive, contemporary teaching practices and demonstrate teaching about change through brief presentation, video clips, break-out groups, and participant discussion. The take-home kit includes content material overviewing these change processes (both written and powerpoint) and a catalog of public-domain videos to support teaching. We focus also on using this approach to develop the next generation of psychodynamic faculty who are less steeped in the psychoanalytic traditions than their predecessors.

Practice Gap
Psychodynamic therapy training is popular among residents and residency applicants, enhances skills in a variety of clinical settings, and is an ACGME requirement. But, a generation of older psychotherapy faculty, often psychoanalysts, are retiring; historical and bias-laden psychoanalytic concepts are often difficult to grasp and/or clash with a more contemporary understanding of race, culture, gender and identity; and there is a

need to develop more engaging, “experience near” and jargon-free conceptualizations and teaching techniques for the current generation of learners.

Focusing on change in psychodynamic therapy, and teaching residents (and younger faculty) about how to make it happen, makes learning psychodynamics salient, digestible, teachable, and ultimately, perhaps measurable.

Agenda
5 Minutes – Introductions and disclosures
5 Minutes – Grappling with the challenges of psychodynamic training from a new Program Director’s perspective (Campbell)
5 Minutes – Innovative approaches to teaching psychodynamics in the PGY3 and 4 years (Lewis and Wald)
20 minutes – Change mechanisms in psychodynamic therapy: An evidence-based framework (Summers)
5 minutes – Video Clip #1
10 minutes – Small break-out groups/pair share to discuss and identify mechanisms of change in video clip #1 (Faculty)
5 minutes- Report out to large group (Faculty)
5 minutes – Video clip #2
15 minutes – Large group discussion of video clip #2 (Faculty)
10 minutes - Large group discussion about opportunities and barriers to implementation of this curriculum (Faculty)
5 minutes - Workshop evaluation

Scientific Citations
1. Barber, J.P., Milrod, B., Gallop, R., Solomonov, N., Rudden, M.G., McCarthy, K.S.. & Chambless, D.L. (2020). Processes of therapeutic change: Results from the Cornell-Penn Study of Psychotherapies for Panic Disorder. Journal of Counseling Psychology, 67(2), 222-231. http://dx.doi.org/10.1037/cou0000417 DOI: 10.1037/cou0000417

2. Keefe, J.R, Solomonov, N., DeRubeis, R.J., Phillips, A.C., Busch, F.N., Barber, J.P., Chambless, D.L., & Milrod, B.L. (2019). Focus is key: Panic-focused interpretations are associated with symptomatic improvement in panic-focused psychodynamic psychotherapy, Psychotherapy Research, 29:8, 1033-1044. DOI: 10.1080/10503307.2018.1464682

3. Sudak D, Brenner A: The Future of Psychotherapy Training, Academic Psychiatry online August 7, 2024. https://doi.org/10.1007/s40596-024-02022-5

4. Summers RF, Barber JP, Zilcha-Mano S: Psychodynamic Therapy: A Guide to Evidence Based Practice, 2nd Edition. New York, Guilford Press, 2024.

5. Tadmon D, Olfson M, 'Trends in Outpatient Psychotherapy Provision by U.S. Psychiatrists: 1996–2016, American Journal of Psychiatry, December 8, 2021, Volume 179, Number 2, accessed Sept 15, 2024,

https://doi.org/10.1176/appi.ajp.2021.21040338

Title
Integrating Lifestyle Interventions into Psychiatric Residency Training

Primary Category
Curriculum

Presenters
Ramaswamy Viswanathan, MD, SUNY Downstate Medical Center
Steve Sugden, MD, MPH,
Gia Merlo, MBA, MD,

Educational Objectives
1. Describe how dietary changes improve mood and enhance remission rates from depression and may prevent the risk of cognitive disorders.
2. Identify evidence-based connectedness strategies that support mental health.
3. Evaluate the evidence for the efficacy of increasing exercise and other physical activity for people with psychiatric disorders.

Abstract
Lifestyle medicine is a burgeoning evidence-based modality. Lifestyle psychiatry targets health behavior change, brain health, and patient well-being through the lens of the biopsychosocial-lifestyle model of health. More importantly, this new biopsychosocial-lifestyle lens turns the focus on contextual, social-environmental, and social-economic position factors as they govern lifestyle behaviors. Lifestyle psychiatry is not based in complementary or alternative medicine, but rather, it employs a conventional medicine lens to psychopathology. Lifestyle treatment modalities can be beneficial whether a person wants to focus on well-being, use lifestyle as an adjunct treatment for diagnosed psychiatric disorders, or a primary modality for mental health disorders when they are mild to moderate without safety concerns. Overall, this session will introduce the clinical applications of lifestyle psychiatry, integrate the foundations of lifestyle medicine, neuroscience related to personality and individual factors, cognitive-behavioral approaches, positive psychology, psychopathology, neurobiology, and health neuroscience. We will discuss how lifestyle approaches can be taught in psychiatry residency training.

Practice Gap
Despite the growing number of medications, psychotherapeutic and other interventions, many patients with mental illnesses do not sufficiently improve. Psychiatric patients also suffer from increased physical morbidity and shorter lifespan. Many psychiatrists and trainees are not aware of evidence-based literature that shows incorporating lifestyle interventions significantly improves both physical and mental health; that there are well-designed clinical trials showing that, some of which also show brain imaging and neurochemical, and other biologic changes that may underlie these improvements. Most residency training programs do not include lifestyle interventions in their curriculum. Thus many trainees graduate without the knowledge and skill set needed to incorporate lifestyle medicine in their treatment approach. They are not aware of nuanced and specific interventions related to physical activity, sleep, nutrition, gut microbiota, chronic inflammation, stress amelioration, positive social connectedness, and avoidance of harmful substances.

Agenda
15 minutes: Introduction and importance of lifestyle in psychiatry
10 minutes: Inflammation and Neuroplasticity
25 minutes: Nuts and Bolts of Lifestyle Psychiatry along the six pillars, including nutrition, physical activity, connectedness, stress, sleep, and toxic substance exposure
15 minutes: An unmet need: integrating lifestyle training into psychiatry training
25 minutes: Questions and Answers

Scientific Citations
Marx W, Manger SH, Blencowe M, Murray G, Ho FY, Lawn S, et al. Clinical guidelines for the use of lifestyle-based mental health care in major depressive disorder: World Federation of Societies for Biological Psychiatry (WFSBP) and Australasian Society of Lifestyle Medicine (ASLM) taskforce. World J Biol Psychiatry. 2023;24(5):333–86. doi: 10.1080/15622975.2022.2112074. Epub 2022 Oct 6. PMID: 36202135.

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Merlo G, Bachtel G, Sugden SG. Gut microbiota, nutrition, and mental health. Front Nutr. 2024;11:1337889. doi:10.3389/fnut.2024.1337889. PMID: 38406183; PMCID: PMC10884323.

Richardson K, Petukhova R, Hughes S, Pitt J, Yücel M, Segrave R. The acceptability of lifestyle medicine for the treatment of mental illness: perspectives of people with and without lived experience of mental illness. BMC Public Health. 2024;24(1):171. Doi: 10.1186/s12889-024-17683-y. PMID: 38218774; PMCID: PMC10787508.

Title
It's not always an imposter syndrome: Tolerating uncertainty in psychiatry.

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Paul Baker, MD, The Warren Alpert Medical School of Brown University
Samir Patel, MD, The Warren Alpert Medical School of Brown University

Educational Objectives
By the end of this workshop, participants should be able to:
1. Anticipate common sources of uncertainty in psychiatric training and its effects on residents.
2. Utilize principles of adult learning to engage residents in reflecting on their own experiences of uncertainty and developing professional identity.
3. Apply lessons in managing uncertainty to curricula within participants' own programs.

Abstract
Uncertainty is ubiquitous within psychiatry. Trainees must learn to tolerate clinical uncertainty, a skill that is directly correlated with general self-efficacy. Trainees must also learn to differentiate between the limitations of their individual knowledge and that of the field as a whole. Under a model of competency-based education, learning how to manage uncertainty needs to be made more explicit than has been the case historically. Since comfort with uncertainty does not correlate with the choice of medical specialty, we cannot expect psychiatry residents to have a greater "innate" capacity to manage uncertainty. This workshop will describe an experiential learning model implemented in our residency program with the explicit goal of cultivating residents' resilience by improving their capacity to tolerate uncertainty. In collaboration with the residents, we identified several common sources of uncertainty in training and practice. These include the power differential inherent in the supervisor-trainee relationship, the impact of race, class and politics in clinical encounters, ego-vulnerabilities within trainees, the desire for personal fulfillment from clinical encounters, and so on. These sessions were deliberately held with the entire residency cohort, as research suggests that discussing uncertainty between peers of different levels of training can boost reflection and manage stress associated with uncertainty. This series has been well-received by residents, resulting in an expansion of the series after its initial pilot year. Time in the

workshop will be used to model how this experiential learning is conducted with residents.

Practice Gap
Learning to tolerate uncertainty is a vital part of medical and psychiatric education. Despite the importance of this developmental task, there is limited research on the ways in which residents learn to manage uncertainty in their clinical work and professional identities. Lessons in tolerating uncertainty are often implicit rather than explicit and highly dependent on individual supervisor-trainee relationships. When residents are unable to tolerate their feelings of uncertainty and its attendant shame, they may be at higher risk to engage in unprofessional behavior in training and clinical practice.

Agenda
5 minutes: Welcome and Introduction.
15 minutes: Review of the impact of uncertainty and the need to develop new strategies to help residents tolerate uncertainty.
15 minutes: Small group discussion – how to discuss identity and power in training and supervision.
15 minutes: Large group debrief and further discussion.
15 minutes: Small group discussion—teaching residents to manage “the what-ifs?” in clinical practice.
15 minutes: Large group debrief.
10 minutes: Closing comments and evaluation.

Scientific Citations
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Title
Organizational Equity: Building More Equitable Training Programs

Primary Category
Program Administration and Leadership

Presenters
Belinda Bandstra, MA, MD, University of California, Davis
Lillian Houston, MD, Southern Illinois University School of Medicine
Kai Anderson, MD, MA, Central Michigan University College of Medicine
Enrico Castillo, MD, MS, UCLA Neuropsychiatric Institute & Hospital/Greater Los Angeles Healthcare System (VAMC)
Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center

Educational Objectives
Upon completion of this session, participants will be able to:
1. Define organizational equity.
2. Describe examples implemented at AADPRT to improve equity in its leadership structure.
3. Identify opportunities within your institution to enhance organizational equity.
4. Develop a plan to apply organizational equity principles to your residency program, department, or institution.
5. Discuss challenges of implementing an equitable structure at your institution.

Abstract
How do you select your chief residents? How do you select applicants for awards? How do you select members for a committee? How are opportunities distributed in your organization? Distinct from “diversity” and “inclusion,” with which it is sometimes conflated, “equity” is defined by the World Health Organization as “the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation).” The inquiry into the presence of unfair, avoidable or remediable differences among groups, and the effort to decrease those differences, is important for the work of organizations. In the business world, organizational equity defines the relative distribution of power and resources among key internal organizational stakeholders, including directors, executives, managers and all other employees (Bantukul et al. 2021). Within those contexts, organizational equity audits involve collecting and systematically reviewing a range of data sources, such as information about employee recruitment, hiring, retention and advancement, employee pay and benefits, employee experiences, engagement and satisfaction, and leadership prioritization and resource commitment, to leverage accountability in making progress toward greater equity (Capper et al., 2020). The American Association of Directors of Psychiatric Residency

Training developed an organizational equity committee in 2022, in an effort to intentionally identify and address questions of equity in its own leadership and constituency. This interactive workshop aims to define the concept of organizational equity and share the process and findings of AADPRT's Organizational Equity Committee in its first two years of existence. We will discuss an approach to implement concepts of organizational equity in attendees' home institutions and spheres of influence. We will create a plan to apply this framework in individual training programs and departments. Finally, we will discuss challenges of implementing such structures in our organizations.

Practice Gap

We are at a pivotal moment when health inequities are at the center of many conversations. While the term equity is often used, its precise meaning is frequently misunderstood. Furthermore, while many champion equity at broad societal levels, attaining equity in local contexts can be difficult to achieve. Organizational equity is a useful framework to implement a fair and just distribution of power in leadership and resource allocation. This framework has been essential in organizations like AADPRT and can be incorporated into psychiatry departments and residency training programs to improve opportunities and outcomes for institutions and communities. This workshop will teach attendees how to implement organizational equity in a psychiatry department and training program.

Agenda

Introductions and small group discussion of organizational equity followed by large group debrief - 15 minutes
Mini-didactic on the concept of organizational equity - 10 minutes
Small group case discussion - 15 minutes
Mini-didactic on AADPRT's organizational equity efforts - 15 minutes
Think-Pair-Share on ways to improve organizational equity at participants' home institutions - 15 minutes
Large group debrief - 10 minutes
Final thoughts/questions - 10 minutes

Scientific Citations

Bantukul, A, Carter, T, Fevry, C, Schlobohm, A, and Sloan, R. (2021). Organizational Equity: A Key Metric for Successful Organizations [white paper]. Retrieved August 31, 2024 from Kean Institute of Private Enterprise, UNC Kenan-Flagler Business School: Organizational_Equity_02232021.pdf (unc.edu).

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Liera, R., & Desir, S. (2023, July). Taking equity-mindedness to the next level: The equity-minded organization. In Frontiers in Education (Vol. 8, p. 1199174). Frontiers Media SA.

AADPRT magpadayon!
LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
Overcoming Communication Challenges During the Disciplinary Process: Guidance for New PDs

Primary Category
Program Administration and Leadership

Presenters
Bini Moorthy, MD, University of Missouri-Kansas City School of Medicine
Kim Lan Czelusta, MD, Baylor College of Medicine
Akhil Anand, MD, Case Western Reserve University/University Hospitals of Cleveland Program
Narpinder Malhi, MD, Christiana Care Health System

Educational Objectives
1. Review guidelines in the assessment and management of residents with difficulties
2. Discuss challenges in recognizing and dealing with professionalism lapses in trainees
3. Identify barriers regarding communications about the disciplinary process with faculty and residents
4. Discuss strategies in mitigating adverse outcomes

Abstract
Professionalism is a core ACGME requirement that must be taught, assessed, and remediated for residents to meet professional standards during training. Assessing, monitoring, teaching, and remediating a resident with professionalism concerns can be overwhelming for Program Directors. Although professionalism can feel intuitive and obvious, it is also complex and one of the most time-consuming and challenging core competencies to address. Programs cannot assume that all residents and faculty agree about what professionalism entails. In addition, Program Directors often need to have difficult conversations with faculty and residents during and after a resident disciplinary action. Balancing transparency about the disciplinary process and confidentiality for the resident can be exceedingly difficult and lead to unintended consequences. Content and timing of communications is critical in mitigating fear amongst residents and negative ACGME survey results. Program director's communication, whether verbal, written and/or nonverbal, can have several interpretations with suboptimal outcomes. Program directors can face burnout and often need support and guidance while navigating the disciplinary process. The focus of our workshop will be to review the steps in the assessment and management of residents with difficulties. We would like to highlight the hidden challenges of the Program Director's communications related to the disciplinary process and explore strategies to mitigate adverse outcomes.

Practice Gap

This workshop is designed to increase the knowledge and skill of participants by reviewing the options available to residency programs' when dealing with a difficult resident situation. Professionalism is the most challenging learning deficits to identify and address. Program Directors (PDs) can be caught off guard and ill-prepared to handle such situations. PDs are expected to communicate with the residents, faculty and GME, in an effective manner. PDs can face scrutiny during this process and should be aware of the hidden threats involved. PDs must balance transparency and confidentiality while considering the resident's needs to ensure a fair and equitable process. Our workshop will address how to best handle communication challenges, maintain professional balance and integrity of the program. Using a case-based, interactive format, we hope to generate discussion from participants and share our experiences on effective strategies for management and communication when addressing professionalism issues.

Agenda

Objectives and introduction - 5 minutes
Overview of the assessment and management of residents with difficulties - 15 min
Case presentations - 15 minutes
Small group discussion- 25 minutes
Large group discussion - 15 minutes
Final thoughts on best practices - 15 minutes

Scientific Citations

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Title
Sustaining Inclusion: Charting Psychiatry's Future After SCOTUS Rulings

Primary Category
Recruitment and Selection

Presenters
Lauren Hanna, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell
Min Hyung (Arlene) Lee, MD, Zucker School of Medicine at Hofstra/Northwell at Mather Hospital Program
Brian Hodge, MD, Zucker School of Medicine at Hofstra/Northwell at Mather Hospital Program
Sarah Marks, MD, MS, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Educational Objectives
1. Understand and appreciate the importance of sustaining diversity in medical education and residency training to ensure culturally competent care and address healthcare disparities in diverse populations
2. Explain the key aspects of recent anti-DEI legislation and how it impacts recruitment practices
3. Appreciate how your program's underlying vision and mission should drive recruitment practices (tying recruitment practices with deliberate program goals)
4. Engage in group discussions to identify and formulate practical strategies for residency programs to continue upholding mission-aligned admissions practices that support DEI goals in the post-ruling landscape

Abstract
The 2023 Supreme Court ruling has created uncertainty and challenges for residency programs seeking to foster diverse and inclusive training environments. By placing new constraints around the consideration of race in admissions processes, the decision could potentially reduce the diversity of incoming residency classes. This workshop aims to review the impact of the Supreme Court ruling on race-conscious admissions and foster discussion on navigating its implications for residency program recruitment. Participants will explore how two different residency programs have adapted their admissions processes to align with their mission of maintaining a diverse cohort and will develop actionable plans for fostering diversity within their own residency classes and recruitment practices. Through interactive group activities and discussions, attendees will collaboratively devise strategies to sustain diversity, equity, and inclusion in residency programs in the wake of anti-DEI legislation.

Practice Gap
On June 29, 2023, the Supreme Court ruled on Students for Fair Admissions vs. Harvard and Students for Fair Admissions vs. University of North Carolina, fundamentally altering race-conscious admissions practices by finding that considering race or ethnicity in admissions violated the Equal Protection Clause of the 14th Amendment. Prior to this ruling, affirmative action policies were implemented to actively consider race in admissions to increase diversity and equity within educational institutions. Despite the ruling, it remains essential for residency programs to find ways to uphold their mission-aligned admissions processes and crucial that programs evaluate their current admissions practices to assess how they can effectively promote diversity and equity under the new legal constraints.

Agenda
20 min – Workshop introduction and presentation on history of structural racism, affirmative action, and recent anti-DEI legislation
25 min – Small group activity on mission-aligned recruitment practices
25 min – Small group discussion on barriers to and practical strategies for continuing to uphold anti-racist and DEI-driven recruitment practices
20 min – Large group discussion

Scientific Citations
Blackstock, O. J., Isom, J. E., & Legha, R. K. (2024). Health care is the new battlefront for anti-DEI attacks. PLOS Global Public Health, 4(4), e0003131. https://doi.org/10.1371/journal.pgph.0003131

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LEADING AND EDUCATING AMIDST CHANGE
2025 ANNUAL MEETING

Title
The Challenge of Identifying Fraudulent AI-generated Scientific Literature

Primary Category
Curriculum

Presenters
Madhavi Nagalla, MD, Western Michigan University School of Medicine
Bryan Makowski, MD, Western Michigan University School of Medicine
Heide Rollings, MD, Pine Rest Christian Mental Health Services

Educational Objectives
1] Demonstrate knowledge of the capacity for ChatGPT and other artificial intelligence tools to create realistic fraudulent articles.
2] Critique the limitations of Chat GPT and integrate this knowledge into the analysis of scientific literature.
3] Explore the potential of artificial intelligence tools to craft apparently authentic appearing scientific misinformation and how this could impact medical communication.

Abstract
The ACGME identifies one of the core milestones of psychiatric training as "Evidence Based and Informed Practice". This includes the capacity of residents to identify the "best available evidence" and the capacity to "Critically appraise and apply evidence even in the face of uncertainty and conflicting evidence"(1). With the advent of AI produced misinformation which can appear authentic even to experts in the field, the process of searching the internet for evidence from scientific studies is now potentially marred by misinformation(2). Misinformation in medicine is not a new phenomenon, however the unique aspect of AI to bring the appearance of expertise to misinformation with minimal time investment has not been well explored. Additionally, surveys show that physicians lack education in AI (3). Our session emphasizes that physicians should have training in how to critically assess the capabilities, benefits, limitations, and risks of AI in clinical practice.

This workshop will present a recent paper published in Journal of Medical Internet Research (4) and explore a paper about Pharmacogenomics testing written entirely by AI (5). Participants in the workshop will review the fraudulent paper produced by ChatGPT and then engage in a group discussion focused on the potential impact AI could have upon medical communication and also strategies to identify and address AI generated materials.

Practice Gap
The ACGME identifies one of the core milestones of psychiatric training as "Evidence Based and Informed Practice". This includes the capacity of residents to identify the

"best available evidence" and the capacity to "Critically appraise and apply evidence even in the face of uncertainty and conflicting evidence". With the advent of AI produced misinformation which can appear authentic even to experts in the field, the process of searching the internet for evidence from scientific studies is now potentially marred by misinformation. Recent surveys show that physicians lack education about AI. Our workshop focuses on filling this gap in training by educating learners regarding the capabilities, benefits, limitations, and risks of AI in clinical practice.

Agenda

Minutes 0-10: Review of AI generated content
Minutes 10-15: Small group discussion of AI generated content.
Minutes 15-25: Large group discussion of AI generated content.
Minutes 25-45: Presentation. The presenters will briefly introduce some basic principles of ChatGPT's function and discuss the prompts to produce the fraudulent paper.
Minutes 45-55: Large group discussion on methods to detect and avoid publishing AI produced content as human produced and how to avoid clinical decision making using fraudulent data.
Minutes 55-60: Bathroom and leg stretching break.
Minutes 60-70: Presentation. The presenters will briefly discuss some potential implications of AI produced misinformation.
Minutes 70-90: Large group wrap up and questions with a focus to brainstorm strategies that programs/faculty/trainees can take to identify and address AI generated materials .

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Title
The Life Cycle of A Chief Resident: From Selection To Development

Primary Category
Program Administration and Leadership

Presenters
Jennifer Ferrer, MD, Kaiser Permanente Southern California Program
Kathlene Trello-Rishel, MD, UT Southwestern Medical Center
Joseph Dragonetti, MD, Wake Forest University/Baptist Medical Center
Zhongshu Yang, MBBS, PhD, Kaiser Permanente Northern California Program (San Jose)
Angela Song, MD, MPH, Kaiser Permanente Northern California Program (San Jose)

Educational Objectives
Upon completion of this workshop, participants will be able to:
Develop a guideline for the Chief Resident selection process in Psychiatry using a DEI perspective
Identify common Leadership Competencies relevant to Chief Residents in Psychiatry and consider how they can be taught, applied and assessed in one's Home Institution.
Utilize a framework for Leadership Development in Chief Residents including both knowledge (content) and experiential (process) aspects of training

Abstract
In line with the ACGME's recognition of how increasing diversity in the physician workforce positively impacts health care access and patient outcomes, our workshop intends to support and promote a more standardized selection process of more diverse chief residents with key recommendations in mind including an open call for applications, standardized/structured interviews and the formation of a diverse selection committee to conduct a transparent selection process based on explicitly defined criteria (5).

After the identification of a Chief Resident, a deliberate approach to leadership skill development is essential. A curriculum that utilizes both didactic and experiential approaches is recommended. Didactic instruction is effective for imparting content knowledge that can help residents understand common leadership challenges and their solutions. However, this instruction will have a low yield for skill development unless paired with supervised leadership practice where residents practice application of leadership principles learned. Available evidence suggests that small group teaching, project-based learning, mentoring, and coaching are valuable components of leadership curricula and longitudinal curricula are more likely to be successful (2).

Appropriate skills are essential in order to measure the impact of leadership training. Residencies in various specialties have proposed and studied different competencies,

grouping them into categories such as self-care, professionalism, interpersonal skills, emotional intelligence, and coaching/supervision. (3,4) Some of the psychiatry residency milestones have leadership skills included in their description (usually in level 5), highlighting important areas that may deserve further emphasis for junior leaders in psychiatry. Additionally, there are certain competence domains that become more important as psychiatrists transition into leadership roles: whereas many trainees are focused on the medical knowledge and patient care domains, the domains of systems-based practice, professionalism, and interpersonal and communication skills become much more important and foundational for those in leadership roles. Frameworks for developing a broadly applicable psychiatry-specific leadership competencies will be reviewed.

Practice Gap

There are no clear best practices of chief resident selection, training and development. One key area warranting increased attention with opportunity for further study is addressing equity and bias in CR selection (1).

The importance of leadership skills for chief residents is undeniable. The ACGME acknowledges that the role and relative emphasis of leadership training will vary among programs and residents. Therefore, there are few requirements for leadership training for psychiatry. Curricula that facilitate leadership skill development are variable across programs, many gaps exist in understanding the value and best ways to teach leadership training (2).

Another challenge for programs is the establishment of a framework including the key dimensions for appropriate competencies that can be used to guide and measure the impact of chief resident training. Effectively developing chief residents early in their chief year sets a foundation for success.

Agenda

Introduction/Poll/Didactic: 10 min Chief Resident Interview and Selection Process using a DEI framework
Small Group: 10 min Discuss Chief Resident Interview and Selection Process at own Institutions. Share additional DEI practices to be implemented
Large Group: 10 min Share insights from small group discussion.
Didactic:10 min Chief Leadership Competencies and Applications in the Real World
Small group 15 min Discuss Leadership challenges that Chief Resident can face utilizing an assigned case scenarios- 3-4 examples (or can use own scenario). Case Scenario examples: Resident being bullied 2/2 race or sex orientation. Supporting impaired learners. Change Management- how to navigate being the “mediator” or “liaison” between admin leadership and the residents.
Large Group: 10 min Key Takeaways from small group discussion

Didactic: 10 min Best Practices for Developing a Chief Resident Leadership Development Curriculum. Utilize mentoring/coaching as a way to foster Leadership Development.
Conclusion/Q&A/Survey: 15 minutes

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Title
The many faces of PD burnout: what it looks like, how to prevent it, and how to rekindle the flame

Primary Category
Wellness, Burnout, Resilience

Presenters
Brendan Scherer, MD, San Mateo County Behavioral Health and Recovery Services.
Theadia Carey, BS, MS, MD, Authority Health/Michigan State
Sai Vedanti, MD, Authority Health/Michigan State

Educational Objectives
Participants will be able to describe signs and symptoms of burnout
Participants will appreciate the negative impacts of burnout on training environments: budgets, morale, turnover rates, reduced educational success
Participants will reflect upon the ways that burnout will present to various disciplines, including resident/fellows, APDs, themselves, and DIOs/Chairs and how someone in each role might respond
Participants will become familiar with the evidence and resources showing what can be done to help minimize program director burnout
Participants will develop a wellness/recovery action plan for their own potential burnout, with suggestions to various members of the training environment for what should be done

Abstract
This workshop focuses on what we know about burnout in program leadership (PDs/APDs), how that will present to people at different levels of training/hierarchy, and will provide some guidelines for what can be done to recognize, address and mitigate burnout. Burnout includes a triad of symptoms, including depersonalization, emotional exhaustion, and a decreased sense of personal accomplishment. Some work has been done to determine the prevalence of burnout in program directors, though much is yet to be learned. The factors that play a role in the higher rate of burnout in physicians will be covered briefly, and the audience will be asked to assess itself for aspects of burnout. The symptoms of burnout, while experienced internally, will manifest to trainees, APDs/colleagues, and chairs/DIOs in a variety of ways. The panel will review, by current stage in training, what is known about the presentations of burnout in that sphere. Factors that are known to help prevent burnout will be reviewed, and individual experiences of burnout and mitigation strategies will be discussed. This will facilitate several small group exercises, in which the skills to address burnout in colleagues will

be practiced and then cross-hierarchical personalized wellness plans, incorporating individual actions and desired institutional changes, will be developed

Practice Gap

While there is increasing knowledge about the prevalence of burnout in program directors, and the corresponding impact this has on the training program and institutions (increased turnover, increased anxiety in fellows and residents, increased costs, increased burnout in other providers), there has been limited effort to explore the way burnout manifests in interdisciplinary and hierarchical systems, nor guidelines of what people should do, depending on their role, in response to PD burnout. Here we look at what symptoms of burnout might present as to residents/fellows, Assistant/Associate Program Directors, DIOs, and PDs themselves, and provide guidance on how to appropriately prepare and respond.

Agenda

Kahoot with questions about prevalence and impact of burnout (5-10 minutes)
Introduction: Burnout: how it will manifest to residents, PDs, APDs, and DIO. Emphasis on job turnover, academic deterioration, economic loss to the system, institutional knowledge loss, worsened morale. (10 minutes)
1-question audience poll on their burnout/Word cloud from audience on their burnout sources (5 minutes)
Information on resources/resiliency for burnout/impairment. Actions the resident, APD or DIO can take if burnout noted. Role of emotional intelligence. Discuss what successful program directors say has enabled longevity. (10 minutes)
Small groups: role play providing feedback to the PD about their signs of burnout. (10 minutes)
Cross-hierarchy discussion of pre-communication about burnout. How to be vulnerable, facilitate de-idealization, and be a good role-model (10 minutes)
Small groups: develop a personal PD wellness action plan, focusing on internal and systemic strategies. Report outs. (15 minutes)
Advocacy for AADPRT Wellness curriculum.
Questions/answers.

Scientific Citations

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