

Division of Substance Abuse and Mental  
Health

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# Policies & Procedures

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The Delaware Psychiatry  
Residency Program

Approved on July 1, 2009

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# Table of Contents

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<a href="#"><u>Mission Statement for the Sponsorship of the Psychiatry Residency Program</u></a>	Section 1
<a href="#"><u>Graduate Medical Education Committee (GMEC) Mandate</u></a>	Section 2
<a href="#"><u>Benefits and Stipend</u></a>	Section 3
<a href="#"><u>Sample Agreement between the State of Delaware and Delaware Health and Social Services and Residents</u></a>	Section 4
<a href="#"><u>Moonlighting Policy</u></a>	Section 5
<a href="#"><u>Individual PGY Goals, Objectives, and Clinical Duties</u></a>	Section 6
<a href="#"><u>Remediation, Dismissal, and Due Process Policy</u></a>	Section 7
<a href="#"><u>ACGME General and Special Requirements for Psychiatry</u></a>	Section 8
<a href="#"><u>Policy on Sexual Harassment Prevention</u></a>	Section 9
<a href="#"><u>American Psychiatric Association Ethical Standards</u></a>	Section 10
<a href="#"><u>Policy on the Availability of Support Services</u></a>	Section 11
<a href="#"><u>Confidential Evaluation, Treatment Referral, and Resident Impairment Policy</u></a>	Section 12
<a href="#"><u>Supervision of Psychiatric Residents Policy</u></a>	Section 13
<a href="#"><u>Work Environment Policy</u></a>	Section 14
<a href="#"><u>Attendance Policy: Academic Credit, Leave of Absence, and Seminar Attendance</u></a>	Section 15
<a href="#"><u>Resident Appointment Eligibility, Selection, Promotion and Graduation Policy</u></a>	Section 16
<a href="#"><u>Evaluation Policy</u></a>	Section 17

## **Mission Statement for the Sponsorship of the Psychiatry Residency Program**

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The Delaware Psychiatric Center (a Joint Commission accredited hospital) is dedicated to providing an organized educational program for the training of psychiatry residents in a four-year residency training program. The bulk of training occurs in learning obtained through providing patient care under supervision. In addition, the Delaware Psychiatric Center provides a day free of clinical duties for didactic teaching. As the quality of patient care and an educational atmosphere are closely related, the Delaware Psychiatric Center will insure that the psychiatric residency program does not rely on residents to meet patient care needs at the expense of educational objectives.

The Delaware Psychiatric Center, under authority of the DPC Governing Body, has established an Institutional Graduate Medical Education Committee (IGMEC) which meets, at least, quarterly with recorded minutes to insure compliance with the General Requirements of the Essentials of Accredited Residencies in Graduate Medical Education, and the Special Requirements for Residency Training in Psychiatry.

The IGMEC will advise and monitor the following issues: institutional policies on quality assurance, resident financial support and benefits, resident supervision and working environment, ancillary support, conditions of resident employment and counseling/support services, maintenance of appropriate liaison with other institutions sponsored by the institution, establishment and implementation of institutional policies and procedures for discipline and grievance relevant to graduate medical programs, assurance of appropriate benefits and support services for resident positions, appropriate working conditions and work hours for residents, review of ethical, socioeconomic, medical/legal, and cost-containment issues that affect graduate medical education.

The IGMEC authorizes the Psychiatry Residency Program Director to provide the mechanism to assure that psychiatric residents and faculty perform according to expectations.

Institutional agreements will be made between a sponsoring institution and any other participating institutions or organizations for the provision of services to the sponsor's graduate medical education program as specified in the General Requirements. Rotations taken outside of the Delaware Psychiatric Center must enhance the educational program and be funded adequately.

The Delaware Psychiatric Center will provide residents with an educational environment of self-study and professional growth under:

- Guidance
- Participation in safe, effective, and compassionate patient care under supervision
- Participation in the educational and scholarly activities of the training program
- Participation in the institutional programs involving the medical staff and adherence to policies and procedures of the institution
- Participation in institutional committees

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- Participation in the evaluation of quality of education provided by the program
- The understanding of ethical, socioeconomic, and medical/legal issues that affect graduate medical education and how to apply containment measures in the provision of patient care.

The number and variety of patients will be adequate to support the educational requirements of the training program. Patients benefit from the presence of the psychiatric residency training program by the enhanced academic environment, lowered physician to patient ratio, and faculty supervision structure. The teaching faculty enhances their clinical skills by having the opportunity to teach psychiatric residents and also by participating in other educational activities, including Grand Rounds.

## **Graduate Medical Education Committee (GMEC) Mandate**

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*Last Revision: 12-07-1997*

**Purpose:** The Graduate Medical Education Committee's (GMEC) function is to ensure high quality training for The Delaware Psychiatry Residency Program. In this regard, the GMEC shall strive to help maintain a good balance of clinical experience, clinical teaching, and didactic teaching while adhering to the Accreditation Council for Graduate Medical Education (ACGME) Institutional and Special Requirements in Psychiatry.

**Scope:** This policy applies to the Delaware Psychiatry Residency Program.

1. The GMEC shall advise and monitor the establishment and implementation of policies and procedures for the selection, evaluation, promotion, and discipline of residents and overall functioning of the residency program. (Please see separate policies for each of these matters.)
2. GMEC members are appointed by the Program Director of The Delaware Psychiatry Residency Program. The appointments are for the academic year. Members are requested to give sixty (60) days written notice of their intent to resign from the GMEC to the Program Director. The Program Director may withdraw a member's appointment to the committee by giving the member sixty (60) days written notice. The member can appeal that decision to the Medical Director of the Delaware Psychiatric Center whose decision will be final. The makeup of the GMEC is intended to have a mixture of administrative, didactic, and clinical faculty, including one resident representative, usually the Chief Resident. The number of members is intended to be approximately eight in order to insure active participation and adequate knowledge of psychiatric residency training issues.
3. The GMEC meets on a monthly basis with extra meetings scheduled as necessary. Members are given meeting minutes and any other relevant material that may help the members make informed decisions as to the administration of the residency program. All members have been given copies of the ACGME General Requirements, the Special Requirements for Psychiatry, the written Policies & Procedures manual, the curriculum/didactic schedule, resident rotation schedule, and the goals and objectives for each post-graduate year (PGY) and rotation.
4. An agenda is handed out at each meeting with opportunity to discuss any new business. Ongoing and new issues are discussed. Written policies and procedures are reviewed, at least once a year, for completeness, effects, and adherence to General and Special Requirements guidelines. The GMEC will be chaired by the Psychiatry Residency Program Director. Issues will be voted on in a simple majority fashion. A minimum of four members need to present for an official meeting to take place.
5. The GMEC will form a subcommittee for curriculum planning and administration. The subcommittee will be made up of GMEC members, and a resident member will report back to the full GMEC, at least, twice yearly, on curriculum issues and will submit a schedule of courses at least twice per year.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

6. Other subcommittees may be established as needed in regards to Grand Rounds planning, budget, and other needs.
7. The GMEC will, at least twice yearly, review the evaluations for each resident, seminar/instructor, and rotation/supervisor, and the residency as a whole.
8. The GMEC will be responsible for implementing the necessary actions described in the disciplinary and grievance policies.

## **Resident Benefits**

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*Last Revision: 07/01/2009*

1. Contractual Obligations:  
Residents are appointed for twelve (12) months and reappointed annually based upon a satisfactory evaluation of performance by the GMEC. Contracts of less than twelve (12) months may be given under special circumstances.
2. Salary:  
Delaware Psychiatric Center offers a competitive salary. See attachment A in section 4.
3. Book Allowance:  
\$500.00 per resident per academic year through Rittenhouse Book Distributors, Inc.
4. Vacation / Personal Time / Worker's Compensation:  
Residents will receive 15 days of paid personal time. Personal time can be used towards vacation and sick time as per GMEC guidelines. Unused vacation time will be forfeited at the end of the academic year and will not be carried over from one academic year to another. Unused personal time will not be redeemed for equivalent salary.
5. Holidays:  
Residents must observe the holiday schedule of the hospital/institution at which they are rotating. If required to work a holiday, a "comp" day does not accrue
6. Conference Time:  
Residents may receive up to five (5) days of paid leave to attend conference and external training per academic year at the discretion of the Program Director. Unused conference time will be forfeited at the end of the academic year and will not carry over to the next academic year. Conference time will not be redeemed for equivalent salary.
7. Family Leave:  
Residents, who apply to the Family and Medical Leave Act of 1993, are covered for the following:
  - a. Care for an employee's child after birth, or placement for adoption or foster care;
  - b. To care for an employee's spouse, son, daughter, or parent who has a serious health condition; and/or
  - c. For a serious health condition that renders employees unable to perform their job.
8. On-Call Duty:  
Residents are provided adequate sleeping quarters for on-call duty.
9. Parking:  
Parking is provided free of charge on the Delaware Psychiatric Center campus.

10. Health Insurance Reimbursement:

Residents are given the choice to receive insurance, which includes, but is not limited to, health, dental, and life, through the State of Delaware.

11. Malpractice Insurance:

Residents will be reimbursed for the malpractice insurance courtesy of the program, through the APA endorsed PRMS (Professional Risk Management Services, Inc.) For a more detailed description of PRMS, please visit their website at [www.prms.com/index.htm](http://www.prms.com/index.htm).

Travel Funds:

The Institute may pay for all or most of all expenses when a resident presents a project, presentation, and/or research at a national meeting. In addition, the program encourages the involvement of residents in local and national psychiatric organizations and will support such activities as our budget allows.



SAMPLE AGREEMENT BETWEEN  
THE STATE OF DELAWARE  
DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH  
AND

\_\_\_\_\_ M.D.

THIS AGREEMENT is entered into between the State of Delaware, Division of Substance Abuse and Mental Health (The "Division") for the Department of Health and Social Services and \_\_\_\_\_, (Psychiatric Resident, PGY1 for the period July 1, 2009 through June 30, 2010).

WHEREAS: This AGREEMENT is being entered into by the Division which has determined the need to provide a full-time, four-year educational program in psychiatry which is approved by the Accreditation Council for Graduate Medical Education. Residents are appointed for twelve (12) months and re-appointed annually based upon a satisfactory evaluation of performance by the Program Director and the Graduate Medical Education Committee.

NOW, THEREFORE, for and in consideration of the mutual covenants hereinafter stipulated to be kept and performed, IT IS AGREED between the parties as follows:

1. Salary:

The Division shall provide the Resident with a stipend on a bi-weekly basis. Stipends are subject to all deductions required by state and federal law and such other deductions as Resident may authorize. (See Attachment A)

2. Malpractice Insurance:

Residents are required to have malpractice insurance and are responsible for adherence to DHSS Policy Memorandum 32 (PM32) for obtaining reimbursement for the insurance. In lieu of applying for reimbursement of paid malpractice insurance premiums as provided by DHSS Policy Memorandum 32 (PM32), Resident may apply in advance of premium payment for a draw against the total available allocation for malpractice insurance reimbursement in accordance with DHSS Policy Memorandum 32 (PM32). DSAMH is under no obligation to issue an advance draw to the Resident and may at its sole discretion approve or deny the issuance of an advance draw. The advance draw will be made payable to the Resident who will be required to maintain malpractice insurance and provide DSAMH with proof of premium payment, copies of the insurance policy and a certificate of insurance coverage and, in all other respects, comply with the requirements of PM32. Resident may apply for such an advance draw for payment of each installment of malpractice insurance premium with DSAMH funding limited to the amounts approved in PM32. Should insurance coverage be terminated or the Resident leave the residency program

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

prior to the expiration of the policy purchased with these funds, the Resident will be required to repay DSAMH on a pro-rated portion of the annual premium amount.

3. Medical Insurance:  
Residents are given the option to purchase medical, health, dental and vision insurance through the State of Delaware with deductions from the stipend. Delaware Psychiatric Center's Human Resource staff will provide information and options during orientation.
4. Worker's Compensation:  
Residents must comply with reporting requirements for any injuries sustained during the assigned rotations.
5. Personal Time:  
Residents will receive 15 days of paid personal time. Personal time can be used towards vacation and sick time as per GMEC guidelines. Unused vacation time will be forfeited at the end of the academic year and will not be carried over from one academic year to another. Unused personal time will not be redeemed for equivalent salary.
6. Holidays:  
Residents must observe the holiday schedule of the hospital/institution at which they are rotating. If required to work a holiday, a "comp" day does not accrue
7. Conference Time:  
Residents may receive up to five (5) days of paid leave to attend conference and external training per academic year at the discretion of the Program Director. Unused conference time will be forfeited at the end of the academic year and will not carry over to the next academic year. Conference time will not be redeemed for equivalent salary.
8. On-Call Duty:  
Residents are provided adequate sleeping quarters for on-call duty. On-call duties are part of training and no extra compensation is provided for on-call responsibilities.
9. Family and Medical Leave:  
Residents are eligible for FMLA. Any extended absence must be approved by the Residency Director.
10. Parking:  
Parking is provided free of charge on the Delaware Psychiatric Center campus.
11. Travel Funds:  
The program may consider paying for expenses when a resident presents a project, presentation, and/or research at a national meeting. In addition, the program

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

encourages the involvement of residents in local and national psychiatric organizations and will support such activities as our state budget allows.

12. The Resident shall take all opportunities for learning and perform satisfactorily and to the best of his/her ability the customary obligations of residency, including night and weekend call as determined by the assigned service during the period beginning July 1, 2009 through June 30, 2010. The Resident shall attend all supervision and didactic seminars.
13. The Resident's clinical work will be evaluated for knowledge and performance by his/her supervisors, seminar leaders and oral examination; the Resident shall demonstrate satisfactory performance in all areas examined in order to receive credit for the residency training period beginning July 1, 2009 through June 30, 2010.
14. The Resident shall be responsible for becoming immediately knowledgeable and keeping current with all the Division's policies and procedures which relate to the Resident's practice and shall correct any and all identified deviance from such policies and procedures expeditiously.
15. Residents are obligated to participate in criminal and other background check, Child Abuse Registry, drug testing, and meet requirements for the State of Delaware "Board of Medical Practice" to participate in the training program. The Division reserves absolute right to terminate contract immediately if these requirements are not met.
16. Termination of Agreement:  
The Delaware Psychiatry Residency Program reserves the right to terminate this Agreement or to take other action including, but not limited to, suspension of Resident participation in the Program if: (A) the Resident breaches any term or condition of this Agreement; (B) it is discovered that material facts presented by Resident at the time of application or re-application are misleading or untrue; (C) Resident agreement is terminated, subject to the due process requirements; (D) Resident fails to meet the performance or conduct standards of the Residency Program or to make reasonable progress towards those standards; (E) Resident violates the rules, regulations, policies or procedures of the Delaware Psychiatric Center and affiliated rotation sites; (F) Resident is convicted or enters a plea of guilty or nolo contendere to a felony or misdemeanor or any crime ; (G) Resident places the welfare of any patient in jeopardy; (H) Resident actions are not commensurate with good medical practice; (I) disciplinary action is imposed on Resident by a licensing board; (J) Resident displays conduct not commensurate with good moral standards including, but not limited to, unprofessional conduct; (K) if there is reasonable suspicion that Resident capacity is diminished by the use of drugs or alcohol; (L) if there is reasonable suspicion that Resident effective capacity has been seriously diminished by emotional, mental or physical factors; (M) Resident fails to fulfill residency responsibilities; (N) Resident fails to keep charts, records and reports, accurate, current and signed, including discharge summaries; (O) the Resident must demonstrate satisfactory performance in all areas examined and obtain required

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

training licenses in order to be promoted to the next training year. In order to be offered a PGY-3 agreement, passing result of the step 3 exam must be in the residency office 90 days prior to the end of the PGY-2 agreement.

17. This AGREEMENT may be terminated by either the Division or the Resident upon thirty (30) days' written notice to the other party. In the event of termination for any reason, the Division shall pay for all services rendered to the date of termination.
18. Both parties have entered into this AGREEMENT in good faith and acknowledge their respective ethical and legal obligations to fulfill its term until its expiration date. The AGREEMENT may be terminated in writing by either party in the event of substantial failure by the other party to fulfill its obligations under this AGREEMENT, through no fault of the terminating party, provided that no termination may be effected unless the other party is given thirty (30) days' written notice (delivered by certified mail, return receipt requested) of intent to terminate.  
  
Both parties will inform the other of cause or causes and provide the other opportunity to discuss freely and grievances, differences, or dissatisfactions which may exist with the exception that the Residency Training Director and/or Residency Program Graduate Medical Education Committee may suspend privileges to practice upon recognition of a serious practice problem without thirty (30) days' notice. The Delaware Psychiatry Residency Program Disciplinary and Grievance Policy will apply to all residents.
19. This AGREEMENT shall not be altered, changed, modified, or amended except by a written instrument executed by the Division and the Resident on the same form in this Agreement.
20. The Resident shall not enter into any sub-agreement for any portion of the services covered by this AGREEMENT.
21. This AGREEMENT includes all the terms and conditions agree upon between the Resident and the Division and shall not be amended except by written instrument executed with the same formality as this AGREEMENT.
22. This AGREEMENT shall be interpreted and any disputes shall be resolved according to the laws of the State of Delaware in courts of competent jurisdiction.
23. The waiver of any breach of this AGREEMENT by either party shall not operate as a waiver by such party of any of its rights or remedies as to any other breach.
24. If any provisions contained in this AGREEMENT are to be held unenforceable by a court of law or equity, this AGREEMENT shall be construed as if such provisions did not exist, and the unenforceability of such provisions shall not be to render any other provisions of this AGREEMENT unenforceable.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

25. This AGREEMENT is intended for the benefit of the Resident and the Division and is not intended to give any right to third parties.
26. The Resident shall perform all residency duties in a full-time capacity. All professional activities outside the Residency Program will be considered by the Division on a case-by-case basis according to the policies of the Residency Program (see Appendix A).
27. DSAMH shall provide the Resident with written clinical responsibilities (see Appendix B).
28. DSAMH shall provide the Resident with procedures for discipline (see Appendix C) and redress of grievances (see Appendix D).
29. DSAMH shall provide the Resident with a copy of the ACGME General Requirements and Special Requirements for Psychiatry (see Appendix E).
30. DSAMH shall provide the Resident with policies and procedures whereby complaints of sexual harassment and exploitation may be addressed (see Appendix F).
31. DSAMH shall provide the Resident with a copy of the American Psychiatric Association Ethical Standards (see Appendix G).
32. DSAMH shall provide the Resident with information concerning the availability of counseling, medical, psychological and support services (see Appendix H).
33. The Resident's signing of this AGREEMENT acknowledges the receipt and understanding of Appendixes A, B, C, D, E, F, G and H.

Dated: \_\_\_\_\_  
\_\_\_\_\_, Resident

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Dated: \_\_\_\_\_  
Kevin A. Huckshorn  
Director

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Dated: \_\_\_\_\_  
Rita M. Landgraf, Secretary

*Appendix A*

**I. Hours of Duty & On-Call Hours Policy**  
**1. Moonlighting Policy**

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**I. Hours of Duty & On-Call Hours Policy**

*Last Revision: 11-30-2007  
07-16-2004  
01-05-1998*

**Purpose:** Division of Substance Abuse and Mental Health, as the Sponsoring Institution, is committed to and responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.

**Scope:** This policy applies to the Delaware Psychiatry Residency Program.

**Policy:** The Sponsoring Institution policy is that resident duty and on-call hours will be in compliance with the guidelines established by the ACGME and that no exceptions to the ACGME duty and on-call hour requirements are permitted. The Institution will provide a supportive educational environment.

**Definitions:**

- **Duty hours** are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care; time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site. The resident shall perform all duties in full-time capacity.
- **New patient** is defined as any patient for whom the resident/fellow has not previously provided care.
- **One day off** is defined as one (1) continuous 24-hour period free from all clinical, educational, and administrative duties.

**Procedures:**

1. Hours of Duty:
  - a. Through carefully constructed duty hour assignments, it is recognized that faculty and residents collectively have responsibility for the safety and welfare of patients.
  - b. The Delaware Psychiatry Residency Program ensures that the learning objectives of the program are not compromised by exclusive reliance on residents to fulfill service obligations.
  - c. The resident is expected to be rested and alert during duty hours. Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply Institutional policies to prevent and counteract its potential negative effects on patient care and learning.
  - d. Didactic and clinical education is a priority in the allotment of residents' time and energy.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- e. Basic duty hours will be from 8:00 am to 4:30 pm, Monday through Friday. Patient obligations should be completed during the allotted time.
  - f. Working hours may differ from basic duty hours. Hours will be stipulated by each site rotation.
  - g. If, patient needs arise, minimum expectations of the resident are to ensure patient safety and appropriate treatment.
  - h. During outpatient psychiatry rotation, residents may be required to work evening hours to accommodate a higher functioning patient population.
  - i. If residents collectively find themselves working long hours, rotations will be carefully examined and adjusted so as to insure time for reading and other activities.
  - j. If a scheduled duty assignment is inconsistent with the Resident Agreement or the policy governing duty hours, the involved resident should bring that inconsistency first to the attention of the Residency Program Director for reconciliation or correction.
  - k. If the Residency Program Director does not reconcile or correct the inconsistency, it should be the obligation of the resident to notify the Graduate Medical Education Committee (GMEC), who should take the necessary steps to reconcile or correct the raised inconsistency.
2. On-Call Hours:
- a. Hours are from 4:30 pm to 8:00 am on weekdays, and from 8:00 am to 8:00 am on weekends and holidays.
  - b. The backup system includes a senior resident who is available via pager and will be available to come into the hospital to assist, if necessary.
  - c. An attending psychiatrist will be available via phone, and, if necessary, in person to discuss admission, diversion, or any other patient matter 24 hours a day, 7 days a week
  - d. The Residency Program Director will ensure that faculty is available to provide appropriate on call coverage.
  - e. If the Residency Program Director is unavailable, another faculty member will be designated as the Residency Program Director backup.

**Requirements:**

- 1. The resident:
  - a. Must not exceed 80 hours per week over a four-week period
  - b. Must not be scheduled to work more than 24 consecutive hours
  - c. Must have scheduled on-duty assignments separated by not less than ten (10) non-working hours.
  - d. Must have one day off per week.
    - i. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.
  - e. Must not accept new patients after 24 hours of continuous duty.
- 2. In-house call must occur no more frequently than every third night, averaged over a four-week period.
- 3. Duty Hours Exceptions:

- a. A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.
  - b. In preparing a request for an exception the Residency Program Director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.
  - c. Prior to submitting the request to the Review Committee, the Program Director must obtain approval of the Institution's GMEC and DIO.
4. If a resident moonlights, internal moonlighting must be considered part of the 80-hour weekly limit on duty hours (see Moonlighting Policy for further instruction), or 88-hour weekly limit with approved exception. The Program Director ensures that moonlighting or extra sessions will not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

**Monitoring of Duty Hours:**

1. Residents' duty hours are tracked and reviewed intermittently by the GMEC.
2. The Chief Resident attends the GMEC meeting and provides a report on the residents' duty hours.
3. The GMEC makes the final decision about residents' duty hours and ensure that the duty hours are in compliance with the ACGME guidelines.

## **II. Moonlighting Policy**

**Purpose:** Moonlighting activities, whether internal or external, may be inconsistent with sufficient time for rest and restoration to promote the residents' educational experience and safe patient care. Therefore, the purpose of this policy is to outline parameters relative to residents' moonlighting requests and activities.

**Scope:** This policy applies to the Delaware Psychiatry Residency Program.

**Policy:** Residents must not be required to engage in moonlighting. Moonlighting is only allowed on a limited basis for PGY-IV residents. A resident requesting to engage in moonlighting activities must submit the approved moonlighting form, licensing and evidence of medical liability coverage. Professional liability coverage is not provided by the Delaware Psychiatry Residency Program. Moonlighting ***must not*** be undertaken without the approval of the Program Director or Graduate Medical Education Committee (GMEC).

**Definitions:**

***Moonlighting*** is defined as professional and patient care activities outside the scope of the postgraduate training program.

**Procedures:**

- A resident requesting approval to engage in moonlighting activities must complete the approved moonlighting form.
- The completed form must include the type of position, hours, and supervision.
- The resident must submit the completed form, licensing and evidence of medical liability coverage to the Program Director.
- The Program Director will initiate a review of the request by the GMEC.



A. GMEC Review Criteria:

1. Moonlighting may be approved on limited basis in PGY-IV, if the resident is in good standing.
2. Moonlighting may be approved if the moonlighting does not interfere with resident obligations.
3. Moonlighting may be approved if the amount of moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
4. Upon approval of a resident's request to engage in moonlighting activities by the GMEC, a statement of permission from the Program Director must be placed in the resident's file.
5. Upon approval of a resident's request to engage in moonlighting activities by the GMEC, internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.
6. Upon approval of a resident's request to engage in moonlighting activities by the GMEC, the resident's performance must be monitored for the effect of these activities upon his/her performance. Adverse effects may lead to the withdrawal of permission for the resident to engage in moonlighting activities.

## Moonlighting Form

\_\_\_\_\_, a resident of The Delaware Psychiatry Residency Program,  
has entered into an agreement to provide services to the Department of  
\_\_\_\_\_ at  
\_\_\_\_\_ for the period of  
\_\_\_\_\_ through \_\_\_\_\_.

*(Moonlighting Institution Name)*

The Delaware participating resident understands he/she may engage in such employment only if the employment is and remains in accordance with the limitations of The Delaware Psychiatry Residency Program Moonlighting Policy.

The resident has appropriate insurance and licensure/training/skills as follows:

### 1. Professional Liability Insurance

\_\_\_\_\_ Professional liability insurance has been obtained by participating resident.

\_\_\_\_\_ Professional liability insurance has been provided for the resident by the participating Institution.

### 2. Licensure/Training for Moonlighting Activities

Medical Staff Services confirms:

\_\_\_\_\_ The resident has a valid independent medical license.

\_\_\_\_\_ The resident has the appropriate training and skills to carry out assigned duties.

Program Director Signature:

\_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_  
*(Please print)*

**Moonlighting activities also require Designated Institutional Official (DIO) signature below:**

Designated Institutional Official Signature:

\_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_  
*(Please print)*

*Appendix B*

**Individual PGY Goals, Objectives, and Clinical Duties**

*Last Revision: 12-31-2007*

**PGY-I Resident**

The PGY-I resident will make the transition to becoming a medical professional. The acquisition of the necessary knowledge, skills, and attitudes will be demonstrated by substantial completion of the goals and objectives of each clinical rotation, attendance at seminars, and satisfactory performance on the PRITE and mock board examinations.

**Primary Responsibilities:**

**A. Knowledge:**

1. Understand differential diagnoses of mental, neurological, and psychiatric disorders;
2. Have a working knowledge of the DSM-IV-TR;
3. Understand the biopsychosocial approach to patients;
4. Implement patient confidentiality and ethics into everyday practice;
5. Become aware of contradictions of pharmacologic agents and electroconvulsive therapy; and
6. Understand the American Medical Association (AMA) guidelines for accepting gifts from the industry.

**B. Skills:**

1. Develop empathic relationships with patients;
2. Use supervision;
3. Complete medical records and documentation requirements thoroughly and on time;
4. Secure competent medical, psychiatric, and neurological history and examinations;
5. Function as a member of a treatment team;
6. Begin to manage multiple tasks at one time;
7. Begin to function as physician leader in psychiatric inpatient/emergency settings;
8. Participate in developing and implementing psychiatric treatment using the biopsychosocial model; and
9. Appreciate the complexities of interacting with pharmaceutical representatives.

**C. Attitudes:**

1. Respectfully interact with patients, families, and staff;
2. Diligently discharge work task obligations;
3. Display ability to be introspective and self-questioning;
4. Accept responsibilities as a physician;
5. Tolerate ambiguity and uncertainty;
6. Thoughtfully receive and give feedback or criticism;
7. Accept limits of knowledge and skills, and request assistance; and
8. Begin to appreciate strengths and areas requiring improvement in terms of functioning as a competent physician.

**Clinical Responsibilities:**

**A. Inpatient Psychiatry:**

The resident is primarily responsible for the treatment of psychiatric patients on this rotation. Residents complete the psychiatric assessment form, physical examination form, vital information at a glance form, orders, and initial treatment plan at the time of admission. All admissions are reviewed for completeness and accuracy by a psychiatric attending that cosigns all notes, orders, and assessments. Residents continue ongoing treatment with selected patients. All notes and orders are cosigned by a teaching attending. All clinical decisions are discussed with the multi-disciplinary treatment team prior to being enacted. By the end of the inpatient psychiatry rotation, located at the Delaware Psychiatric Center, the resident the resident is expected to:

1. Patient Care:
  - a. Obtain information from the patient interview, family contact, old charts, and outpatient providers to complete an assessment of the following areas:
    - i. History of Present Illness (Complete assessment of symptomology, chronological order of events, recent stressors and precipitants, and level of functioning);
    - ii. Past Medical History;
    - iii. Past Psychiatric History;
    - iv. Substance Abuse History;
    - v. Family History;
    - vi. Social History; and
    - vii. Developmental History.
  - b. Complete a comprehensive mental status examination.
  - c. Assess for dangerousness to self and/or others.
  - d. Use precautions appropriately including close observation, suicide precautions, and one-to-one.
  - e. Understand and appropriately apply criteria for inpatient hospitalization.
  - f. Determine if a patient is medically stable enough for psychiatric hospitalization.
  - g. Formulate a basic treatment plan including the following:
    - i. Acute stabilization;
    - ii. Medication management;
    - iii. Psychosocial interventions;
    - iv. Group and individual therapy;
    - v. Psychoeducation;
    - vi. PT/OT/Art Therapy; and
    - vii. Discharge planning.
  - h. Demonstrate a basic understanding of individual, group, and family treatment in inpatient setting.
  - i. Document the full history, mental status examination, hospital course, basic differential diagnosis, basic diagnostic formulation, and basic treatment plan in the discharge summary.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- j. Provide appropriate documentation on patients seen in the ER (if applicable) including a complete HPI, MSE, and clinical rationale for triage decisions and treatment recommendations.
2. Medical Knowledge:
    - a. Make a reasonable differential diagnosis based on DSM-IV-TR criteria to include all 5-axes.
    - b. Display proficiency in using at least one high, medium, and low potency typical neuroleptic.
    - c. Display basic ability to use Haldol and Prolixin decanote preparations.
    - d. Display proficiency in using all non-Clozapine atypical neuroleptics.
    - e. Display basic skills in using Clozapine, including when to consider a Clozapine trial.
    - f. Display familiarity with major side-effects of all neuroleptics (EPS, anticholinergic, orthostasis, etc.)
    - g. Name and describe the three major forms of acute EPS and basic treatments.
    - h. Describe Tardive Dyskinesia (TD), properly use AIMS test, and become aware of treatments for TD.
    - i. Name receptors responsible for orthostasis, sedation, weight gain, and sexual dysfunction.
    - j. Name at least five anticholinergic symptoms.
    - k. Describe NMS and detail treatment plan if it emerges.
    - l. Display basic familiarity with dosing at least one secondary and one tertiary amine TCA, one MAOI, Trazodone, Wellbutrin, all SSRI's, Effexor, Serzone, and Remeron.
    - m. Name at least three major side-effects of each of the above medications.
    - n. Name at least three contraindications to using each of the above medications.
    - o. Display basic familiarity with dosing, pre-treatment testing, follow-up monitoring, and major contraindications to Li, VPA, and CBZ.
    - p. Name at least four major side-effects for Li, VPA, and CBZ.
    - q. Display basic skills in using Lamictal.
    - r. Display proficiency in using at least three BZDs and Buspar.
    - s. Know which BZDs lack active metabolites.
    - t. Know the basic side-effects of BZDs and Buspar.
    - u. Know relative contraindications for BZD use.
    - v. Display an awareness of both potentially common and lethal drug interactions (Demerol and Phenelzine; CBZ and Clozapine; and the like.)
    - w. Display and become aware of basic drug mechanisms of action, receptor blockade profiles, and indications for selection and use of specific agents.
    - x. Display proficiency in using sedative-hypnotics and neuroleptics for acute behavioral control.
  3. Interpersonal and Communication Skills:
    - a. Co-lead community and team meetings on the unit.
    - b. Be empathetic and develop rapport with patients.
    - c. Work effectively as part of a multidisciplinary team.
    - d. Work effectively as a team player with peers.
    - e. Communicate effectively with supervisors.

- f. Be effective and empathetic working with families.
  - g. Effectively liaison with professional colleagues in other fields (i.e. primary care physicians.)
  - h. Adapt his/her style of interaction specific to age and cognitive capacity.
4. Professionalism:
- a. Exemplify personal and intellectual integrity, and demonstrate an understanding of the ethical values and codes of a member of the medical profession.
  - b. Recognize and adapt to cultural differences.
  - c. Obtain and provide cross coverage, as needed.
  - d. Assist with and ask for assistance in emergencies, as appropriate.
  - e. Do appropriate sign-outs addressing pertinent issues for patients.
  - f. Demonstrate a commitment to ethical principles when dealing with patients and families.
  - g. Demonstrate respect for patients and colleagues in interactions.
  - h. Demonstrate a sensitivity and awareness of the patient's culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
  - i. Demonstrate respect towards patients and family members.
  - j. Demonstrate respect for physician and non-physician colleagues.
  - k. Communicate effectively with peers regarding cross-coverage and sign-out of patients.
  - l. Follow through with patient care recommendations.
  - m. Use ethical behavior with respect for patient confidentiality.
  - n. Establish and maintain professional boundaries.
5. Practice-Based Learning:
- a. Use information technology to access online medical information and support his/her own education.
  - b. Locate, critique, and assimilate evidence from scientific studies as it relates to patients' health problems.
  - c. Analyze practice experience and perform practice-based improvement activities.
  - d. Incorporate material discussed in supervision into clinical work.
  - e. Display motivation and eagerness to learn.
6. Systems-Based Practice:
- a. Know how types of medical practice and delivery systems differ from one another.
  - b. Be aware of different costs of health care for different services.
  - c. Advocate for quality patient care and assist patients in dealing with system complexities.
  - d. Demonstrate a basic understanding of medical-legal issues as it relates to inpatient psychiatry:
    - i. Voluntary and involuntary admission procedures and paperwork;
    - ii. Testifying in hearings;
    - iii. Court-ordered patients;
    - iv. Issues of confidentiality; and
    - v. Forced medications/medication panels.

**B. Primary Care (Family Medicine & Internal Medicine rotations):**

Residents are responsible for the initial work-up of patients under supervision of the rotation's supervisor, teaching attendings via daily rounds and/or additional communication direct the treatment of the patients. Residents follow patients from time of admission to discharge, and are the primary care givers throughout the hospitalization. By the end of the four (4) month primary care rotation (two (2) months of Internal Medicine at Coatesville Veteran Administrative Medical Center, and two (2) months of Family Medicine at Christiana Care Health System's Wilmington Hospital) the resident the resident is expected to:

1. Patient Care:
  - a. Perform and document a relevant history and examination on culturally diverse patients to include as appropriate:
    - i. Chief complaint;
    - ii. History of present illness;
    - iii. Past medical history;
    - iv. A comprehensive review of systems;
    - v. A biological family history;
    - vi. A sociocultural history;
    - vii. A developmental history (especially for children); and
    - viii. A situationally germane general and neurological examination.
  - b. Delineate appropriate differential diagnoses.
  - c. Evaluate, assess, and recommend effective management of patients.
  - d. Determine a formulation, differential diagnosis, laboratory investigation, and management plan.
  - e. Perform competently the diagnostic and therapeutic procedures considered essential to the practice of primary care.
  - f. Provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life.
2. Medical Knowledge:
  - a. Demonstrate knowledge of major disorders, including considerations relating to age, gender, race, and ethnicity, based on the literature and standards of practice. This knowledge shall include:
    - i. The epidemiology of the disorder;
    - ii. The etiology of the disorder, including medical, genetic, and sociocultural factors;
    - iii. The phenomenology of the disorder;
    - iv. An understanding of the impact of physical illness on the patient's functioning;
    - v. The experience, meaning, and explanation of the illness for the patient and family, including the influence of cultural factors and culture-bound syndromes;
    - vi. Effective treatment strategies; and
    - vii. Course and prognosis.
  - b. Display knowledge of healthcare delivery systems, including patient and family counseling.
  - c. Display knowledge of the application of ethical principles in delivering medical care.

- d. Demonstrate the ability to reference and utilize electronic systems to access medical, scientific, and patient information.
  - e. Demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
  - f. Apply an open-minded, analytical approach to acquiring new knowledge.
  - g. Develop clinically applicable knowledge of the basic and clinical sciences that underlie the practice of primary care.
  - h. Apply this knowledge to clinical problem-solving, clinical decision making, and critical thinking.
3. Interpersonal and Communication Skills:
- a. Demonstrate the following abilities:
    - i. Listen to and understand patients and to attend to nonverbal communication;
    - ii. Communicate effectively with patients using verbal, nonverbal, and written skills as appropriate;
    - iii. Develop and maintain a therapeutic alliance with patients by instilling feelings of trust, honesty, openness, rapport, and comfort in the relationship with physician.
    - iv. Partner with patients to develop an agreed upon healthcare management plan;
    - v. Transmit information to patients in a clear and meaningful fashion;
    - vi. Understand the impact of physicians' own feelings and behavior so that it does not interfere with appropriate treatment;
    - vii. Communicate effectively and work collaboratively with allied healthcare professionals and with other professionals involved in the lives of patients and families; and
    - viii. Educate patients, their families, and professionals about medical, psychosocial, and behavioral issues.
  - b. Serve as an effective consultant to other medical specialists, mental health professionals, and community agencies by demonstrating the abilities to:
    - i. Communicate effectively with the requesting party to refine the consultation question;
    - ii. Maintain the role of consultant;
    - iii. Communicate clear and specific recommendations; and
    - iv. Respect the knowledge and expertise of the requesting professionals.
  - c. Demonstrate the ability to communicate effectively with patients and their families by:
    - i. Gearing all communication to the educational and intellectual levels of patients and their families;
    - ii. Demonstrating socio-cultural sensitivity to patients and their families;
    - iii. Providing explanations of psychiatric and neurological disorders and treatment that are jargon-free and geared to the educational/intellectual levels of patients and their families;
    - iv. Providing preventive education that is understandable and practical;
    - v. Respecting the patients' cultural, ethnic, religious, and economic backgrounds;
    - vi. Developing and enhancing rapport and a working alliance with patients and their families; and
    - vii. Ensuring that the patient and/or family have understood the communication



- d. Maintain up-to-date medical records and write legible prescriptions. These records must capture essential information and respect patient privacy, and they must be useful to health professionals outside family medicine.
  - e. Demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
  - f. Provide effective and professional consultation to other physicians and health care professionals and sustain therapeutic and ethically sound professional relationships with patients, their families, and colleagues.
4. Professionalism:
- a. Demonstrate responsibility for their patients' care, including:
    - i. Responding to communication from patients and health professionals in a timely manner;
    - ii. Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary;
    - iii. Using medical records for appropriate documentation of the course of illness and its treatment ;
    - iv. Providing coverage if unavailable, for example when out of town or on vacation;
    - v. Coordinating care with other members of the medical and/or multidisciplinary team; and
    - vi. Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary.
  - b. Demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest.
  - c. Demonstrate respect for patients and their families, and their colleagues as person, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations.
  - d. Demonstrate an understanding of and sensitivity to end of life care and issues regarding provision of care.
  - e. Review their professional conduct and remediate when appropriate.
  - f. Participate in the review of the professional conduct of their colleagues.
  - g. Become aware of safety issues, including acknowledging and remediating medical errors, should they occur.
  - h. Exemplify personal and intellectual integrity, and demonstrate an understand of the ethical values and codes of a member of the medical profession.
  - i. Recognize and adapt to cultural differences
  - j. Obtain and provide cross coverage, as needed
  - k. Assist with and ask for assistance in emergencies, as appropriate
  - l. Do appropriate sign-outs addressing pertinent issues for patients
  - m. Demonstrate a commitment to ethical principles when dealing with patients and families
  - n. Demonstrate respect for patients and colleagues in interactions
  - o. Demonstrate a sensitivity and awareness of the patient's culture, age, gender, socioeconomic status, sexual orientation, spirituality, and disabilities

- p. Demonstrate respect towards patients and family members
  - q. Demonstrate respect for physician and non-physician colleagues
  - r. Communicate effectively with peers regarding cross-coverage and sign-out of patients
  - s. Follow through with patient care recommendations
  - t. Use ethical behavior with respect for patient confidentiality
  - u. Establish and maintain professional boundaries
5. Practice-Based Learning:
- a. Recognize the limitations in their own knowledge base and clinical skills, and understand and address the need for lifelong learning.
  - b. Demonstrate appropriate skills for obtaining and evaluating up-to-date information from scientific and practice literature and other sources to assist in the quality care of patients. This shall include, but not be limited to:
    - i. Use of medical libraries;
    - ii. Use of information technology, including Internet-based searches and literature databases (e.g., Medline);
    - iii. Use of drug information databases; and
    - iv. Active participation, as appropriate, in educational courses, conferences, and other organized educational activities both at the local and national levels.
  - c. Evaluate caseload and practice experience in a systematic manner. This may include:
    - i. Case-based learning;
    - ii. Use of best practices through practice guidelines or clinical pathways;
    - iii. Review of patient records;
    - iv. Obtaining evaluations from patients (e.g., outcomes and patient satisfaction);
    - v. Employment of principles of quality improvement in practice;
    - vi. Obtaining appropriate supervision and consultation; and
    - vii. Maintaining a system for examining errors in practice and initiating improvements to eliminate or reduce errors.
  - d. Use information technology to access online medical information and support his/her own education.
  - e. Locate, critique, and assimilate evidence from scientific studies as it relates to patients' health problems.
  - f. Analyze practice experience and perform practice-based improvement activities.
  - g. Incorporate material discussed in supervision into clinical work.
  - h. Display motivation and eagerness to learn.
  - i. Be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
  - j. Identify areas for improvement and implement strategies to enhance knowledge, skills, attitudes and processes of care.
6. Systems-Based Practice:
- a. Have a working knowledge of the diverse systems involved in treating patients of all ages, and understand how to use the systems as part of a comprehensive system of care in general and as part of a comprehensive, individualized treatment plan. This will include the:
    - i. Use of practice guidelines;

- ii. Ability to access community, national, and allied health professional resources that may enhance the quality of life of patients;
  - iii. Demonstration of the ability to lead and delegate authority to healthcare teams needed to provide comprehensive care for patients;
  - iv. Demonstration of skills for the practice of ambulatory medicine, including time management, clinical scheduling, and efficient communication with referring physicians;
  - v. Use of appropriate consultation and referral mechanisms for the optimal clinical management of patients with complicated medical illness;
  - vi. Demonstration of awareness of the importance of adequate cross-coverage; and
  - vii. Use of accurate medical data in the communication with and effective management of patients
- b. Recognize the limitation of healthcare resources and demonstrate the ability to act as an advocate for patients within their sociocultural and financial constraints.
  - c. Demonstrate knowledge of the legal aspects of diseases as they impact patients and their families.
  - d. Demonstrate an understanding of risk management.
  - e. Demonstrate knowledge of and interact with managed health systems including:
    - i. Participating in utilization review communications and, when appropriate, advocating for quality patient care;
    - ii. Educating patients concerning such systems of care.
  - f. Demonstrate knowledge of community systems of care and assist patients to access appropriate care and other support services. This requires knowledge of treatment settings in the community, which include ambulatory, consulting, acute care, partial hospital, skilled care, rehabilitation, and substance abuse facilities; halfway houses; nursing homes and home care; and hospice organizations delivery setting.
  - g. Demonstrate knowledge of the organization of care in each relevance and the ability to integrate the care of patients across such settings.
  - h. Know how types of medical practice and delivery systems differ from one another.
    - i. Be aware of different costs of health care for different services
  - j. Advocate for quality patient care and assist patients in dealing with system complexities.

**C. Neurology:**

Residents are supervised by the rotation's supervisor. All clinical decisions are made in conjunction with the teaching attending. Residents actively participate in the assessments and treatment of those patients with neurological disabilities.

By the end of the two (2) month neurology rotation, located at the Elsmere Veteran Administrative Medical Center, the resident is expected to:

- 1. Patient Care:
  - a. Perform and document a relevant history and examination on diverse patients to include as appropriate:
    - i. Chief complaint;
    - ii. History of present illness;

- iii. Past medical history;
  - iv. A comprehensive review of systems;
  - v. A biological family history;
  - vi. A sociocultural history;
  - vii. A developmental history (especially for children); and
  - viii. A situationally germane general and neurological
- b. Delineate appropriate differential diagnoses.
  - c. Evaluate, assess, and recommend effective management of patients.
  - d. Determine if a patient's symptoms are the result of a disease affecting the central and/or peripheral nervous system or are of another origin (e.g., of a systemic, psychiatric, or psychogenic illness.)
  - e. Determine a formulation, differential diagnosis, laboratory investigation, and management plan.
  - f. Develop and maintain the technical skills to perform lumbar puncture, and to identify and describe abnormalities seen in common neurological disorders on radiographic testing.
  - g. Evaluate the application and relevance of investigative procedures and interpretation in the diagnosis of neurological disease.
2. Medical Knowledge:
- a. Demonstrate knowledge of major disorders, including considerations relating to age, gender, race, and ethnicity, based on the literature and standards of practice. This knowledge shall include.
    - i. The epidemiology of the disorder;
    - ii. The etiology of the disorder, including medical, genetic, and sociocultural factors;
    - iii. The phenomenology of the disorder;
    - iv. An understanding of the impact of physical illness on the patient's functioning;
    - v. The experience, meaning, and explanation of the illness for the patient and family;
    - vi. Effective treatment strategies; and
    - vii. Course and prognosis.
  - b. Display knowledge of healthcare delivery systems, including patient and family counseling.
  - c. Display knowledge of the application of ethical principles in delivering medical care.
  - d. Demonstrate the ability to reference and utilize electronic systems to access medical and scientific information.
  - e. Understand neurologic disorders and diseases across the lifespan, including treatment for the following:
    - i. Dementia and behavioral neurology disorders;
    - ii. Epilepsy and related disorders;
    - iii. Neuromuscular disorders;
    - iv. Demyelinating and dysmyelinating disorders of the central nervous system;
    - v. Cerebrovascular disorders;
    - vi. Infectious diseases of the nervous system;
    - vii. Neoplastic disorders and tumors of the nervous system;
    - viii. Nervous system trauma;
    - ix. Toxic and metabolic disorders of the nervous system;
    - x. Acute, chronic pain;

- xi. Sleep disorders;
  - xii. Changes in mental state secondary to therapy and treatment;
  - xiii. Critical care and emergency neurology;
  - xiv. Coma and brain death;
  - xv. Headache and facial pain; and
  - xvi. Movement disorders including abnormalities caused by drugs.
3. Interpersonal and Communication Skills:
- a. Demonstrate the following abilities:
    - i. Listen to and understand patients and to attend to nonverbal communication;
    - ii. Communicate effectively with patients using verbal, nonverbal, and written skills as appropriate;
    - iii. Develop and maintain a therapeutic alliance with patients by instilling feelings of trust, honesty, openness, rapport, and comfort in the relationship with physicians;
    - iv. Partner with patients to develop an agreed upon healthcare management plan;
    - v. Transmit information to patients in a clear and meaningful fashion;
    - vi. Understand the impact of physicians' own feelings and behavior so that it does not interfere with treatment;
    - vii. Communicate effectively and work collaboratively with allied healthcare professionals and with other professionals involved in the lives of patients and families; and
    - viii. Educate patients, their families, and professionals about medical, psychosocial, and behavioral issues.
  - b. Serve as an effective consultant to other medical specialists, mental health professionals, and community agencies by demonstrating the abilities to:
    - i. Communicate effectively with the requesting party to refine the consultation question;
    - ii. Maintain the role of consultant;
    - iii. Communicate clear and specific recommendations; and
    - iv. Respect the knowledge and expertise of the requesting professionals.
  - c. Demonstrate the ability to communicate effectively with patients and their families by:
    - i. Gearing all communication to the educational and intellectual levels of patients and their families;
    - ii. Demonstrating sociocultural sensitivity to patients and their families;
    - iii. Providing explanations of psychiatric and neurological disorders and treatment that are jargon-free and geared to the educational/intellectual levels of patients and their families;
    - iv. Providing preventive education that is understandable and practical;
    - v. Respecting the patients' cultural, ethnic, religious, and economic backgrounds;
    - vi. Developing and enhancing rapport and a working alliance with patients and their families; and
    - vii. Ensuring that the patient and/or family have understood the communication.
      - (1) Maintain up-to-date medical records and write legible prescriptions. These records must capture essential information while simultaneously respecting patient privacy, and they must be useful to health professionals outside psychiatry and neurology.

4. Professionalism:
  - a. Demonstrate responsibility for their patients' care, including:
    - i. Responding to communication from patients and health professionals in a timely manner;
    - ii. Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary;
    - iii. Using medical records for appropriate documentation of the course of illness and its treatment;
    - iv. Providing coverage if unavailable, for example when out of town or on vacation;
    - v. Coordinating care with other members of the medical and/or multidisciplinary team; and
    - vi. Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary.
  - b. Demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest.
  - c. Demonstrate respect for patients and their families, and their colleagues as person, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political learning, and sexual orientations.
  - d. Demonstrate an understanding of and sensitivity to end of life care and issues regarding provision of care.
  - e. Review their professional conduct and remediate when appropriate.
  - f. Participate in the review of the professional conduct of their colleagues.
  - g. Become aware of safety issues, including acknowledging and remediating medical errors, should they occur.
  - h. Exemplify personal and intellectual integrity, and demonstrate an understanding of the ethical values and codes of a member of the medical profession.
  - i. Recognize and adapt to cultural differences.
  - j. Obtain and provide cross coverage, as needed.
  - k. Assist with and ask for assistance in emergencies, as appropriate.
  - l. Do appropriate sign-outs addressing pertinent issues for patients.
  - m. Demonstrate a commitment to ethical principles when dealing with patients and families.
  - n. Demonstrate respect for patients and colleagues in interactions.
  - o. Demonstrate a sensitivity and awareness of the patient's culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
  - p. Demonstrate respect towards patients and family members.
  - q. Demonstrate respect for physician and non-physician colleagues.
  - r. Communicate effectively with peers regarding cross-coverage and sign-out of patients.
  - s. Follow through with patient care recommendations.
  - t. Use ethical behavior with respect for patient confidentiality.
  - u. Establish and maintain professional boundaries

5. Practice-Based Learning:
  - a. Recognize the limitations in their own knowledge base and clinical skills, and understand and address the need for lifelong learning.
  - b. Demonstrate appropriate skills for obtaining and evaluating up-to-date information from scientific and practice literature and other sources to assist in the quality care of patients. This shall include, but not be limited to:
    - i. Use of medical libraries;
    - ii. Use of information technology, including Internet-based searches and literature databases (e.g., Medline);
    - iii. Use of drug information databases; and
    - iv. Active participation, as appropriate, in educational courses, conferences, and other organized educational activities both at the local and national levels.
  - c. Evaluate caseload and practice experience in a systematic manner. This may include:
    - i. Case-based learning;
    - ii. Use of best practices through practice guidelines or clinical pathways;
    - iii. Review of patient records;
    - iv. Obtaining evaluations from patients (e.g., outcomes and patient satisfaction);
    - v. Employment of principles of quality improvement in practice;
    - vi. Obtaining appropriate supervision and consultation; and
    - vii. Maintaining a system for examining errors in practice and initiating improvements to eliminate or reduce errors.
  - d. Use information technology to access online medical information and support his/her own education.
  - e. Locate, critique, and assimilate evidence from scientific studies as it relates to patients' health problems.
  - f. Analyze practice experience and perform practice-based improvement activities.
  - g. Incorporate material discussed in supervision into clinical work.
  - h. Display motivation and eagerness to learn.
6. Systems-Based Practice:
  - a. Have a working knowledge of the diverse systems involved in treating patients of all ages, and understand how to use the systems as part of a comprehensive system of care in general and as part of a comprehensive, individualized treatment plan. This will include the:
    - i. Use of practice guidelines;
    - ii. Ability to access community, national, and allied health professional resources that may enhance the quality of life of patients;
    - iii. Demonstration of the ability to lead and delegate authority to healthcare teams needed to provide comprehensive care for patients;
    - iv. Demonstration of skills for the practice of ambulatory medicine, including time management, clinical scheduling, and efficient communication with referring physicians;
    - v. Use of appropriate consultation and referral mechanisms for the optimal clinical management of patients with complicated medical illness;
    - vi. Demonstration of awareness of the importance of adequate cross-coverage; and

- vii. Use of accurate medical data in the communication with and effective management of patients.
- b. Recognize the limitation of healthcare resources and demonstrate the ability to act as an advocate for patients within their sociocultural and financial constraints.
- c. Demonstrate knowledge of the legal aspects of diseases as they impact patients and their families.
- d. Demonstrate an understanding of risk management.
- e. Demonstrate knowledge of an interact with managed health systems including:
  - i. Participating in utilization review communications and, when appropriate, advocating for quality patient care; and
  - ii. Educating patients concerning such systems of care.
- f. Demonstrate knowledge of community systems of care and assist patients to access appropriate care and other support services. This requires knowledge of treatment settings in the community, which include ambulatory, consulting, acute care, partial hospital, skilled care, rehabilitation, and substance abuse facilities; halfway houses; nursing homes and home care; and hospice organizations.
- g. Demonstrate knowledge of the organization of care in each relevant delivery setting and the ability to integrate the care of patients across such settings.
- h. Know how types of medical practice and delivery systems differ from one another.
  - i. Be aware of different costs of health care for different services
- j. Advocate for quality patient care and assist patients in dealing with system complexities.

**D. Emergency Psychiatry (CAPES):**

The resident is primarily responsible for the treatment of psychiatric patients on this rotation. Residents complete the psychiatric assessment form, physical examination form, orders, and initial treatment plan at the time of admission. All admissions are reviewed for completeness and accuracy by a psychiatric attending that cosigns all notes, orders, and assessments. Residents are responsible for ongoing treatment. All clinical decisions are discussed with a multi-disciplinary treatment team.

By the end of the one (1) month emergency psychiatry rotation, located at the Christiana Care Health System's Wilmington Hospital, the resident is expected to:

- 1. Patient Care:
  - Assess and begin to manage crisis situations with appropriate supervision as needed.
  - a. Effectively accept and prioritize the sign-out of cases at the beginning of a shift.
  - b. Efficiently and appropriately acquire clinical information in a variety of ways including: patient interview, family interview, calling collateral sources of information, reviewing old records.
  - c. Effectively manage the violent or agitated patient through the judicious use of verbal de-escalation, medications, and restraints.
  - d. Understand the risk factors in assessment of suicidal and homicidal patients.
  - e. Assess and manage psychotic patients in the emergency setting.
  - f. Integrate biopsychosocial constructs into formulation of cases.



- g. Check levels of psychiatric medications (including Lithium, Depakote, Tegretol, Pemelor) and assess how these levels relate to the last dose.
  - h. Understand the psychosocial aspects of treatment with patients, including crisis counseling, psychoeducation, community referrals.
  - i. Appropriately document his/her decision-making process and written justification for his/her professional judgment.
  - j. Assess a patient medically through history and physical exam and ability to recognize and manage uncomplicated medical needs.
  - k. Evaluate the cognitive capacity of medically ill patients and comment on the patient's ability to make decisions.
  - l. Develop initial treatment plans including safety and biopsychosocial aspects.
  - m. Obtain appropriate history and physical for the patient in detoxification.
  - n. Recognize complicating medical factors in the patient with an addiction.
  - o. Monitor a patient in detoxification and be familiar with symptoms and signs of alcohol and heroin withdrawal.
  - p. Understand informed consent and the ability to document risk/benefit discussion of treatment options with patients.
2. Medical Knowledge:
- a. Formulate a comprehensive differential diagnosis including medical causes for psychiatric presentations.
  - b. Gain an evolving knowledge of the indications and pharmacologic properties of psychotropic medications commonly used in the emergency setting.
  - c. Assess for and treat the following pharmacologic emergencies: anticholinergic toxicity, NMS, serotonin syndrome, dystonic reactions.
  - d. Gain knowledge of medication interactions and major side effects of medications.
  - e. Gain knowledge of the indications for various methods of detoxification, including for heroin, alcohol and benzodiazepines.
  - f. Appropriately dose medications for alcohol and heroin withdrawal.
3. Interpersonal and Communication Skills:
- a. Effectively collaborate and liaison with a multidisciplinary team in delivering psychiatric emergency services.
  - b. Effectively work with non-psychiatric staff in the education and management of patients in crisis.
  - c. Give thorough, clear, concise sign-outs for patients at the end of a shift.
  - d. Rapidly form and foster effective therapeutic relationships with patients in crisis.
  - e. Efficiently summarize and present data collected, including labs and collateral information.
  - f. Effectively work with addictions treatment personnel.
  - g. Be emphatic and develop rapport with patients.
  - h. Work effectively as part of a multidisciplinary team.
  - i. Work effectively as a team player with peers.
  - j. Communicate effectively with supervisors.
  - k. Effectively liaison with professional colleagues in other fields.
  - l. Adapt his/her style of interaction specific to age and cognitive capacity.

4. Professionalism:
  - a. Demonstrate personal and intellectual integrity.
  - b. Demonstrate an understanding of the ethical values and codes of a member of the medical profession when dealing with patients and families.
  - c. Obtain and provide cross coverage as needed.
  - d. Assist with and ask for assistance in emergencies as appropriate.
  - e. Do appropriate sign-outs addressing pertinent issues for patients.
  - f. Demonstrate respect for patients, families and colleagues in interactions, including a sensitivity and awareness of the patient's culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
  - g. Follow through with patient care recommendations.
  - h. Demonstrate respect for patient confidentiality.
  - i. Establish and maintain professional boundaries.
  - j. Maintain a professional appearance appropriate to clinical site.
  
5. Practice-Based Learning:
  - a. Use information technology to access on-line medical information and support his/her own education.
  - b. Locate, critique, and assimilate evidence from scientific studies as it relates to patients' health problems.
  - c. Analyze practice experience and perform practice-based improvement activities.
  - d. Incorporate material discussed in supervision into clinical work.
  - e. Demonstrate motivation and eagerness to learn.
  
6. Systems-Based Practice:
  - a. Formulate and access an appropriate disposition with appropriate assistance: assessment of hospitalization vs. discharge with appropriate safety assessment, referrals for treatment, including day hospital, addictions treatment, etc., community resources, referrals for living situations (i.e., shelters, halfway houses, etc).
  - b. Do sufficient documentation and liaison effectively with insurance companies.
  - c. Gain knowledge of how types of medical practice and delivery systems differ from one another.
  - d. Gain knowledge of different costs of health care for different service.
  - e. Advocate for quality patient care and assist patients in dealing with system complexities.

## **PGY-II Resident**

The PGY-II resident will build on the foundation of the PGY-I year in making the transition to a psychiatric physician. The acquisition of the necessary knowledge, skills, and attitudes will be demonstrated by the substantial completion of the goals and objectives of each clinical rotation, attendance at seminars, and satisfactory performance on the PRITE and mock board examinations.

### **Primary Responsibilities:**

#### **A. Knowledge:**

1. Understand differential diagnoses and initial treatment approaches of acute psychiatric disorders;
2. Have a comprehensive knowledge of psychopharmacology;
3. Have an understanding of available community treatment and referral resources;
4. Understand different theories, differential diagnoses, and treatment of child and adolescent psychiatric disorders;
5. Have a basic understanding of psychotherapy theory and practice;
6. Have a basic understanding of family and system concepts; and
7. Understand the neuropsychiatric foundations of psychiatric disorders.

#### **B. Skills:**

1. Function as a physician leader in inpatient, emergency, and consultation & liaison settings;
2. Conduct rapid assessment and initial treatment of psychiatric emergencies;
3. Conduct psychiatric diagnostic interviews with children, adolescents, and families;
4. Act as a consultant with non-psychiatric physicians and health care professionals;
5. Utilize systems knowledge to interact with families, hospitals, and community agencies;
6. Judiciously apply a broad range of pharmacologic treatments;
7. Participate in administrative committees of the residency program; and
8. Critically approach the scientific psychiatric literature.

#### **C. Attitudes:**

1. Display competent functioning as physician leader of a treatment team;
2. Display intellectual curiosity and knowledge pertinent to a clinical situation;
3. Respect the opinions and knowledge of health care colleagues;
4. Understand countertransference, transference, and boundary issues as they relate to psychiatric care; and
5. Formulate comprehensive assessment of strengths and deficits, and devise an appropriate plan to address them.

**Clinical Responsibilities:**

**A. Inpatient Psychiatry:**

The resident is primarily responsible for the treatment of psychiatric patients on this rotation. Residents complete the psychiatric assessment form, physical examination form, vital information at a glance form, orders, and initial treatment plan at the time of admission. All admissions are reviewed for completeness and accuracy by a psychiatric attending that cosigns notes, orders, and assessments according to DPC updated policies and procedures. Residents continue ongoing treatment with selected patients. All clinical decisions are discussed with the multi-disciplinary treatment team prior to being enacted. By the end of the five (5) month Inpatient Psychiatry rotation, located at the Delaware Psychiatric Center, the resident is expected to:

1. Demonstrate further mastery in the knowledge and skills introduced during the PGY-I inpatient experiences.
2. Conduct:
  - a. A comprehensive psychiatric interview;
  - b. A family interview;
  - c. Supportive psychotherapy with increasing awareness of dynamic issues; and
  - d. An inpatient group therapy meeting.
3. Make appropriate use of laboratory examinations, imaging, psychobiological testing and other considerations as indicated in the work up of inpatients.
4. Make accurate psychiatric diagnosis, differential diagnosis and diagnostic formulations.
5. Formulate a provisional treatment plan and with a following attending supervising implement it.
6. Use a broad range of pharmacologic agents appropriately, being aware of key drug interactions, toxicology and evidence-based efficacy and safety.
7. Work harmoniously with other staff, personal, faculty, and other residents.
8. Become aware of unique personal and emotional responses to patients and develop tools to use them effectively and neutralize countertransference reactions as appropriate.

**B. Consultation & Liaison:**

The resident is primarily responsible for the assessment of psychiatric patients on this rotation. Residents complete the psychiatric consultation form with recommendations for intervention. All consultations are reviewed for completeness and accuracy by a psychiatric attending that cosigns notes, orders, and assessments according to institutions policies and procedures.. Residents are responsible for ongoing treatment. By the end of the two (2) month Consultation & Liaison rotation, located at both the Christiana Care Health System's Wilmington & Christiana Hospitals, the resident is expected to:

1. Patient Care:
  - a. Gather data from appropriate sources, including chart, hospital staff, family, and other relevant individuals.

- b. Adapt his/her interview style in medically ill patients in a variety of settings (i.e., adapt to patients on ventilators, recognize stress and fatigue in patients, prioritize questions, and do multiple, brief interviews).
  - c. Formulate a good HPI, including psychiatric symptoms and recent stressors precipitating hospitalization, as well as acute medical issues and their relationship to psychiatric symptoms.
  - d. Formulate a complete psychiatric work-up, including history of present illness, past medical history, past psychiatric history, substance abuse history, family history, social history, developmental history and mental status examination.
  - e. Do a comprehensive assessment of cognitive capacity if patients and learn applicable rating scales.
  - f. Evaluate for psychopathologic processes in patients with concomitant medical and surgical conditions.
  - g. Assess for suicidality and dangerousness and evaluate risk factors and need for hospitalization.
  - h. Assess for homicidality and dangerousness and evaluate risk factors and need for hospitalization.
  - i. Evaluate for competency in medically ill patients.
  - j. Monitor the patient's course during hospitalization and provide continuing input as needed.
  - k. Manage time, including appropriate length of notes with increased number of consults.
  - l. Do complete and adequate documentation addressing medicolegal risks.
2. Medical Knowledge:
- a. Understand indications for a variety of somatic therapies in medical and surgical patients.
  - b. Understand the use of psychotropic medications and ECT in medical/surgical patients and appreciate physiologic effects, contraindications, drug interactions and dosing concerns.
  - c. Understand the use of psychosocial treatments, including brief psychotherapy, behavioral management techniques, family therapy and psychoeducation.
  - d. Gain knowledge of diagnostic criteria, common and emergent etiologies, medical work-up and biopsychosocial treatment for delirium.
  - e. Gain knowledge of dosing strategies and indications for the use of haloperidol and lorazepam in delirious patients.
  - f. Gain knowledge of the organic work-up for psychiatric symptoms.
  - g. Gain knowledge of medications that have psychiatric symptoms as side effects.
  - h. Gain knowledge of drug interactions between psychotropics and nonpsychotropic medications.
  - i. Gain knowledge of the appropriate indications and dosing strategies for psychostimulants in the medically ill.
  - j. Gain knowledge of the use, risks and benefits, and dosing strategies of psychotropics in pregnancy.
  - k. Gain knowledge of the diagnostic criteria, evaluation, work-up and management of neuroleptic malignant syndrome.

- l. Gain knowledge of the diagnostic criteria and differences between factitious disorder, malingering, and conversion disorder.
  - m. Gain knowledge of the core concepts of competency and the process once a patient has been deemed incompetent.
  - n. Gain knowledge of the eight issues processed with patients in medical crisis counseling.
  - o. Gain knowledge of the biopsychosocial management of personality disorders in medical settings.
3. Interpersonal and Communication Skills:
- a. Formulate the Impression and Plan so that it consists of concrete recommendations and delineates clearly the role of the consultant and the role of the consulting team in the plan.
  - b. Present concise and relevant data to supervisors and use supervision appropriately.
  - c. Understand the stressors the consulting team faces and be clear about the discharge date as recommendations are being made.
  - d. Advise and guide consultees about the role of the medical disease and medications in the patient's presenting symptoms.
  - e. Work as a member of a multidisciplinary staff to maximize the care of complex medically ill patients
  - f. Provide appropriate direction to consultees regarding management of dangerous or psychotic patients who must be treated on general hospital units.
  - g. Engage in effective interactions with a variety of consultees, including determination of consultation questions, and reporting of findings and recommendations.
  - h. Maintain verbal contact with the consulting team.
  - i. Develop a therapeutic alliance with respect for privacy in medically ill patients.
  - j. Work cooperatively as part of a multidisciplinary team, utilizing input from other members of the team.]
  - k. Empathic and develop rapport with patients.
  - l. Work effectively as a team player with peers.
  - m. Effective and empathic working with families.
  - n. Effectively liaison with professional colleagues in other fields (i.e., primary care physician).
  - o. Adapt his/her style of interaction specific to age and cognitive capacity.
4. Professionalism:
- a. Demonstrate personal and intellectual integrity.
  - b. Demonstrate an understanding of the ethical values and codes of a member of the medical profession when dealing with patients and families.
  - c. Obtain and provide cross coverage as needed.
  - d. Assist with and ask for assistance in emergencies as appropriate.
  - e. Do appropriate sign-outs addressing pertinent issues for patients.
  - f. Demonstrate respect for patients, families and colleagues in interactions, including a sensitivity and awareness of the patient's culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
  - g. Follow through with patient care recommendations.

- h. Demonstrate respect for patient confidentiality.
  - i. Establish and maintain professional boundaries.
  - j. Maintain a professional appearance appropriate to clinical site.
5. Practice-Based Learning:
- a. Use information technology to access on-line medical information and support his/her own education.
  - b. Locate, critique, and assimilate evidence from scientific studies as it relates to patients' health problems.
  - c. Analyze practice experience and perform practice-based improvement activities.
  - d. Incorporate material discussed in supervision into clinical work.
  - e. Demonstrate motivation and eagerness to learn
6. Systems-Based Learning:
- a. Formulate and access an appropriate disposition with appropriate assistance: assessment of hospitalization vs. discharge with appropriate safety assessment, referrals for treatment, including day hospital, addictions treatment, etc., community resources, referrals for living situations (i.e., shelters, halfway houses, etc).
  - b. Do sufficient documentation and liaison effectively with insurance companies.
  - c. Gain knowledge of how types of medical practice and delivery systems differ from one another.
  - d. Gain knowledge of different costs of health care for different service.
  - e. Advocate for quality patient care and assist patients in dealing with system complexities.

**C. Child & Adolescent Psychiatry:**

The resident is primarily responsible for the treatment of patients with alcohol and drug dependence. Residents complete a psychiatric assessment form, physical examination form, orders, and initial treatment plan at the time of assessment. All assessments are reviewed for completeness and accuracy by an attending supervisor who cosigns all notes, orders, and assessments. Residents are responsible for all ongoing treatment. All clinical decisions are discussed with multi-disciplinary treatment team members prior to being enacted.

By the end of the two (2) month Child & Adolescent Psychiatry rotation, located at both the Terry Children's Psychiatric Center and Silver Lake Treatment Consortium, the resident is expected to:

1. Patient Care:
- a. Master techniques and strategies for diagnostic assessment of preschool, school age, and adolescent patients.
  - b. Gain experience with behavior modification techniques, parent management techniques, brief therapy, and longer term psychodynamic therapy.
  - c. Develop competency and appropriately prescribe and manage stimulant medication for ADHD.
  - d. Develop competency and appropriately prescribe and manage nonstimulant medication for ADHD.

- e. Develop competency and appropriately prescribe and manage medications for depression and anxiety in children and adolescents.
  - f. Be aware of the various structured diagnostic tests (CBCL, Conners, CDI etc.).
2. Medical Knowledge:
- a. Understand normal growth and development.
  - b. Be familiar with the various diagnostic conditions seen during childhood and adolescence including ADHD, Conduct Disorder, Anxiety Disorders, Oppositional Defiant Disorder, Autism, Spectrum Disorders, Mood Disorders, Obsessive-Compulsive Disorders, Substance Abuse Disorders and Learning Disabilities.
  - c. Understand the difference in symptom manifestation between children, adolescents and adults.
  - d. Understand the occurrence of commonalities in children and adolescents.
  - e. Understand the importance and impact of family dynamics among children and adolescents.
  - f. Understand the importance and impact of school experiences and peer relationships.
  - g. Become familiar with the various classifications of medications and their appropriate uses with child and adolescent patients.
  - h. Learn the appropriate use of antipsychotics in children and adolescents.
  - i. Learn the appropriate use of mood stabilizers children and adolescents.
  - j. Be familiar with techniques and applications of play therapy.
3. Interpersonal and Communication Skills:
- a. Be empathic and develop rapport with patients.
  - b. Work effectively as part of a multidisciplinary team.
  - c. Work effectively as a team player with peers.
  - d. Communicate effectively with supervisors.
  - e. Be effective and empathic working with families.
  - f. Effectively liaison with professional colleagues in other fields (i.e., primary care physician).
  - g. Adapt his/her style of interaction specific to age and cognitive capacity.
4. Professionalism:
- a. Display personal and intellectual integrity, and show an understanding of the ethical values and codes of a member of the medical profession.
  - b. Obtain and provide cross coverage as needed.
  - c. Assist with and ask for assistance in emergencies as appropriate.
  - d. Do appropriate sign-outs, addressing pertinent issues for patients.
  - e. Commit to ethical principles when dealing with patients and families
  - f. Show respect for patients and colleagues in interactions.
  - g. Display sensitivity to and awareness of the patient's culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
  - h. Respect patients and family members.
  - i. Respect physician and non-physician colleagues.
  - j. Follow through with patient care recommendations.
  - k. Behave ethically with respect for patient confidentiality.



- l. Establish and maintain professional boundaries.
  - m. Maintain a professional appearance appropriate to clinical site.
5. Practice-Based Learning:
- a. Use information technology to access on-line medical information and support his/her own education.
  - b. Locate, critique, and assimilate evidence from scientific studies as it relates to patients' health problems.
  - c. Analyze practice experience and perform practice-based improvement activities.
  - d. Incorporate material discussed in supervision into clinical work.
  - e. Demonstrate motivation and eagerness to learn.
6. Systems-Based Practice:
- a. Display knowledge of how types of medical practice and delivery systems differ from one another.
  - b. Display knowledge of different costs of health care for different service.
  - c. Advocate for quality patient care and assist patients in dealing with system complexities.

**D. Substance Abuse:**

By the end of the one (1) month substance abuse rotation, located at Brandywine Counseling, Inc., the resident is expected to:

1. Patient Care:
  - a. Conduct a thorough interview with substance abusing patients that will detail drug using histories, prior treatment, patient motivation for treatment and co-morbidity.
  - b. Match patients with addictive disorders to proper levels of treatment utilizing objective recommendations according to the American Society of Addiction Medicine categories.
  - c. Use treatment methods focusing on patient denial, such as motivational interviewing and supportive confrontation, to convert involuntary patients into voluntary patients involved in their own care.
  - d. Apply the chronic illness model of treatment in attending to their addicted patients on this rotation.
  - e. Assist addicted patients in moving through the different levels of treatment in this system.
  - f. Treat patients with co-morbid disorders both psychotherapeutically and pharmacologically.
  - g. Function as a primary therapist, co-therapist, and family or couples therapist with addicted patients.

2. Medical Knowledge:
  - a. Demonstrate understanding of the stages of recovery with addicted patients from emergency care, withdrawal from various drugs (including heroin, cocaine and alcohol), stabilization and early recovery.
  - b. Demonstrate understanding of the recovery environments and the roles played by families and collaterals in the treatment process.
  - c. Apply several informational and diagnostic tools in diagnosing addictive disorders such as: CAGE, AUDIT, DAST, SMAST, ASI.
  - d. Demonstrate understanding of the several models of addictive disorders and international strategies for highly resistant patients.
  - e. Demonstrate an understanding of all aspects of the DSM IV Criteria for Substance-Related Disorders, Substance-Induced Disorders and Remission Stages.
  - f. Treat patients for opiate agonist treatment based on an understanding of the complexities of Methadone, Buprenorphine and its varieties.
  - g. Use specific detoxification regimens both for alcohol and heroin.
  - h. Judiciously use antagonist medication (Naltrexone) used in the treatment of heroin dependence.
  - i. Demonstrate understanding of psychopharmacological adjunctive agents for the treatment of alcoholism, including Naltrexone and Disulfiram.
  - j. Demonstrate an understanding of the pharmacokinetics of all major categories of drugs.
  - k. Demonstrate understanding of the basic principles of intoxication, withdrawal and the detoxification for major categories of drugs of abuse (opiates, benzodiazepines, alcohol).
3. Interpersonal and Communication Skills:
  - a. Demonstrate an understanding of his/her own attitudes towards substance abusing patients and the ability to differentiate between recovering versus practicing addicts and alcoholics.
  - b. Be empathic and develop rapport with patients.
  - c. Work effectively as part of a multidisciplinary team.
  - d. Work effectively as a team player with peers.
  - e. Communicate effectively with supervisors.
  - f. Work effectively and empathically with families.
  - g. Effectively liaison with professional colleagues in other fields.
  - h. Adapt his/her style of interaction specific to age and cognitive capacity.
4. Professionalism:
  - a. Demonstrate personal and intellectual integrity.
  - b. Demonstrate an understanding of the ethical values and codes of a member of the medical profession when dealing with patients and families.
  - c. Obtain and provide cross coverage as needed.
  - d. Assist with and ask for assistance in emergencies as appropriate.
  - e. Do appropriate sign-outs addressing pertinent issues for patients.

- f. Demonstrate respect for patients, families and colleagues in interactions, including a sensitivity and awareness of the patient's culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
  - g. Follow through with patient care recommendations.
  - h. Demonstrate respect for patient confidentiality.
  - i. Establish and maintain professional boundaries.
  - j. Maintain a professional appearance appropriate to clinical site.
5. Practice-Based Learning:
- a. Use information technology to access on-line medical information and support his/her own education.
  - b. Locate, critique, and assimilate evidence from scientific studies as it relates to patients' health problems.
  - c. Analyze practice experience and perform practice-based improvement activities.
  - d. Incorporate material discussed in supervision into clinical work.
  - e. Demonstrate motivation and eagerness to learn.
6. Systems-Based Practice:
- a. Demonstrate understanding of the complicated medical, dental, vocational, financial, and psychosocial needs of addicted patients. This includes dealing with a high percentage of homeless patients.
  - b. Demonstrate understanding of 12 Step Programs, meetings and philosophy.
  - c. Participate as a member of an interdisciplinary team and be able to learn treatment perspectives provided from team members from Social Work, Psychology, Pharmacy, Nursing and Certified Addiction Counselors.
  - d. Demonstrate an understanding of the rationale for placement of patients internally and in community programs.
  - e. Be an advocate for addicted patients and facilitate proper placement by accurately representing information to collaborating programs.
  - f. Demonstrate an understanding of how types of medical practice and delivery systems differ from one another.
  - g. Demonstrate an understanding of the different costs of health care for different addiction services.
  - h. Advocate for quality patient care and assist patients in dealing with system complexities.

**E. Geriatric Psychiatry:**

The resident is primarily responsible for the treatment of psychiatric patients on this rotation. Residents complete the psychiatric assessment form, physical examination form, vital information at a glance form, orders, and initial treatment plan at the time of admission. All admissions are reviewed for completeness and accuracy by a psychiatric attending that cosigns all notes, orders, and assessments. Residents continue ongoing treatment with selected patients. All notes and orders are cosigned by a teaching attending. All clinical decisions are discussed with the multi-disciplinary treatment team prior to being enacted.

By the end of the one (1) month Geriatric Psychiatry rotation, located at the Delaware Psychiatric Center, the resident is expected to:

1. Patient Care:
  - a. Perform appropriate testing and work-up of newly admitted elderly patients.
  - b. Appropriately use neuroimaging and EEG in the differential diagnosis of psychiatric illness in the elderly.
  - c. Distinguish between dementia and delirium.
  - d. Make a differential diagnosis of delirium and dementia, including iatrogenic causes.
  - e. Evaluate the patient's decisional competency.
  - f. Recognize and treat substance use (especially alcohol and prescription drug abuse) including withdrawal protocols, psychoeducation, and appropriate outpatient referrals.
  - g. Adapt interview style, to communicate effectively with older adults, compensating for hearing, visual, and cognitive deficits. Residents will demonstrate respectful and caring behaviors in interactions with patients and their families.
  - h. Gather accurate key information from the patient, collateral sources, and other health care professionals as needed to complete a patient history, Mental Status Exam, structured cognitive assessment (*vascular, frontotemporal, Diffuse Lewey body dementia spectrum, Alzheimer's, etc.*), functional assessment, medical/neurological assessments, abuse assessments, caregiver issues, and community and home assessments.
  - i. Develop a multi-axial diagnosis, incorporating the biopsychosocial formulation as it relates to the elderly.
  - j. Treatment planning will incorporate a Biopsychosocial model, and enlist a multidisciplinary approach as relevant to the illness and circumstances.
  - k. The medical/psychiatric interface will be examined developing a comprehensive and organized approach to the evaluation of geriatric individuals with multiple medical co-morbidities.
  - l. Pharmacotherapy of geriatric psychiatric and cognitive disorders will be prescribed with particular attention to principles of geriatric psychopharmacology.
  - m. Inquire about herbal/non-regulated medication use, and be aware of drug interactions.
  - n. Become familiar with the benefits, risks, and indications for ECT in older adults.
  - o. Incorporate a developmental perspective in the formulation of geriatric cases as well as understanding the indications for the various psychotherapies and modifications required for elderly individuals.
  - p. Be knowledgeable about social/community resources and support systems available to the geriatric patient.
2. Medical Knowledge:
  - a. Display knowledge of neuropsychological testing used to assess geriatric patients.
  - b. Appreciate various presentations of psychiatric disorders in the elderly, and the impact on functional status, morbidity, and mortality, including: mood disorders, psychotic disorders, anxiety disorders, cognitive disorders, personality disorders, and other illnesses.
  - c. Make a broad differential diagnosis for mania and late onset psychosis.

- d. Display knowledge of the interaction of medical and psychiatric illness.
  - e. Understand indications and benefits and risks of cholinesterase inhibitors and NMDA receptor antagonists.
  - f. Understand indications and benefits and risks of typical and atypical antipsychotics, anxiolytics, mood stabilizers and antidepressants in the treatment of behavioral complications of dementia.
  - g. Understand anticholinergic side effects of psychotropics and other medications.
  - h. Manage a complex regimen of medications, including knowledge of potential drug interactions.
  - i. Use age-appropriate dosing strategies and be aware of pharmacokinetic and pharmacodynamic differences in the elderly.
3. Interpersonal and Communication Skills:
- a. Take a leadership role for patient care.
  - b. Express findings in coherent, orderly oral and written presentations including a discussion of the differential diagnosis and biopsychosocial treatments.
  - c. Create and sustain a therapeutic and ethically sound relationship with geriatric psychiatric patients and their families from a spectrum of available ethnic, racial, cultural, gender, socioeconomic, and educational backgrounds.
  - d. Use effective listening skills and adapt communication to accommodate sensory, cognitive, and functional deficits of patients and provide information appropriately, with adequate accommodations for deficits.
  - e. Engage with a family and perform an assessment of family functioning.
  - f. Effectively work with a multidisciplinary treatment team utilizing the abilities of all the mental health professionals for the benefit of the patient.
  - g. Be empathic and develop rapport with patients and families.
  - h. Work effectively as a team player with peers.
  - i. Communicate effectively with supervisors.
  - j. Effectively liaison with professional colleagues in other fields (i.e., primary care physician).
  - k. Adapt his/her style of interaction specific to age and cognitive capacity.
4. Professionalism:
- a. Demonstrate personal and intellectual integrity, and have an understanding of the ethical values and codes of a member of the medical profession.
  - b. Obtain and provide cross coverage as needed.
  - c. Assist with and ask for assistance in emergencies as appropriate.
  - d. Do appropriate sign-outs, addressing pertinent issues for patients.
  - e. Commit to ethical principles when dealing with patients and families.
  - f. Demonstrate respect for patients and colleagues in interactions.
  - g. Demonstrate sensitivity to and awareness of the patient's culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
  - h. Respect patients and family members.
  - i. Respect physician and non-physician colleagues.
  - j. Follow through with patient care recommendations.
  - k. Perform ethical behavior with respect for patient confidentiality.

- l. Establish and maintain professional boundaries.
  - m. Maintain a professional appearance appropriate to clinical site.
5. Practice-Based Learning:
- a. Use information technology to access on-line medical information and support his/her own education.
  - b. Locate, critique, and assimilate evidence from scientific studies as it relates to patients' health problems.
  - c. Analyze practice experience and perform practice-based improvement activities.
  - d. Incorporate material discussed in supervision into clinical work.
  - e. Demonstrate motivation and eagerness to learn.
  - f. Locate, critically appraise, and assimilate evidence from scientific studies and literature reviews related to their geriatric patients' mental health problems to determine how quality of care can be improved in relation to practice.
  - g. Obtain and use information about their own population of geriatric psychiatric patients and the larger population from which their patients are drawn.
6. Systems-Based Practice:
- a. Plan appropriate follow-up care, including medication management, therapy and day program.
  - b. Understand indications for nursing home placement vs. assisted living or board and care placements.
  - c. Display knowledge of the regulations governing nursing home placement, including the role of Adult Evaluation Review Service.
  - d. Display knowledge of regulations governing psychotropic prescriptions and restraints in nursing homes.
  - e. Become familiar with the diverse systems involved in the care of older patients and their families, and how to use and integrate these resources into a comprehensive psychiatric treatment plan.
  - f. Become aware of community systems of care and know how to help patients access appropriate care and other support services such as the area agencies on aging, social work, etc.
  - g. Practice cost-effective care without compromising quality of care.

**F. Emergency Psychiatry (Night Float):**

The resident is primarily responsible for the treatment of psychiatric patients on this rotation. Residents complete the psychiatric assessment form, physical examination form, orders, and initial treatment plan at the time of admission. All admissions are reviewed for completeness and accuracy by a psychiatric attending that cosigns all notes, orders, and assessments. Residents are responsible for ongoing treatment. All clinical decisions are discussed with a multi-disciplinary treatment team.

By the end of the one (1) month emergency psychiatry rotation, located at the Christiana Care Health System's Wilmington Hospital, the resident is expected to:

1. Patient Care:
  - a. Assess and begin to manage crisis situations with appropriate supervision as needed.
  - b. Effectively accept and prioritize the sign-out of cases at the beginning of a shift.
  - c. Efficiently and appropriately acquire clinical information in a variety of ways including: patient interview, family interview, calling collateral sources of information, reviewing old records.
  - d. Effectively manage the violent or agitated patient through the judicious use of verbal de-escalation, medications, restraints.
  - e. Make a complete suicide risk assessment including lethality of method, details of planning, level of hopelessness, risk of rescue ratio, and social support as well as document the assessment.
  - f. Make a complete homicide risk assessment including prior history, legal history, and presence of paranoia as well as document the assessment.
  - g. Assess and manage psychotic patients in the emergency setting.
  - h. Integrate biopsychosocial constructs into formulation of cases.
  - i. Check levels of psychiatric medications (including Lithium, Depakote, Tegretol, Pamelor) and assess how these levels relate to the last dose.
  - j. Understand the psychosocial aspects of treatment with patients, including crisis counseling, psychoeducation, community referrals.
  - k. Effectively document patient history as well as the decision-making process and justification for professional judgment.
  - l. Assess a patient medically through history and physical exam and ability to recognize and manage uncomplicated medical needs.
  - m. Develop initial treatment plans including safety and biopsychosocial aspects.
  - n. Obtain appropriate history and physical for the patient in detoxification.
  - o. Recognize complicating medical factors in the patient with an addiction.
  - p. Monitor a patient in detoxification and be familiar with symptoms and signs of alcohol and heroin withdrawal.
  - q. Understand informed consent and document risk/benefit discussion of treatment options with patients.
  - r. Work as independently as possible but know when to seek supervision.
2. Medical Knowledge:
  - a. Formulate a comprehensive differential diagnosis including medical causes for psychiatric presentations.
  - b. Gain an evolving knowledge of the indications and pharmacologic properties of psychotropic medications commonly used in the emergency setting.
  - c. Assess for and treat the following pharmacologic emergencies: anticholinergic toxicity, NMS, serotonin syndrome, dystonic reactions.
  - d. Gain knowledge of medication interactions and major side effects of medications.
  - e. Gain knowledge of the indications for various methods of detoxification, including for heroin, alcohol and benzodiazepines.
  - f. Appropriately dose medications for alcohol and heroin withdrawal.
3. Interpersonal and Communication Skills:

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- a. Effectively collaborate and liaison with a multidisciplinary team in delivering psychiatric emergency services.
  - b. Effectively work with non-psychiatric staff in the education and management of patients in crisis.
  - c. Give thorough, clear, concise sign-outs for patients at the end of a shift.
  - d. Rapidly form and foster effective therapeutic relationships with patients in crisis.
  - e. Efficiently summarize and present the results and conclusions of data collected, including labs and collateral information.
  - f. Effectively work with addictions treatment personnel.
  - g. Be emphatic and develop rapport with patients.
  - h. Work effectively as part of a multidisciplinary team.
  - i. Work effectively as a team player with peers.
  - j. Communicate effectively with supervisors.
  - k. Effectively liaison with professional colleagues in other fields.
  - l. Adapt his/her style of interaction specific to age and cognitive capacity.
4. Professionalism:
- a. Demonstrate personal and intellectual integrity.
  - b. Obtain and provide cross coverage as needed.
  - c. Assist with and ask for assistance in emergencies as appropriate.
  - d. Do appropriate sign-outs, addressing pertinent issues for patients.
  - e. Commit to ethical principles when dealing with patients and families.
  - f. Respect patients and colleagues during interactions.
  - g. Demonstrate sensitivity to and awareness of the patient's culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
  - h. Respect patients and family members.
  - i. Respect physician and non-physician colleagues.
  - j. Follow through with patient care recommendations.
  - k. Perform ethically with respect for patient confidentiality.
  - l. Establish and maintain professional boundaries.
  - m. Maintain a professional appearance appropriate to clinical site.
5. Practice-Based Learning:
- a. Use information technology to access on-line medical information and support his/her own education.
  - b. Locate, critique, and assimilate evidence from scientific studies as it relates to patients' health problems.
  - c. Analyze practice experience and perform practice-based improvement activities.
  - d. Incorporate material discussed in supervision into clinical work.
  - e. Demonstrate continuous motivation and eagerness to learn.
  - f. Perform a videotaped patient interview, and review interview with attending physician.
6. Systems-Based Practice:
- a. Formulate and access an appropriate disposition with appropriate assistance: assessment of hospitalization vs. discharge with appropriate safety assessment,



*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- referrals for treatment, including day hospital, addictions treatment, etc., community resources, referrals for living situations (i.e., shelters, halfway houses, etc).
- b. Perform sufficient documentation and liaison effectively with insurance companies.
  - c. Gain knowledge of how types of medical practice and delivery systems differ from one another.
  - d. Gain knowledge of different costs of health care for different service.
  - e. Advocate for quality patient care and assist patients in dealing with system complexities.

### **PGY-III Resident**

The PGY-III resident will build on the foundation of the PGY-I year and continued learning of PGY-II year in making the transition to a psychiatrist who can function independently with a modest level of supervision. The acquisition of the necessary knowledge, skills, and attitudes will be demonstrated by the substantial completion of the goals and objectives of each clinical rotation, attendance at seminars, and satisfactory performance on the PRITE and mock board examinations.

### **Primary Responsibilities:**

#### **A. Knowledge:**

1. Show appreciation of scientific basis for psychiatric knowledge;
2. Understand and implement intermediate theories and practice of psychotherapies;
3. Have an advanced knowledge of groups and family systems;
4. Have a working knowledge of ethical and legal issues of psychiatric practice; and
5. Understand the neuropsychiatric approach to patient assessment and treatment.

#### **B. Skills:**

1. Conduct supervised, independent outpatient pharmacotherapy and psychotherapy in an outpatient setting;
2. Present clinical and scientific material in a group and/or educational setting;
3. Gain leadership skills in educational and administrative venues; and
4. Be able to critically evaluate and summarize the scientific psychiatric literature and present a summary of findings.

#### **C. Attitudes:**

1. Conduct conscientious work in an outpatient setting of increasing independence;
2. Have an informed skepticism and curiosity about psychiatric knowledge;
3. Have the willingness to function as a resource to colleagues and co-workers; and
4. Conduct an ongoing assessment of personal strengths and deficits, and develop strategies to address them.

### **Clinical Responsibilities:**

#### **A. Outpatient Psychiatry:**

The resident is primarily responsible for the treatment of psychiatric outpatients during this rotation. Residents complete a psychiatric assessment form, orders, and initial treatment plan at the time of assessment. All assessments are reviewed for completeness and accuracy by a psychiatric attending that cosigns all notes, orders, and assessments. Residents are responsible for ongoing treatment. All clinical decisions are discussed in individual and group supervision with the rotation's supervisor.

By the end of the twelve (12) full-time, consecutive months outpatient psychiatry rotation, located at both the Wilmington and Dover Community Mental Health Clinics, the resident is expected to:

1. Patient Care:
  - a. Learn to utilize a biopsychosocial approach in the outpatient treatment of individuals with severe mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder, and recurrent major depression.
  - b. Learn to treat severe mental illness pharmacologically and to manage medications, including antipsychotics, mood stabilizers and adjunctive medications, in an outpatient clinic.
  - c. Learn to perform supportive psychotherapy and combined psychotherapy and psychopharmacological treatment of patients with severe mental illness.
  - d. Learn to manage crises in outpatient treatment with patients with severe mental illness and demonstrate an understanding of criteria for more intensive treatment.
  - e. Learn to perform recommended physical and laboratory assessments for initial outpatient treatment and continuing follow-up of patients with severe mental illness.
  - f. Learn to address, at a basic level, somatic issues relevant to patients with severe mental illness (such as smoking cessation, diabetes, and hypertension) and facilitate and support appropriate somatic care.
  - g. Learn to perform family through supervised patient/family sessions.
  - h. Learn to perform group therapy through a longitudinal supervised experience as a group co-leader.
  
2. Medical Knowledge:
  - a. Understand the concepts of recovery and consumer empowerment and how to utilize these concepts in the treatment of patients with severe mental illness.
  - b. Develop advanced skill in selecting specific antidepressants for specific patient presentations (e.g. anxious depression, array of anxiety disorders, atypical depression, elderly patients, etc.).
  - c. Develop advanced skill in combining antidepressants, using augmenters and other treatment strategies to address treatment refractory depression.
  - d. Develop advanced skill in treating refractory bipolar disorder/impulse control disorders using combination mood stabilizer therapies in addition to other somatic treatments (Inderal, Ca-channel blockers, ECT, etc.).
  - e. Learn treatment options for refractory psychotic disorders.
  - f. Develop advanced proficiency in appropriately using neuroleptics to treat special populations and illnesses which lack a psychotic component.
  - g. Develop advanced skill in treating common and serious antidepressant-induced side-effects (sexual dysfunction, insomnia, central serotonin syndrome, etc.).
  - h. Develop advanced skill in treating common and serious mood stabilizer-induced side-effects (alopecia, hypothyroidism, creatinine elevations, ataxia, etc.).
  - i. Gain advanced knowledge of most CYP 450 mediated drug interactions pertinent to antidepressant and mood stabilizer therapy.
  - j. Gain detailed knowledge of specific and special properties of various benzodiazepines (PO Valium is fastest PO BZD; use of SL Xanax in panic disorder; conversion to Klonopin for BZD tapers; etc.).
  - k. Develop basic skill in atypical uses of traditional and newer mood stabilizers (VPA for panic or migraine, Neurontin for neuropathic pain, etc.).

1. Learn the three antidepressants that don't produce sexual dysfunction when used as monotherapy.
3. Interpersonal and Communication Skills:
  - a. Collaborate with other treatment and care providers, including multidisciplinary team members, psychosocial rehabilitation staff, case managers, and somatic providers around treatment of severely mentally ill individuals.
  - b. Effectively liaison with professional colleagues in other fields (i.e., primary care physician).
  - c. Work with patients and their families utilizing approaches including psychoeducation, outreach and liaison with community services.
  - d. Express findings in coherent, orderly oral and written presentations including a discussion of the differential diagnosis and biopsychosocial treatments.
  - e. Communicate effectively with supervisors.
4. Professionalism:
  - a. Demonstrate personal and intellectual integrity, and have an understanding of the ethical values and codes of a member of the medical profession.
  - b. Obtain and provide cross coverage as needed.
  - c. Assist with and ask for assistance in emergencies as appropriate.
  - d. Do appropriate sign-outs, addressing pertinent issues for patients.
  - e. Commit to ethical principles when dealing with patients and families.
  - f. Demonstrate respect for patients and colleagues in interactions.
  - g. Demonstrate sensitivity to and awareness of the patient's culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
  - h. Respect patients and family members.
  - i. Respect physician and non-physician colleagues.
  - j. Follow through with patient care recommendations.
  - k. Perform ethical behavior with respect for patient confidentiality.
  - l. Establish and maintain professional boundaries.
  - m. Maintain a professional appearance appropriate to clinical site.
5. Practice-Based Learning:
  - a. Use information technology to access on-line medical information and support his/her own education.
  - b. Locate, critique, and assimilate evidence from scientific studies as it relates to patients' health problems.
  - c. Analyze practice experience and perform practice-based improvement activities.
  - d. Incorporate material discussed in supervision into clinical work.
  - e. Demonstrate motivation and eagerness to learn.
6. Systems-Based Practice:
  - a. Understand community resources relating to individuals with severe mental illness, including psychosocial rehabilitation programs, employment programs, day hospitals, crisis beds, and residential programs.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- b. Understand how types of medical practice and delivery systems differ from one another.
- c. Become aware of different costs of health care for different services.
- d. Advocate for quality patient care and assist patients in dealing with system complexities.

## **PGY-IV Resident**

PGY-IV residents will develop a mature facility in the knowledge, skills, and attitudes developed in the earlier years. Success will be demonstrated by substantial completion of the goals and objectives of each clinical rotation, attendance of seminars, and satisfactory performance on the PRITE and mock board examinations.

### **Primary Responsibilities:**

#### **A. Knowledge:**

1. Have an advanced knowledge in the content areas of previous years;
2. Have an advanced knowledge in one modality of psychotherapy; and
3. Have a working knowledge of the economics of health care and employment agreements.

#### **B. Skills:**

1. Have advanced skills in the areas developed in previous years;
2. Organize educational/scientific material and teach it to others, including early year residents;
3. Function as a leader of the health care team;
4. Negotiate an employment agreement post-residency;
5. Function as a resource and leader to less experienced residents; and
6. Interact ethically with the pharmaceutical industry.

#### **C. Attitudes:**

1. Generously share skills and knowledge with others;
2. Comfortably accept and utilize leadership skills in educational, administrative, and clinical settings; and
3. Continue the process of self-assessment and development.

### **Clinical Responsibilities:**

#### **A. Forensic Psychiatry:**

The resident is primarily responsible for the treatment of forensic psychiatric inpatients during this rotation. All assessments are reviewed for completeness and accuracy by a psychiatric attending that cosigns all notes, orders, and assessments. All clinical decisions are discussed in individual and group supervision with the rotation's supervisor.

By the end of the two (2) month forensic psychiatry rotation, located at the Delaware Psychiatric Center's Jane Mitchell Building, the resident is expected to:

1. Patient Care:
  - a. Obtain information from the patient interview, family contact, old charts, and outpatient providers to complete a thorough assessment of the following areas:
    - i. History of Present Illness – Complete assessment of symptomology, chronological order of events, recent stressors and precipitants, and level of functioning;

- ii. Past Medical History;
  - iii. Past Psychiatric History;
  - iv. Substance Abuse History;
  - v. Family History;
  - vi. Social History; and
  - vii. Developmental History.
- b. Complete a comprehensive mental status examination;
  - c. Be able to assess dangerousness in patients, in both civil and criminal contexts;
  - d. Be able to evaluate victims of violence, including rape;
  - e. Be able to critically review forensic reports;
  - f. Understand the need to balance patients' rights against those of society;
  - g. Be able to detect malingered mental illness;
  - h. Use precautions appropriately including close observation, suicide precautions, and one-to-one;
  - i. Understand and appropriately apply criteria for inpatient hospitalization;
  - j. Determine if a patient is medically stable enough for psychiatric hospitalization;
  - k. Be able to perform a forensic psychiatric assessment under supervision of attending;
  - l. Be able to produce a forensic psychiatric report addressing various legal issues;
  - m. Be able to treat patients within a broad range of forensic settings and effectively manage high-risk patients;
  - n. Be able to evaluate mentally ill and mentally retarded offenders;
  - o. Be able to give expert evidence in court;
  - p. Demonstrate a basic understanding of individual, group, and family treatment as it relates to forensic psychiatry; and
  - q. Document the full history, mental status examination, hospital course, basic differential diagnosis, basic diagnostic formulation, and basic treatment plan in the discharge summary. The resident should be able to complete to forensic reports by the end of forensic rotation.
2. Medical Knowledge:
- a. Understand the concepts of recovery and consumer empowerment and how to utilize these concepts in the treatment of patients with severe mental illness.
  - b. Develop advanced skill in selecting specific antidepressants for specific patient presentations (e.g. anxious depression, array of anxiety disorders, atypical depression, elderly patients, etc.).
  - c. Develop advanced skill in combining antidepressants, using augmenters and other treatment strategies to address treatment refractory depression.
  - d. Develop advanced skill in treating refractory bipolar disorder/impulse control disorders using combination mood stabilizer therapies in addition to other somatic treatments (Inferal, Ca-channel blockers, ECT, etc.).
  - e. Learn treatment options for refractory psychotic disorders.
  - f. Develop advanced proficiency in appropriately using neuroleptics to treat special populations and illnesses which lack a psychotic component.
  - g. Develop advanced skill in treating common and serious antidepressant-induced side-effects (sexual dysfunction, insomnia, central serotonin syndrome, etc.).

- h. Develop advanced skill in treating common and serious mood stabilizer-induced side-effects (alopecia, hypothyroidism, creatinine elevations, ataxia, etc.).
  - i. Gain advanced knowledge of most CYP 450 mediated drug interactions pertinent to antidepressant and mood stabilizer therapy.
  - j. Gain detailed knowledge of specific and special properties of various benzodiazepines (PO Valium is fastest PO BZD; use of SL Xanax in panic disorder; conversion to Klonopin for BZD tapers; etc.).
  - k. Develop basic skill in atypical uses of traditional and newer mood stabilizers (VPA for panic or migraine, Neurontin for neuropathic pain, etc.).
  - l. Learn the three antidepressants that don't produce sexual dysfunction when used as monotherapy.
  - m. Make a reasonable differential diagnosis based on DSM-IV-TR criteria to include all 5 axes;
  - n. Complete two forensic reports.
3. Interpersonal and Communication Skills:
- a. Co-lead team meetings on the unit;
  - b. Be empathetic and develop rapport with patients;
  - c. Work effectively as part of a multidisciplinary team;
  - d. Work effectively as a team player with peers;
  - e. Communicate effectively with supervisors;
  - f. Be effective and empathetic working with families;
  - g. Effectively liaison with professional colleagues in other fields (i.e. primary care physicians); and
  - h. Adapt his/her style of interaction specific to age and cognitive capacity
4. Professionalism:
- a. Exemplify personal and intellectual integrity, and demonstrate an understanding of the ethical values and codes of the medical profession;
  - b. Show respect for the legal process;
  - c. Recognize and adapt to cultural differences;
  - d. Obtain and provide cross coverage, as needed;
  - e. Assist with and ask for assistance in emergencies, as appropriate;
  - f. Do appropriate sign-outs addressing pertinent issues for patients;
  - g. Demonstrate a commitment to ethical principles when dealing with patients and families;
  - h. Demonstrate respect for patients and colleagues in interactions;
  - i. Demonstrate a sensitivity and awareness of the patient's culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities;
  - j. Demonstrate respect towards patients and family members;
  - k. Demonstrate respect for physician and non-physician colleagues;
  - l. Communicate effectively with peers regarding cross-coverage and sign-out of patients;
  - m. Follow through with patient care recommendations;
  - n. Use ethical behavior with respect for patient confidentiality; and
  - o. Establish and maintain professional boundaries.



5. Practice-Based Learning:
  - a. Use information technology to access online medical information and support his/her own education;
  - b. Locate, critique, and assimilate evidence from scientific studies as it relates to patients' health problems;
  - c. Become aware of the psychiatrist's limited role in judicial decision making;
  - d. Analyze practice experience and perform practice-based improvement activities;
  - e. Incorporate material discussed in supervision into clinical work; and
  - f. Display motivation and eagerness to learn.
  
6. Systems-Based Practice:
  - a. Know how types of medical practice and delivery systems differ from one another;
  - b. Be able to liaison with lawyers, police, corrections, and court;
  - c. Be aware of different costs of health care for different services;
  - d. Understand important issues in forensic psychiatric administration;
  - e. Be able to work in a forensic psychiatric multi-disciplinary team;
  - f. Advocate for quality patient care and assist patients in dealing with system complexities; and
  - g. Demonstrate a basic understanding of medical-legal issues as it relates to forensic psychiatry:
    - i. Testifying in hearings;
    - ii. Court-ordered patients;
    - iii. Issues of confidentiality; and
    - iv. Forced medications/medication panels.

**B. Electroconvulsive Therapy (ECT):**

The resident is primarily responsible for the treatment of ECT psychiatric outpatients during this rotation. All assessments are reviewed for completeness and accuracy by a psychiatric attending that cosigns all notes, orders, and assessments. All clinical decisions are discussed in individual supervision with the rotation's supervisor.

By the end of the one (1) month ECT rotation, located at Christiana Care Health System's Wilmington Hospital, the resident is expected to:

1. Patient Care:
  - a. Gather data from appropriate sources, including chart, hospital staff, family, and other relevant individuals to assess the need for ECT;
  - b. Demonstrate knowledge regarding the clinical indications and contraindications for ECT, the evaluation of patients for this treatment modality, all aspects of ECT administration, and the management of patients over and following the treatment course, including maintenance of ECT; and
  - c. Participate in and show competencies in the administration of ECT, including familiarity with unilateral and bilateral electrode placement, contemporary ECT devices, and seizure monitoring.

2. Medical Knowledge:
  - a. Gain an in-depth experience with the administration of and indications for ECT involving inpatients and outpatients;
  - b. Gain knowledge regarding the risks, benefits, and side effects of ECT;
  - c. Have an understanding of clinical situations in which ECT may be the treatment of choice, including in patients with a non-psychiatric illness;
  - d. Understand the general perception by the public of ECT, the state of the evidence regarding these perceptions, and answers to commonly asked questions about ECT; and
  - e. Understand informed consent and the legal aspects of ECT.
  
3. Interpersonal and Communication Skills:
  - a. Engage in effective interactions with consultants, patients, other medical providers, including the reporting of findings and other recommendations;
  - b. Adapt his/her style of interaction specific to age and cognitive capacity;
  - c. Effectively engage the patient and his/her family in a discussion regarding risks, benefits, and side effects of ECT; and
  - d. Be able to address fears, myths, and misinformation about the use of ECT.
  
4. Professionalism
  - a. Demonstrate personal and intellectual integrity;
  - b. Demonstrate an understanding of the ethical values and codes of a member of the medical profession when dealing with patients and families;
  - c. Demonstrate respect for patients, families and colleagues in interactions, including a sensitivity and awareness of the patient's culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities;
  - d. Follow through with patient care recommendations;
  - e. Demonstrate respect for patient confidentiality;
  - f. Establish and maintain professional boundaries; and
  - g. Maintain a professional appearance appropriate to clinical site.
  
5. Practice-Based Learning:
  - a. Use information technology to access on-line medical information and support his/her own education;
  - b. Locate, critique, and assimilate evidence from scientific studies as it relates to patients' health problems;
  - c. Analyze practice experience and perform practice-based improvement activities;
  - d. Incorporate material discussed in supervision into clinical work; and
  - e. Demonstrate motivation and eagerness to learn
  
6. Systems-Based Practice:
  - a. Do sufficient documentation and liaison effectively with insurance companies;
  - b. Gain knowledge of how types of medical practice and delivery systems differ from one another;
  - c. Gain knowledge of different costs of health care for different service; and

- d. Advocate for quality patient care and assist patients in dealing with system complexities.

C. **Electives:**

GMEC will review objectives and update policies to include electives offered to PGY-IV resident.

*Appendices C & D*  
**Remediation, Dismissal, and Due Process Policy**

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*Last Revision: 11-30-2007*

*01-15-2004*

*06-20-1997*

**Purpose:** The purpose of this policy is (1) to develop a framework for disciplinary procedures to address the various disciplinary actions that may occur for reasons of remediation for academic deficiencies or dismissal for professional misconduct; and (2) to develop a framework in which residents may appeal disciplinary actions without fear of intimidation or retaliation, in compliance with the ACGME Institutional Requirements. The Sponsoring Institute encourages residents to first attempt to resolve any concerns informally by meeting with the supervisor or Residency Program Director.

**Scope:** This policy applies to the Delaware Psychiatry Residency Program.

**Policy:** It is the policy of the Sponsoring Institution that the following processes for disciplinary action, grievances, and due process will be adhered to by psychiatry residents and Program Director, employees, faculty, staff and administration. *Any considerations for dismissal will follow the Disciplinary process. Performance evaluations or the placement of residents on probation may not be appealed.*

**Procedures:**

A. Disciplinary Action:

1. Remediation:

A resident may be placed on a non-probationary action plan, academic probation or suspension to correct deficiencies in his/her academic performance at his/her level of training, or if behavioral problems interfere with a resident's clinical performance or ability to benefit from training.

2. Dismissal:

A resident may be dismissed from a program per the Disciplinary and Grievance processes. Specifically, transgressions while fulfilling resident duties involving disregard for patient safety, refusal to comply with or accept an assignment, using training time for personal gain, falsifying medical records, willful damage to the Delaware Psychiatric Center, or affiliate properties, physical threats and/or assaults, possession of alcoholic beverages or illegal drugs, intoxication, cognitive impairment, possession of a weapon, and/or disregard for American Psychiatric Association ethical standards may be subject to immediate suspension by the Program Director and/or the GMEC Disciplinary Committee. Following such action, the disciplinary procedures will be followed. A resident may also be dismissed from the program for a consistent inability to perform at his/her level of training, or if repetitive behavioral problems interfere with a resident's clinical performance or ability to benefit from training.

3. Any notice of suspension (curtailment of clinical responsibilities) or dismissal of a resident must be in writing, must generally state the reasons for the action, and must be reviewed with the resident, who must sign and date indicating the material has been reviewed with him/her. The notice must inform the resident of his/her right to appeal as described in the Grievance process. A copy of this signed notice should also be sent to the GMEC. Any removal from remediation (as described in A. 1) should also be made in writing to the resident and a copy should be placed in the residency office and resident's permanent record.

### **Disciplinary Process:**

The primary purposes of the disciplinary process are to discourage performance deficiencies and work problems, rehabilitate the resident, and prevent further occurrences. This process is based on the following principles:

- That the GMEC expectations of a resident's performance and behavior are reasonable;
- That expectations are applied uniformly to all residents;
- That the resident is aware of the expectations prior to training;
- that the resident is given verbal warning and written reprimand prior to further disciplinary action being taken, except when more urgent action was warranted;
- That a fair investigation is conducted; and
- That the degree of discipline is related to the seriousness of the deficiency.

A. Continued poor academic and clinical performance, violations of work rules, and instances of unacceptable behavior or misconduct will be subject to progressive discipline. Progressive discipline procedures are as follows:

1. Verbal warning is given to the resident by the resident's supervisor and/or the Residency Program Director that behavior and/or performance is unacceptable and that failure to correct the deficiencies may result in further disciplinary action. The verbal warning will contain details of the nature of the behavior and performance and expectations and goals which were violated, expectations for improved performance and behavior, including specific time frames to accomplish improvement and consequences of not meeting required changes within the allotted time. The resident maintains a normal work load and schedule. While a record is kept of these proceedings, it is not made a part of the resident's permanent record. All further disciplinary steps will become of the resident's permanent record, along with the resident's response.
2. The resident's supervisor will notify the Program Director in writing if the resident does not respond to verbal warning. The Program Director will then prepare a written reprimand, if necessary, which will include a description of the unacceptable conduct, specify the necessary improvement, and the consequences for failure to improve. The written reprimand will contain details of the nature of the behavior or performance and expectations and goals which were violated, expectations for improved performance and behavior, including specific time frames to accomplish improvement and consequences of not meeting required changes within the allotted time. The resident maintains a normal work load and schedule.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

3. If oral warning and written reprimand do not succeed in bringing about necessary improvement or if the resident's behavior and/or performance warrant a higher level of discipline, the GMEC Disciplinary Committee will hold a hearing to consider further action which may result in probation, suspension, or dismissal. The GMEC will establish the conditions and terms for further disciplinary action. The following procedures apply:

B. Make-up of the GMEC Subcommittees:

1. Throughout the academic year, the GMEC will operate two ad hoc subcommittees, which are formed on a case-by-case basis: the GMEC Disciplinary Committee and the GMEC Grievance Committee.

The Disciplinary Subcommittee is formed when a written complaint is filed for disciplinary action. The Disciplinary Subcommittee may not include members who have brought a complaint against the resident. The Program Director will attend Disciplinary Meetings, but is not a voting member.

The GMEC Grievance Committee may include members of the GMEC (excluding members who have been involved in disciplinary proceedings, the Program Director, and persons who have brought a complaint against the resident) and/or other clinicians who are credentialed practitioners in their field at DPC. The Grievance Committee will be made up of five (5) members as outlined in the Grievance Policy and may not include a member who filed a complaint against the resident. The Program Director will make recommendations appointing members to each of the two subcommittees which will be approved by the GMEC. A discussion of the Grievance Committee's procedure will be found in the Grievance Policy.

2. When a resident is considered for possible disciplinary action to the GMEC, the Disciplinary Committee will hold a hearing to determine whether to initiate disciplinary action. The Disciplinary Subcommittee may only meet when all five (5) of its voting members are present. If a voting member is unable to attend a meeting, the Program Director may appoint an appropriate substitute.
3. The Disciplinary Committee will use the following procedure to guide them in their function:
  - a. Review all material pertinent to the case and may solicit additional information, either written or oral, as it deems pertinent.
  - b. Give the resident written notice of the deficiencies being evaluated.
  - c. Give the resident a hearing date, at least five (5) days after the written notification of deficiencies.
  - d. Upon receipt, the resident will respond orally and in writing to the written notification, to questions from the Review Committee, and may bring any faculty, residents, staff, or other persons to speak on his/her behalf.
4. The Committee may make the following recommendations:
  - a. That no deficiency exists and that the resident is allowed to return to normal working status;

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- b. That the resident is placed on probationary status lasting up to three months. Probation may involve a normal or modified work load or supervision on the resident's service or alternate clinical duties. Guidelines for performance, remedial training, counseling, supervision, and evaluation are to be established by the Disciplinary Committee. At the end of the probationary period, the situation is reviewed using the procedures above, and further findings and recommendations will be made as indicated. These may include additional probationary periods up to three months in length. If, during the probationary period, the resident's performance is considered deficient, the matter may be referred back to the Disciplinary Committee for review;
  - c. That the resident is withheld formal academic credit;
  - d. That the resident may be suspended without pay for all or part of any period of probation or suspension;
  - e. That the resident is placed on probationary suspension (leave without pay) for a period of up to one year, with recommendations, as appropriate;
  - f. That the resident's contract of employment is not renewed; and
  - g. That the resident is dismissed from the program immediately.
5. Transgressions while fulfilling resident duties involving disregard for patient safety, refusal to obey or accept assignment, using training time for personal gain, falsification of medical records, willful damage to DPC or affiliate properties, falsifying and/or omission on the employment application, theft of DPC or affiliate's property, physical threats and/or assaults, possession of alcoholic beverages or illegal drugs, intoxication, cognitive impairment, possession of a weapon, and disregard for the American Psychiatric Association (APA) Ethical Standards may be subject to immediate discipline and/or suspension by the Program Director and/or GMEC Disciplinary Committee. Following such action, the procedures as outlined in paragraph "A.3" will be followed.
- C. Minutes are kept of all Disciplinary Committee meetings. Once sufficient evidence is gathered, the Disciplinary Committee members vote based on a simple majority vote. The Disciplinary Committee may only meet when at least five of its members are present.
- D. The Disciplinary Committee will issue a written report of its recommendations. Disciplinary recommendations "3.d (iv-vii)" will also need written approval by the Hospital Director of DPC. The resident will be entitled to a copy of this determination. If the decision is recommendation "3.d (i)", the GMEC Disciplinary Committee may not reinstitute the disciplinary decision, except if additional behavior of performance warrants it.
- E. Any disciplinary action above verbal warning will become a part of the resident's permanent record. The resident's written response will also be a part of the permanent record. All permanent records including written reprimand, further disciplinary action, Disciplinary Committee minutes, and Disciplinary Committee recommendations will be available to the resident to make copies under written request. All such disciplinary records will be kept in a separate locked file by the Program Director.

- F. In regard to any disciplinary action, the resident is given an opportunity to provide verbal and/or written explanation for the behavior or performance and give their version of events.
- G. The resident will have the right to grieve any disciplinary action taken by the Disciplinary Committee as outlined in the Grievance Process. This process gives the resident an opportunity to appeal decisions the resident believes are unjustified. When a resident receives notice of suspension, dismissal, or no promotion by the Program Director, he/she will have the right to appeal such action.

**Grievance Process:**

Any resident who has been disciplined will have the opportunity to have the disciplinary decision reviewed by a body whose members have had no involvement with the enactment of the disciplinary decision. This process gives the resident an opportunity to appeal decisions the resident believes are unjustified.

- A. If a resident has been disciplined under The Delaware Psychiatry Residency Program's Disciplinary Process, the resident may request an appeal of the disciplinary decision. While the appeal process is underway, the disciplinary action will be maintained in force.
- B. Within ten (10) days, work and non-work days, of being disciplined, the resident may provide a written request for a grievance hearing to the Graduate Medical Education Committee (GMEC). If the resident does not make a written request within ten (10) days, the disciplinary action stands. Additional appeal may be requested only if further disciplinary action is taken.
- C. The GMEC Grievance Committee will be composed of five (5) members as follows:
  - 1. One faculty member or credentialed DPC staff member and one resident will be chosen by the aggrieved resident.
  - 2. Three faculty members or credentialed DPC staff members, excluding the Residency Program Director or someone who has filed a complaint against the resident or participated in the disciplinary proceedings against the resident, will be chosen by the Program Director.
    - a. If the aggrieved resident does not select a resident and/or other member to the Grievance Committee within ten (10) days, work and non-work days, after being given written request, then the Program Director will fill those slots. The Chair of the Grievance Committee will be chosen by the Program Director.
- D. The Grievance Committee will use the following procedure to guide them in their function:
  - 1. The Grievance Committee will review all material pertinent to the case and may solicit additional information, either written or oral, as it deems pertinent.
  - 2. The resident may respond orally and in writing to any of the actions taken by the Disciplinary Committee, to questions from the Grievance Committee and may bring any faculty, residents, staff, or other persons to speak on the resident's behalf.



- E. The Grievance Committee will determine whether there has been due process involved as outlined in the Disciplinary Process. The Grievance Committee will assess the following criteria:
1. That the GMEC's expectations of a resident's performance and behavior are reasonable;
  2. That these expectations are applied uniformly to all residents;
  3. That the resident was aware of these expectations prior to training;
  4. That the resident was given notice of the misconduct through verbal warning and written reprimand prior to disciplinary action being taken, except when more urgent action was warranted;
  5. That a fair investigation was conducted; and
  6. That the degree of discipline was related to the seriousness of the deficiency.
- F. Minutes are kept of all Grievance Committee meetings. Once sufficient evidence is gathered, the Grievance Committee members vote based on a simple majority vote.
- G. The Grievance Committee will provide a written report of the proceedings to the Disciplinary Committee. A copy will also be given to the resident. This report will limit its focus to whether the six criteria in paragraph "E" have been followed.

If the Grievance Committee's report indicated that it does not concur with the disciplinary action taken by the Disciplinary Committee, the Disciplinary Committee shall amend the disciplinary action.

**Due Process:**

Due process ensures that decisions about resident/fellows are not arbitrary or personally based. It requires that the Residency identify specific evaluative procedures which are applied to all residents, and provide appropriate appeal procedures available to the resident. All steps need to be appropriately documented and implemented. General due process guidelines include:

- During the orientation period, presenting to the residents/fellows, in writing, the program's expectations related to professional functioning. Discussing these expectations in both group and individual settings should also occur.
- Stipulating the procedures for evaluation, including when and how evaluations will be conducted. Such evaluations should occur at meaningful intervals.
- Articulating the various procedures and actions involved in making decisions regarding impairment.
- Communicating, early and often about any suspected difficulties.
- Instituting, when appropriate, a remediation plan for identified inadequacies, including a time frame for expected remediation and consequences of not rectifying the inadequacies.
- Providing a written procedure to the resident/fellow that describes how the resident may appeal the program's action. Such procedures are included in this policy. These policies, included in the Delaware Psychiatry Residency Program Policy and Procedure Manual is provided to residents during orientation.
- Ensuring that residents have sufficient time to respond to any action taken by the program.
- Documenting, in writing and to all relevant parties, the actions taken

**A. There are two areas for which an appeal *cannot* be made: performance evaluations and placement on probation.**

1. In the event a resident encounters any difficulties or problems (e.g., poor supervision, unavailability of supervisor, workload issues, personality clashes, other staff conflicts, or perceived adverse decisions) during his/her training experience, he/she can:
  - a. Discuss the issue with the faculty/staff member involved. If it cannot be resolved informally, the resident should discuss the issue with the Program Director.
  - b. If that does not resolve the issue, the resident may speak with the DIO and may choose to initiate a formal appeal.

***Appendix E***

**ACGME General and Requirements and Special Requirements for Psychiatry**

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*Last Revision: 11-30-2007*

*07-16-2004*

*01-05-1998*

**ACGME Program Requirements for Graduate Medical Education in Psychiatry**

***Common Program Requirements are in BOLD***

*Effective: July 1, 2007*

**Introduction**

**A. Definition of the Specialty**

Psychiatry is a medical specialty focused on the prevention, diagnosis, and treatment of mental, addictive, and emotional disorders. An approved residency program in psychiatry is designed to ensure that its graduates are able to render effective professional care to psychiatric patients. The graduates will possess sound clinical judgment, requisite skills, and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders, together with other common medical and neurological disorders that relate to the practice of psychiatry. Graduates must have a keen awareness of their own strengths and limitations, and recognize the necessity for continuing their own professional development.

**B. Duration and Scope of Education**

**1. Admission Requirements**

Physicians may enter psychiatry programs at either the first-year or second-year postgraduate level. Physicians entering at the second year postgraduate level must document successful completion of a clinical year of education in an ACGME-accredited specialty requiring comprehensive and continuous patient care, such as a program in internal medicine, family medicine, pediatrics, or transitional year program. For physicians entering at the PG-2 level after completion of such a program, the PG-1 year may be credited toward the forty-eight (48) month requirement.

**2. Length of the Program**

- a. Residency education in psychiatry requires 48 months, of which twelve months may be completed in an ACGME accredited child and adolescent psychiatry program. Although residency is best completed on a full-time basis; part-time training at no less than half time is permissible to accommodate residents with personal commitments (e.g., child care).
- b. A program may petition the residency review committee to alter the length of education beyond these minimum requirements by presenting a clear educational rationale consistent with the program requirements. The program director must obtain the approval of the sponsoring institution and the Review Committee prior to implementation and at each subsequent review of the program.
- c. Prior to entry into the program, each resident must be notified in writing of the required length of education for which the program is accredited. The required length of education for a particular resident may not be changed during his or her program without mutual agreement, unless there is a break in education or the resident requires remedial education.

- d. Programs should meet all of the Program Requirements of Residency Education in Psychiatry. Under rare and unusual circumstances, one- or two-year programs may be approved, even though they do not meet the above requirements for psychiatry. Such one- or two-year programs will be approved only if they provide some highly specialized educational and/or research program. These programs may provide an alternative specialized year or two of training, but do not provide complete residency education in psychiatry. The traditional program time and the specialized program must ensure that residents will complete the didactic and clinical requirements outlined in the program requirements.
  - e. Electives should enrich the educational experience of residents in conformity to their needs, interest, and/or future professional plans. Electives must have written goals and objectives, and must be well constructed, purposeful, and lead to effective learning experiences. The choice of electives must be made with the advice and approval of the program director and the appropriate preceptor.
    - (1) The Review Committee encourages programs to identify residents who may be interested in academic psychiatry by introducing subspecialty education and research electives early in the residency program. This will provide an opportunity for education in general psychiatry, and exposure to a psychiatry fellowship (e.g., geriatric psychiatry) through electives.
    - (2) All such electives must demonstrate compliance with the requirements in general psychiatry, and be submitted to the committee prior to implementation for review and approval. Submissions must also outline the educational curriculum necessary to meet the requirements of general psychiatry and how elective education will be structured to prepare the resident for subspecialty education. Prior to entry into the program, residents must be informed in writing that all general psychiatry requirements must be met prior to graduation.
3. First Year of Education
- The program director of the psychiatry residency program must monitor performance and maintain personal contact with residents during the first postgraduate-year while they are on services other than psychiatry. A first postgraduate-year in psychiatry should include:
- a. minimum of four (4) months in a primary care clinical setting that provides comprehensive and continuous patient care in specialties such as internal medicine, family medicine, and/or pediatrics. Neurology rotations may not be used to fulfill this four month requirement. One month of this requirement may be fulfilled by either an emergency medicine or intensive care rotation, provided the experience is predominantly with medical evaluation and treatment and not surgical procedures, and
  - b. no more than eight (8) months in psychiatry.

## **I. Institutions**

### **A. Sponsoring Institution**

**One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites. The sponsoring institution and the program must ensure that the program director has sufficient protected time and**

**financial support for his or her educational and administrative responsibilities to the program.**

**B. Participating Sites**

- 1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.**

**The PLA should:**

- a. identify the faculty who will assume both educational and supervisory responsibilities for residents;**
  - b. specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
  - c. specify the duration and content of the educational experience; and,**
  - d. state the policies and procedures that will govern resident education during the assignment.**
- 2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**
  - 3. The number and distribution of participating training sites must not preclude satisfactory participation by residents in teaching and didactic exercises. Geographic proximity of participating sites will be one factor in evaluating program cohesion, continuity, and peer interaction.**

**II. Program Personnel and Resources**

**A. Program Director**

- 1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**
- 2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
- 3. Qualifications of the program director must include:**
  - a. requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
  - b. current certification in the specialty by the American Board of Psychiatry and Neurology, or specialty qualifications that are acceptable to the Review Committee; and,**
  - c. current medical licensure and appropriate medical staff appointment.**
  - d. In general, the minimum term of appointment must be at least the duration of the program plus one year.**
- 4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**

- a. oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;
- b. approve a local director at each participating site who is accountable for resident education;
- c. approve the selection of program faculty as appropriate;
- d. evaluate program faculty and approve the continued participation of program faculty based on evaluation;
- e. monitor resident supervision at all participating sites;
- f. prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;
- g. provide each resident with documented semiannual evaluation of performance with feedback;
- h. ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;
- i. provide verification of residency education for all residents, including those who leave the program prior to completion;
- j. implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:
  - (1) distribute these policies and procedures to the residents and faculty;
  - (2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
  - (3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
  - (4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
- k. monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
- l. comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
- m. Be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
- n. obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:
  - (1) all applications for ACGME accreditation of new programs;
  - (2) changes in resident complement;
  - (3) major changes in program structure or length of training;
  - (4) progress reports requested by the Review Committee;
  - (5) responses to all proposed adverse actions;

- (6) requests for increases or any change to resident duty hours;
  - (7) voluntary withdrawals of ACGME-accredited programs;
  - (8) requests for appeal of an adverse action;
  - (9) appeal presentations to a Board of Appeal or the ACGME; and,
  - (10) proposals to ACGME for approval of innovative educational approaches.
- o. obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
- (1) program citations, and/or
  - (2) request for changes in the program that would have significant impact, including financial, on the program or institution.
  - (3) The sponsoring institution's designated institutional official must approve all major program changes prior to submission to the ACGME through ADS.
- p. The program director must make resident appointments and assignments in accordance with institutional and departmental policies and procedures.
- q. The program director must supervise residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff.
- r. The program director must regularly evaluate residents' knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician.
- s. The program director must monitor residents' stress, including physical or emotional conditions which inhibit performance or learning, as well as drug- or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Educational situations that consistently produce undesirable stress on residents must be evaluated and modified.
- t. The program director must dedicate no less than 50% (at least 20 hours per week) of his or her professional effort to the psychiatry educational program and receive institutional support for this time. This effort must be devoted to administrative and educational activities of the psychiatry educational program.

## **B. Faculty**

1. **At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.**

### **The faculty must:**

- a. **devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and**
- b. **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**

2. **The physician faculty must have current certification in the specialty by the American Board of Psychiatry and Neurology, or possess qualifications acceptable to the Review Committee.**
  - a. A physician faculty member may be appointed to the School of Medicine as a voluntary faculty member.
3. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
4. **The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
5. **The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
  - a. **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
  - b. **Some members of the faculty should also demonstrate scholarship by one or more of the following:**
    - (1) **peer-reviewed funding;**
    - (2) **publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
    - (3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**
    - (4) **participation in national committees or educational organizations.**
  - c. **Faculty should encourage and support residents in scholarly activities.**
6. The faculty must participate regularly and systematically in the educational program, and must be readily available for consultation whenever a resident is faced with a major therapeutic or diagnostic problem.
7. The faculty should actively participate in the planning, organization, and presentation of conferences as well as in clinical teaching and supervision.
8. A member of the teaching staff in each participating institution must be designated to assume responsibility for the day-to-day activities of the program at that institution, with overall coordination by the program director.

### **C. Other Program Personnel**

**The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.**

#### **1. Associate Program Director**

An associate program director is a member of the physician teaching faculty who assists the program director in the administrative and clinical oversight of the educational program.

The Sponsoring Institution must provide additional dedicated time either for the program director or for associate program directors based on program size and complexity of training sites. At a minimum, a total of 30 hours per week, program director or combined program director and associate program director time, is required for an approved complement of 24 to 40 residents, and 40 hours per week for



an approved complement of 41 to 79 residents.

When a program is approved for 80 or more residents, there must be additional time allocated for directing the program

2. There must be a residency coordinator who has adequate time, based on program size and complexity, to support the residency program.
3. Chair of Psychiatry  
The chair of psychiatry must be:
  - a. a physician who is appointed to and in good standing with the medical staff of an institution participating in the program;
  - b. qualified and have at least three years' experience as a clinician, administrator, and educator in psychiatry;
  - c. certified in psychiatry by the American Board of Psychiatry and Neurology or possess appropriate qualifications judged to be acceptable by the Review Committee;
  - d. actively involved in psychiatry through continuing medical education, professional societies, and scholarly activities; and,
  - e. capable of mentoring medical faculty, residents, administrators and other health care professionals, and possess medical leadership qualifications consistent with other physician chairs within the sponsoring institution.
4. Education Policy Committee  
The director of the residency program should have an educational policy committee composed of members of the psychiatry program teaching staff. This committee should include representation from the residents as well as a member of the teaching staff from each ACGME-approved subspecialty residency that may be affiliated with the psychiatry residency. There should be a written description of the committee, including its responsibility to the sponsoring department or institution and to the program director. This committee should participate actively in:
  - a. planning, developing, implementing, and evaluating all significant features of the residency program, including the selection of residents (unless there is a separate residency selection committee);
  - b. determining curriculum goals and objectives; and
  - c. evaluating both the teaching staff and the residents.

#### **D. Resources**

**The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.**

1. All programs must have adequate patient populations for each mode of required education and, minimally, must include organized clinical services in inpatient, outpatient, emergency, consultation/liaison, and child and adolescent psychiatry.
2. Residency programs must have available to them adequate inpatient and outpatient facilities and other suitable clinical placements where the residents can meet the

educational objectives of the program. The program should specify the facilities in which the goals and objectives are to be implemented.

3. All residents must have available to them offices adequate in size and decor to allow them to interview patients and accomplish their duties in a professional manner. The facility must also provide adequate and specifically-designated areas in which residents can perform basic physical examination and other necessary diagnostic procedures and treatment interventions.
4. There must be adequate space and equipment, including equipment with the capability to record and playback session, specifically designated for seminars, lectures, and other educational activities.

#### **E. Medical Information Access**

**Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.**

### **III. Resident Appointments**

#### **A. Eligibility Criteria**

**The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.**

1. The program director must accept only those applicants whose qualifications of residency include sufficient command of English to permit accurate and unimpeded communication.

#### **B. Number of Residents**

**The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.**

1. In order to promote an educationally-sound, intellectually stimulating atmosphere of effective and graded responsibility, programs must have at least three residents at each level of education. Programs that fall below this prescribed critical mass will be reviewed, and if this deficiency is not corrected, they may be cited for noncompliance, except when the number of PG-4 residents is fewer than three because residents have entered child and adolescent psychiatry training.
2. Any permanent change in the number of approved positions requires prior approval by the Review Committee. Programs seeking interim approval of a permanent increase in the number of approved resident positions should contact the Executive Director of the Review Committee. Prior approval is not required for temporary changes in resident numbers owing to makeup or remedial time for currently-enrolled residents, or to fill vacancies.

Approval of permanent increases above the approved range of residents will require documentation that didactic and clinical education, including supervision, will not be compromised.

**C. Resident Transfers**

- 1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.**
- 2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.**
3. Verification must include evaluation of professional integrity of residents transferring from one program to another, including from a general psychiatry to a child and adolescent psychiatry program.
4. A transferring resident's educational program must be sufficiently individualized so that he/she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation.

**D. Appointment of Fellows and Other Learners**

**The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.**

**IV. Educational Program**

**A. The curriculum must contain the following educational components:**

- 1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;**
- 2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;**
- 3. Regularly scheduled didactic sessions;**
- 4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,**
- 5. ACGME Competencies**

**The program must integrate the following ACGME competencies into the curriculum:**

**a. Patient Care**

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

- (1) must have supervised experience in the evaluation and treatment of patients. These patients should be of different ages and gender from across the life

- cycle, and from a variety of ethnic, racial, sociocultural, and economic backgrounds;
- (2) should be familiar with Axis III conditions that can affect evaluation and care (e.g., CNS lesions, HIV/AIDS, and other medical conditions).
  - (3) should develop competence in:
    - a. formulating a clinical diagnosis for patients by conducting patient interviews, eliciting a clear and accurate history; performing physical, neurological, and mental status examination, including appropriate diagnostic studies; completing a systematic recording of findings; relating history and clinical findings to the relevant biological psychological, behavioral, and sociocultural issues associated with etiology and treatment;
    - b. developing a differential diagnosis and treatment plan for all psychiatric disorders in the current standard nomenclature, i.e., DSM, taking into consideration all relevant data;
    - c. using pharmacological regimens, including concurrent use of medications and psychotherapy;
    - d. understanding the indications and uses of electroconvulsive therapy;
    - e. applying supportive, psychodynamic, and cognitive-behavioral psychotherapies to both brief and long-term individual practice, as well as to assuring exposure to family, couples, group and other individual evidence-based psychotherapies;
    - f. providing psychiatric consultation in a variety of medical and surgical settings;
    - g. providing care and treatment for the chronically-mentally ill with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions;
    - h. participating in psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance and performance improvement;
    - i. providing psychiatric care to patients who are receiving treatment from nonmedical therapists and coordinating such treatment; and,
    - j. recognizing and appropriately responding to family violence (e.g., child, partner, and elder physical, emotional, and sexual abuse and neglect) and its effect on both victims and perpetrators.
  - (4) will have major responsibility for the care of a significant number of patients with acute and chronic psychiatric illnesses;
    - a. Patient care assignments must permit residents to practice appropriate treatment, and to have sufficient time for other aspects of their educational program.
    - b. Residents must be provided structured clinical experiences that are organized to provide opportunities to conduct initial evaluations, to participate in the subsequent diagnostic process, and to follow patients during the treatment phase and/or evolution of their psychiatric disorders/conditions.

- c. Experiences may be completed on a full or part-time basis so long as the stated full-time equivalent experience is met. For residents who plan to enter subspecialty education in child and adolescent psychiatry prior to completing general psychiatry requirements, certain clinical experiences with children, adolescents and families taken during the period when the resident is designated as a child and adolescent psychiatry resident may be counted toward general psychiatry requirements as well as child and adolescent requirements, thereby fulfilling program requirements in both general and child and adolescent psychiatry. The following guidelines must be met for these experiences:
  - i. they must be limited to child and adolescent psychiatry patients;
  - ii. no more than twelve (12) months may be double counted;
  - iii. there should be documentation from the child and adolescent psychiatry program director for all areas for which credit is given in both programs;
  - iv. there will be no reduction in total length of time devoted to education in child and adolescent psychiatry; this must remain at two years; and,
  - v. only the following experiences can be used to meet requirements in both general and child and adolescent psychiatry:
    - (a) one month full-time equivalent of child neurology;
    - (b) one month full-time equivalent of pediatric consultation;
    - (c) one month full-time equivalent of addiction psychiatry;
    - (d) forensic psychiatry experience;
    - (e) community psychiatry experience; and
    - (f) no more than 20% of outpatient experience of the Program Requirements for Psychiatry.
- (5) will have the required clinical experiences which include the following:
  - a. Neurology: two full-time equivalent months of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions. At least one month should occur in the first or second year of the program;
  - b. Inpatient Psychiatry: six (6) but no more than sixteen (16) months full-time equivalent of inpatient psychiatry of which there must be a minimum of six months of significant responsibility for the assessment, diagnosis, and treatment of general psychiatric patients who are admitted to traditional psychiatry units, day hospital programs, research units, residential treatment programs, and other settings that meet the following criteria:
    - i. The patient population is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and gender; and,

- ii. Patient services are comprehensive and continuous and allied medical and ancillary staff are available for backup support at all times.
- c. Outpatient Psychiatry: twelve (12) month full-time equivalent organized, continuous, and supervised clinical experience in the assessment, diagnosis, and treatment of outpatients with a wide variety of disorders and treatment modalities, with experience in both brief and long-term care of patients. Each resident must have significant experience treating outpatients longitudinally for at least one year. This longitudinal experience should include:
  - i. evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly under supervision;
  - ii. exposure to multiple treatment modalities that emphasize developmental, biological, psychological and social approaches to outpatient treatment;
  - iii. opportunities to apply psychosocial rehabilitation techniques, and to evaluate and treat differing disorders in a chronically ill patient population; and,
  - iv. no more than 20% of the patients seen may be children and adolescents. This portion of education may be used to fulfill the two (2) month Child and Adolescent Psychiatry requirements, so long as this component meets the requirement for child and adolescent psychiatry as set forth in d.i and d.ii below.
- d. Child and Adolescent Psychiatry: two (2) month full-time equivalent organized clinical experience in which the residents are:
  - i. supervised by child and adolescent psychiatrists who are certified by ABPN or judged by the Review Committee to have equivalent qualifications; and
  - ii. provided opportunities to assess development and to evaluate and treat a variety of diagnoses in male and female children and adolescents and their families, using a variety of interventional modalities.
- e. Geriatric Psychiatry: one month full-time equivalent organized experience focused on the specific competencies in areas that are unique to the care of the elderly. These include the diagnosis and management of mental disorders in patients with multiple comorbid medical disorders, familiarity with the differential diagnosis and management (including management of the cognitive component) of the degenerative disorders, an understanding of neuropsychological testing as it relates to cognitive functioning in the elderly, and the unique pharmacokinetic and pharmacodynamic considerations encountered in the elderly, including drug interactions.
- f. Addiction Psychiatry: one month full-time equivalent organized experience focused on the evaluation and clinical management of

patients with substance abuse/dependence problems, including dual diagnosis. Treatment modalities should include detoxification, management of overdose, maintenance pharmacotherapy, the use of psychological and social consequences of addiction in confronting and intervening in chronic addiction rehabilitation used in recovery stages from precontemplation to maintenance, and the use of self-help groups.

- g. Consultation/Liaison: two (2) month full-time equivalent in which residents consult under supervision on other medical and surgical services.
- h. Forensic Psychiatry: This experience must expose residents to the evaluation of forensic issues such as patients facing criminal charges, establishing competency to stand trial, criminal responsibility, commitment, and an assessment of their potential to harm themselves or others. This experience should include writing a forensic report. Where feasible, giving testimony in court is highly desirable.
- i. Emergency Psychiatry: This experience must be conducted in an organized, 24-hour psychiatric emergency service, a portion of which may occur in ambulatory urgent-care settings, but not as part of the 12-month outpatient requirement. Residents must be provided experiences in evaluation, crisis evaluation and management, and triage of psychiatric patients. On-call experiences may be a part of this experience, but no more than 50%.
- j. Community Psychiatry: This experience must expose residents to persistently and chronically-ill patients in the public sector, (e.g., community mental health centers, public hospitals and agencies, and other community based settings). The program should provide residents the opportunity to consult with, learn about, and use community resources and services in planning patient care, as well as to consult and work collaboratively with case managers, crisis teams, and other mental health professionals.
- k. Addiction, Community, Forensic, and Geriatric psychiatry requirements can be met as part of the inpatient requirements above the minimum six months, and/or as part of the outpatient requirement

**b. Medical Knowledge**

**Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:**

must meet the following requirements.

- (1) Didactic instruction must be systematically organized, thoughtfully integrated, based on sound educational principles, and include regularly scheduled lectures, seminars, and assigned readings.
- (2) The didactic sessions must be scheduled to ensure a minimum of 70% of resident attendance while adhering to program duty hour policy. Didactic

and clinical education must have priority in the allotment of residents' time and energy.

- (3) The didactic curriculum must include the following specific components:
  - a. the major theoretical approaches to understanding the patient-doctor relationship;
  - b. the biological, genetic, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle;
  - c. the fundamental principles of the epidemiology, etiologies, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, sociocultural, and iatrogenic factors that affect the prevention, incidence, prevalence and long-term course and treatment of psychiatric disorders and conditions;
  - d. comprehensive discussions of the diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, such as neoplasm, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, multiple sclerosis, seizure disorders, stroke, intractable pain, and other related disorders;
  - e. the use, reliability, and validity of the generally accepted diagnostic techniques, including physical examination of the patient, laboratory testing, imaging, neurophysiologic and neuropsychological testing, and psychological testing;
  - f. the use and interpretation of psychological testing (under the supervision and guidance of a qualified clinical psychologist, residents should have experience with the interpretation of the psychological tests most commonly used, some of which experience should be with their own patients);
  - g. the history of psychiatry and its relationship to the evolution of medicine;
  - h. the legal aspects of psychiatric practice, and when and how to refer;
  - i. an understanding of American culture and subcultures, particularly those found in the patient community associated with the educational program, with specific focus for residents with cultural backgrounds that are different from those of their patients;
    - i. use of case formulation that includes neurobiological, phenomenological, psychological, and sociocultural issues involved in the diagnosis and management of cases; and, each program must provide the following:
    - ii. All residents must be educated in research literacy. Research literacy is the ability to critically appraise and understand the relevant research literature and to apply research findings appropriately to clinical practice. The concepts and process of Evidence Based Clinical Practice include skill development in question formulation, information searching, critical appraisal,



and medical decision-making, thus providing the structure for teaching research literacy to psychiatry residents. The program must promote an atmosphere of scholarly inquiry, including the access to ongoing research activity in psychiatry. Residents must be taught the design and interpretation of data.

- iii. The program must provide residents with research opportunities and the opportunity for development of research skills for residents interested in conducting research in psychiatry or related fields. The program must provide interested residents access to and the opportunity to participate actively in ongoing research under a mentor. If unavailable in the local program, efforts to establish such mentoring programs are encouraged.
- iv. The program must ensure the participation of residents and faculty in journal clubs, research conferences, didactics, and/or other activities that address critical appraisal of the literature and understanding of the research process.

**c) Practice-based Learning and Improvement**

**Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:**

- (1) **identify strengths, deficiencies, and limits in one's knowledge and expertise;**
- (2) **set learning and improvement goals;**
- (3) **identify and perform appropriate learning activities;**
- (4) **systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**
- (5) **incorporate formative evaluation feedback into daily practice;**
- (6) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;**
- (7) **use information technology to optimize learning; and,**
- (8) **participate in the education of patients, families, students, residents and other health professionals.**
- (9) taking primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and rotation-specific goals and objectives, as well as attendance at conferences;
  - a. Resident's teaching abilities should be documented by evaluations from faculty and/or learners.
    - i. There must be a record that demonstrates that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. In the

case of transferring residents, the records should include the experiences in the prior and current program.

- ii. The record must be reviewed periodically with the program director or a designee, and must be made available to the surveyor of the program. The record may be maintained in a number of ways and is not limited to a paper driven patient log.

**d) Interpersonal and Communication Skills**

**Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:**

- (1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;**
- (2) communicate effectively with physicians, other health professionals, and health related agencies;**
- (3) work effectively as a member or leader of a health care team or other professional group;**
- (4) act in a consultative role to other physicians and health professionals; and,**
- (5) maintain comprehensive, timely, and legible medical records, if applicable.**
- (6) interviewing patients and family in an effective manner to facilitate accurate diagnosis and biological, psychological and social formulation.

**e) Professionalism**

**Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:**

- (1) compassion, integrity, and respect for others;**
- (2) responsiveness to patient needs that supersedes self-interest;**
- (3) respect for patient privacy and autonomy;**
- (4) accountability to patients, society and the profession; and,**
- (5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.**
- (6) high standards of ethical behavior which include respect for patient privacy and autonomy, maintaining appropriate professional boundaries, and understanding the nuances specific to psychiatric practice. Programs are expected to distribute to residents and operate in accordance with the AMA Principles of Ethics with “Special Annotations for Psychiatry,” as developed by the American Psychiatric Association to ensure that the application and teaching of these principles are an integral part of the educational process.
- (7)

**f) Systems-based Practice**

**Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:**

- (1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;**
- (2) coordinate patient care within the health care system relevant to their clinical specialty;**
- (3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or populationbased care as appropriate;**
- (4) advocate for quality patient care and optimal patient care systems;**
- (5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,**
- (6) participate in identifying system errors and implementing potential systems solutions.**
- (7) knowing how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;
- (8) practicing cost-effective health care and resource allocation that does not compromise quality of care, including an understanding of the financing and regulation of psychiatric practice, as well as information about the structure of public and private organizations that influence mental health care; a
- (9) advocating for quality patient care and assisting patients in dealing with system complexities, including disparity in mental health care;
- (10) working with health care managers and health care providers to assess, coordinate, and improve health care, particularly as it relates to access to mental health care;
- (11) knowing how to advocate for the promotion of mental health and the prevention of disease;
- (12) maintaining a mechanism to ensure that charts are appropriately maintained and readily accessible for patient care and regular review for supervisory and educational purposes;
- (13) collaborating with psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel in the treatment of patients; and
- (14) monitoring clinical records on major rotations to assess resident competencies to:
  - a. document an adequate history and perform mental status, physical, and neurological examinations;
  - b. organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues;
  - c. proceed with appropriate laboratory and other diagnostic procedures;

- d. develop and implement an appropriate treatment plan followed by regular and relevant progress notes regarding both therapy and medication management; and,
- e. prepare an adequate discharge summary and plan.

## **B. Residents' Scholarly Activities**

1. **The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.**
2. **Residents should participate in scholarly activity.**
  - a. Residents will have instruction in research methods in the clinical, biological, and behavioral sciences related to psychiatry, including techniques to appraise the professional and scientific literature and to apply evidence based findings to patient care.
3. **The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.**

## **V. Evaluation**

### **A. Resident Evaluation**

#### **1. Formative Evaluation**

- a. **The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.**
- b. **The program must:**
  - (1) **provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**
  - (2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**
  - (3) **document progressive resident performance improvement appropriate to educational level; and,**
  - (4) **provide each resident with documented semiannual evaluation of performance with feedback.**
- c. **The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.**
- d. Regular evaluations of the knowledge, skills, and professional growth of each resident, using appropriate criteria and procedures, must be maintained, including complete records of evaluations containing explicit statements on the resident's progress toward meeting educational objectives and his or her major strengths and weaknesses.
- e. The program must formally examine the cognitive knowledge of each resident at least annually in the PG-2, PG-3 and PG- 4 years, and conduct an examination across biological, psychological and social spheres that are defined in the program's written goals and objectives.
- f. The program must formally conduct a clinical skills examination. A required component of this assessment is an annual evaluation of the following skills:

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

## **2. Summative Evaluation**

**The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy.**

**This evaluation must:**

- a. **document the resident's performance during the final period of education, and**
- b. **verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.**
- c. The final evaluation should also include a summary of any documented evidence of unethical behavior, unprofessional behavior, or clinical incompetence or a statement that none such has occurred. Where there is such evidence, it must be comprehensively recorded, along with the resident's response(s) to such evidence.

## **B. Faculty Evaluation**

1. **At least annually, the program must evaluate faculty performance as it relates to the educational program.**
2. **These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**

3. **This evaluation must include at least annual written confidential evaluations by the residents.**

#### **C. Program Evaluation and Improvement**

1. **The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:**
  - a. **resident performance;**
  - b. **faculty development;**
  - c. **graduate performance, including performance of program graduates on the certification examination; and,**
  - d. **program quality. Specifically:**
    - (1) **Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**
    - (2) **The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**
2. **If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**
3. **In its evaluation of residency programs, the Review Committee will take into consideration the information provided by the American Board of Psychiatry and Neurology regarding resident performance on the certifying examinations during the most recent five years. The expectation is that the rate of those passing the examination on their first attempt is 50% and that 70% of those who complete the program will take the certifying examination**

#### **VI. Resident Duty Hours in the Learning and Working Environment**

##### **A. Principles**

1. **The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.**
2. **The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.**
3. **Didactic and clinical education must have priority in the allotment of residents' time and energy.**
4. **Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.**

##### **B. Supervision of Residents**

**The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.**

1. **Each resident must receive a minimum of two hours of direct supervision per week, at least one of which is individual.**

**C. Fatigue**

**Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.**

**D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)**

**Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.**

- 1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
- 2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.**
- 3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**

**E. On-call Activities**

- 1. In-house call must occur no more frequently than every third night, averaged over a four-week period.**
  - a. On psychiatry rotations, in-house call must occur no more frequently than every fourth night, averaged over a four week period.**
- 2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**
- 3. No new patients may be accepted after 24 hours of continuous duty.**
  - a. a new patient is defined as any patient for whom the resident has not previously provided care.**
- 4. At-home call (or pager call)**
  - a. The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.**
  - b. Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.**
  - c. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**

**F. Moonlighting**

- 1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**

- 2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.**

**G. Duty Hours Exceptions**

**A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.**

- 1. In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.**
- 2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.**

**VII. Experimentation and Innovation**

**Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Procedures located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.**

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*ACGME-Approved: September 12, 2006 Effective: July 1, 2007*

*Revised Common Program Requirements Effective: July 1, 2007*

*ACGME-Approved Minor Revision: February 12, 2008 Effective: April 12, 2008*



*Appendix F*

**Policy on Sexual Harassment Prevention**

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*Last Revision: 10-01-2005  
12-18-2002*

**Purpose & Scope:** To establish a policy for the Executive Branch of the State of Delaware outlining its position and practice with regard to sexual harassment in the workplace and to outline the method of reporting and resolving complaints.

**Policy:** The State is committed to ensuring that all employees and residents have a working environment free of intimidation, hostility and offensive behavior. This includes freedom from sexual harassment.

- A. Sexual harassment is unwelcome sexual advances or other verbal or physical conduct of a sexual nature when:
  - 1. Submission to such conduct is a term or condition of an individual's employment;
  - 2. Submission to or rejection of such conduct is used as the basis for employment decisions; and/or
  - 3. The conduct unreasonably interferes with the individual's job performance or creates an intimidating, hostile or offensive working environment.
- B. State employees and residents are strictly prohibited from engaging in any form of sexual harassment, including, but not limited to, requests for sexual favors, telling sexual jokes, displaying lewd pictures, touching private areas of a person's body or making lewd gestures, and making sexually-degrading remarks. Other harassing behaviors, such as repeated unwelcome non-work related calls of a sexual nature from an employee or resident from any state facility to another employee's, resident's or individual's home, work place, cellular phone or pager are also strictly prohibited.
- C. The State will not tolerate any such conduct on the part of a State employee, resident or any individual on its worksite. Any employee or resident, who, after a complete and impartial investigation, is found to have engaged in such conduct will be subject to appropriate disciplinary action, up to and including termination. Non-employees who engage in such conduct at a State office will be subject to appropriate action necessary to eliminate the harassment.
- D. No employee or resident will be subjected to retaliation (reprisal) for reporting, testifying, assisting or participating in any manner in an investigation proceeding or hearing resulting from a complaint of discriminatory or harassing behavior. No person shall intimidate, threaten, coerce or discriminate against any individual for the purpose of interfering with that person's right to file a complaint of sexual harassment.

**Procedure:**

NOTE: All parties receiving a report of sexual harassment will treat the allegation with strict confidentiality to the extent possible.

If you are the object of unwelcome sexual conduct, tell the person that you find the behavior unwelcome and ask him or her to stop. If you cannot talk to the person, report the person to your

supervisor or another appropriate person (e.g., the other individual's supervisor, Residency Director, Division Director, Human Resources, etc.) giving details relating to the complaint. This supervisor or manager will tell the person that you find the behavior unwelcome and ask him or her to stop. If the behavior continues, the supervisor and employee should report the person through the procedure outlined below.

- A. Any employee or resident who believes s/he has been the victim of sexual harassment has a right to file a complaint. The reporting procedure is as follows:
1. Immediately report the incident to your supervisor or another appropriate person (e.g., the other individual's supervisor, Residency Director, Division Director, etc.) giving details relating to the complaint.
  2. Any supervisor or manager receiving a complaint must immediately notify his/her Division Director, Human Resources Manager or whoever has been designated to receive such complaints by your Cabinet Secretary/Agency Head.
  3. If your agency has a Human Resources Manager, that individual must also be notified in addition to any individual designated in #2. The Human Resources Manager shall take immediate and appropriate steps to investigate the complaint. If your agency does not have a Human Resources Manager or if the complaint crosses agency lines, then the Office of Management and Budget shall be notified, and a determination will be made as to the appropriate individual(s) to investigate the complaint.
  4. Following investigation of the complaint, the validity of the charge will be determined.
  5. If charges are determined to be valid, the parties will be informed that the applicable Division Director, Cabinet Secretary or Agency Head will take action against the harasser to prevent recurrence in the future (the precise action should not be divulged to the complainant.) If charges are determined to be valid, the offender shall face immediate and appropriate disciplinary action, recommended by Human Resources and/or the Office of Management and Budget and imposed by the appropriate Division Director, Cabinet Secretary or Agency Head. Disciplinary action(s) shall be processed in accordance with Merit System Rules/Union Contract where applicable.
  6. If charges are determined to be invalid or highly questionable based on related facts, the individual investigating the charge will document accordingly and relay to the applicable Division Director, Cabinet Secretary or Agency Head. If charges are determined to be invalid, the parties and the applicable Division Director, Cabinet Secretary or Agency Head will be informed of the decision based on the investigation and related facts, and notified that no further action will be taken.
  7. If the charges are found to be inconclusive, then the Cabinet Secretary or Agency Head will consult with the Director of the Office of Management and Budget or designee per the appropriate course of action.
  8. The individual(s) named in #3, along with the applicable Division Director, Cabinet Secretary or Agency Head (or their designee), will hold a private meeting with each party involved to advise of the results of the investigation.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

A follow-up interview will be held with the complainant approximately two (2) to four (4) weeks after the decision to ensure no reoccurrence and/or retaliation.

9. The individual(s) named in #3 will inform the Cabinet Secretary/Agency Head and the applicable Division Director of the results of all harassment complaints.
  10. Note: Any employee or resident found to have knowingly and willfully filed false charges of sexual harassment will be subject to appropriate disciplinary action.
- B. Employees and residents also have the right to directly contact the statewide EEO/AA Administrator at 577-8977 or the Department of Labor's Office of Labor Law Enforcement at 761-8200 or 422-1134 (Milford). Employees should note that there is a time limit, prescribed by statute, for filing a formal complaint with the Department of Labor's Office of Labor Law Enforcement. The statute of limitations for filing a charge under state law is one hundred twenty (120) days from the date of the discriminatory action and three hundred (300) days under Federal law. Making a complaint pursuant to this policy will not extend the time by which any person must file a formal complaint with the Delaware Department of Labor, The Federal Equal Employment Opportunity Commission, or any court or regulatory body. No provision of this policy is intended to create any individual right or legal cause of action that does not already exist under state or federal law.

*Appendix G*  
**American Psychiatric Association Ethical Standards**

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*Last Revision: 6/17/2009*

American Psychiatric Association  
The Principles of Medical Ethics  
With Annotations Especially Applicable to Psychiatry  
2009 Edition

In 1973, the American Psychiatric Association (APA) published the first edition of *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*. Subsequently, revisions were published as the APA Board of Trustees and the APA Assembly approved additional annotations. In July of 1980, the American Medical Association (AMA) approved a new version of the *Principles of Medical Ethics* (the first revision since 1957), and the APA Ethics Committee<sup>1</sup> incorporated many of its annotations into the new *Principles*, which resulted in the 1981 edition and subsequent revisions. This version includes changes to the *Principles* approved by the AMA in 2001.

Foreword

ALL PHYSICIANS should practice in accordance with the medical code of ethics set forth in the *Principles of Medical Ethics* of the American Medical Association. An up-to-date expression and elaboration of these statements is found in the Opinions and Reports of the Council on Ethical and Judicial Affairs of the American Medical Association.<sup>2</sup> Psychiatrists are strongly advised to be familiar with these documents.<sup>3</sup>

However, these general guidelines have sometimes been difficult to interpret for psychiatry, so further annotations to the basic principles are offered in this document. While psychiatrists have the same goals as all physicians, there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice, even

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<sup>1</sup>The committee included Herbert Klemmer, M.D., Chairperson, Miltiades Zaphiropoulos, M.D., Ewald Busse, M.D., John R. Saunders, M.D., and Robert McDevitt, M.D. J. Brand Brickman, M.D., William P. Camp, M.D., and Robert A. Moore, M.D., served as consultants to the APA Ethics Committee.

<sup>2</sup>*Current Opinions with Annotations of the Council on Ethical and Judicial Affairs*, Chicago, American Medical Association, 2002–2003.

<sup>3</sup>Chapter 7, Section 1 of the Bylaws of the American Psychiatric Association (May 2003 edition) states, "All members of the Association shall be bound by the ethical code of the medical profession, specifically defined in the *Principles of Medical Ethics* of the American Medical Association and in the Association's *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*." In interpreting the Bylaws, it is the opinion of the APA Board of Trustees that inactive status in no way removes a physician member from responsibility to abide by the *Principles of Medical Ethics*.

though the basic principles are the same. The annotations are not designed as absolutes and will be revised from time to time so as to be applicable to current practices and problems.

Following are the *AMA Principles of Medical Ethics*, printed in their entirety, and then each principle printed separately along with an annotation especially applicable to psychiatry.

**Principles of Medical Ethics  
American Medical Association**

**Preamble**

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following *Principles* adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

*Section 1*

A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

*Section 2*

A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

*Section 3*

A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

*Section 4*

A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

*Section 5*

A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

*Section 6*

A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

*Section 7*

A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

*Section 8*

A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

*Section 9*

A physician shall support access to medical care for all people.

## **Principles With Annotations**

Following are each of the AMA *Principles of Medical Ethics* printed separately along with annotations especially applicable to psychiatry.

### **Preamble**

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.<sup>4</sup>

*Section 1*

*A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.*

1. A psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor–patient relationship, and thus upon the well-being of the patient. These requirements become particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.
2. A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.

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<sup>4</sup>Statements in italics are taken directly from the American Medical Association's *Principles of Medical Ethics*.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

3. In accord with the requirements of law and accepted medical practice, it is ethical for a physician to submit his or her work to peer review and to the ultimate authority of the medical staff executive body and the hospital administration and its governing body. In case of dispute, the ethical psychiatrist has the following steps available:
  - a. Seek appeal from the medical staff decision to a joint conference committee, including members of the medical staff executive committee and the executive committee of the governing board. At this appeal, the ethical psychiatrist could request that outside opinions be considered.
  - b. Appeal to the governing body itself.
  - c. Appeal to state agencies regulating licensure of hospitals if, in the particular state, they concern themselves with matters of professional competency and quality of care.
  - d. Attempt to educate colleagues through development of research projects and data and presentations at professional meetings and in professional journals.
  - e. Seek redress in local courts, perhaps through an enjoining injunction against the governing body.
  - f. Public education as carried out by an ethical psychiatrist would not utilize appeals based solely upon emotion, but would be presented in a professional way and without any potential exploitation of patients through testimonials.
4. A psychiatrist should not be a participant in a legally authorized execution.

*Section 2*

*A physician shall uphold the standards of professionalism, be honest in all professional interactions and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.*

1. The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification. Further, the necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity necessary for control. Additionally, the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

2. The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals.
3. A psychiatrist who regularly practices outside his or her area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies.
4. Special consideration should be given to those psychiatrists who, because of mental illness, jeopardize the welfare of their patients and their own reputations and practices. It is ethical, even encouraged, for another psychiatrist to intercede in such situations.
5. Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between the patient and the physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.
6. It is ethical for the psychiatrist to make a charge for a missed appointment when this falls within the terms of the specific contractual agreement with the patient. Charging for a missed appointment or for one not canceled 24 hours in advance need not, in itself, be considered unethical if a patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration for the patient and his or her circumstances.
7. An arrangement in which a psychiatrist provides supervision or administration to other physicians or nonmedical persons for a percentage of their fees or gross income is not acceptable; this would constitute fee splitting. In a team of practitioners, or a multidisciplinary team, it is ethical for the psychiatrist to receive income for administration, research, education, or consultation. This should be based on a mutually agreed-upon and set fee or salary, open to renegotiation when a change in the time demand occurs. (See also Section 5, Annotations 2, 3, and 4.)

*Section 3*

*A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.*

1. It would seem self-evident that a psychiatrist who is a law-breaker might be ethically unsuited to practice his or her profession. When such illegal activities bear directly upon his or her practice, this would obviously be the case. However, in other instances, illegal activities such as those concerning the right to protest social injustices might not bear on either the image of the psychiatrist or the ability of the specific psychiatrist to treat his or her patient ethically and well. While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty



of professionally unethical behavior. Physicians lose no right of citizenship on entry into the profession of medicine.

2. Where not specifically prohibited by local laws governing medical practice, the practice of acupuncture by a psychiatrist is not unethical per se. The psychiatrist should have professional competence in the use of acupuncture. Or, if he or she is supervising the use of acupuncture by nonmedical individuals, he or she should provide proper medical supervision. (See also Section 5, Annotations 3 and 4.)

*Section 4*

*A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.*

1. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he or she must be circumspect in the information that he or she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.

2. A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the students' explicit permission.

3. Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.

4. The ethical responsibility of maintaining confidentiality holds equally for the consultations in which the patient may not have been present and in which the consultee was not a physician. In such instances, the physician consultant should alert the consultee to his or her duty of confidentiality.

5. Ethically, the psychiatrist may disclose only that information which is relevant to a given situation. He or she should avoid offering speculation as fact. Sensitive information such as an individual's sexual orientation or fantasy material is usually unnecessary.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

6. Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.
7. Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same time, the psychiatrist must assure the minor proper confidentiality.
8. When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient.”
9. When the psychiatrist is ordered by the court to reveal the confidences entrusted to him/her by patients, he or she may comply or he/ she may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, to unimpaired treatment should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.
10. With regard for the person’s dignity and privacy and with truly informed consent, it is ethical to present a patient to a scientific gathering if the confidentiality of the presentation is understood and accepted by the audience.
11. It is ethical to present a patient or former patient to a public gathering or to the news media only if the patient is fully informed of enduring loss of confidentiality, is competent, and consents in writing without coercion.
12. When involved in funded research, the ethical psychiatrist will advise human subjects of the funding source, retain his or her freedom to reveal data and results, and follow all appropriate and current guidelines relative to human subject protection.
13. Ethical considerations in medical practice preclude the psychiatric evaluation of any person charged with criminal acts prior to access to, or availability of, legal counsel. The only exception is the rendering of care to the person for the sole purpose of medical treatment.
14. Sexual involvement between a faculty member or supervisor and a trainee or student, in those situations in which an abuse of power can occur, often takes advantage of inequalities in the working relationship and may be unethical because:
  - a. Any treatment of a patient being supervised may be deleteriously affected.
  - b. It may damage the trust relationship between teacher and student.
  - c. Teachers are important professional role models for their trainees and affect their trainees’ future professional behavior.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

*Section 5*

*A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.*

1. Psychiatrists are responsible for their own continuing education and should be mindful of the fact that theirs must be a lifetime of learning.

2. In the practice of his or her specialty, the psychiatrist consults, associates, collaborates, or integrates his or her work with that of many professionals, including psychologists, psychometricians, social workers, alcoholism counselors, marriage counselors, public health nurses, and the like. Furthermore, the nature of modern psychiatric practice extends his or her contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, agency volunteers, and neighborhood aides. In referring patients for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he or she is dealing is a recognized member of his or her own discipline and is competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he or she refers patients. Whenever he or she has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him/her.

3. When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he or she must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if the psychiatrist allows himself/herself to be used as a figurehead.

4. In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment.

5. The psychiatrist should agree to the request of a patient for consultation or to such a request from the family of an incompetent or minor patient. The psychiatrist may suggest possible consultants, but the patient or family should be given free choice of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant or if there is a difference of opinion that the primary therapist cannot resolve, he or she may, after suitable notice, withdraw from the case. If this disagreement occurs within an institution or agency framework, the differences should be resolved by the mediation or arbitration of higher professional authority within the institution or agency.

*Section 6*

*A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.*

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

1. Physicians generally agree that the doctor-patient relationship is such a vital factor in effective treatment of the patient that preservation of optimal conditions for development of a sound working relationship between a doctor and his or her patient should take precedence over all other considerations. Professional courtesy may lead to poor psychiatric care for physicians and their families because of embarrassment over the lack of a complete give-and-take contract.
2. An ethical psychiatrist may refuse to provide psychiatric treatment to a person who, in the psychiatrist's opinion, cannot be diagnosed as having a mental illness amenable to psychiatric treatment.

*Section 7*

*A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.*

1. Psychiatrists should foster the cooperation of those legitimately concerned with the medical, psychological, social, and legal aspects of mental health and illness. Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judiciary branches of the government. A psychiatrist should clarify whether he/ she speaks as an individual or as a representative of an organization. Furthermore, psychiatrists should avoid cloaking their public statements with the authority of the profession (e.g., "Psychiatrists know that...").
2. Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness. Psychiatrists should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine.
3. On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement.
4. The psychiatrist may permit his or her certification to be used for the involuntary treatment of any person only following his or her personal examination of that person. To do so, he or she must find that the person, because of mental illness, cannot form a judgment as to what is in his/ her own best interests and that, without such treatment, substantial impairment is likely to occur to the person or others.
5. Psychiatrists shall not participate in torture.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

*Section 8*

*A physician shall, while caring for a patient, regard responsibility to the patient as paramount.*

New section recently adopted by the AMA.

*Section 9*

*A physician shall support access to medical care for all people.*

New section recently adopted by the AMA.

### **Procedures for Handling Complaints of Unethical Conduct**

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients but also to society, to other health professionals, and to self. The *Principles*, adopted by the American Medical Association, are not laws but standards of conduct that define the essentials of honorable behavior for the physician.

Complaints charging members of the American Psychiatric Association (APA) with unethical behavior or practices shall be investigated, processed, and resolved in accordance with procedures approved by the APA Assembly and the APA Board of Trustees.

If a complaint of unethical conduct against a member is sustained, the member shall receive a sanction ranging from reprimand to expulsion. Any decision to expel a member must be approved by a two-thirds (2/3) affirmative vote of all members of the APA Board of Trustees present and voting.<sup>5</sup>

#### **PART I: INITIAL PROCEDURES**

1. a. Unless the complaint may be decided solely on the basis of extrinsic evidence, all formal complaints charging a member of the APA with unethical behavior shall be made in writing, signed by the complainant, and addressed to the district branch of the charged member ("respondent") or, if addressed to the APA, shall be referred by the APA to the respondent's district branch for investigation<sup>6</sup> and decision in accordance with these Procedures.<sup>7</sup> Cases that may be decided solely on the basis of extrinsic evidenced may be initiated by the forwarding of documentation supporting the complaint to the district branch or APA Ethics Chair without a formal, signed charging letter.
- b. If the respondent is a member-at-large of the APA, the complaint shall be referred to an ad hoc investigating committee, as provided for in Paragraph 2 below.
- c. To be considered pursuant to these Procedures, a complaint alleging unethical conduct must be received within ten (10) years of the alleged conduct<sup>8</sup>.

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<sup>5</sup> Chapter 7, Sections 1, 2, and 3, Bylaws, American Psychiatric Association, May 2005 edition.

<sup>6</sup> As used in these Procedures, the term investigation is meant to include both an information-gathering or investigatory phase of a case and a hearing phase. This term does not apply to the process by which a district branch initially determines whether or not a complaint warrants investigation.

<sup>7</sup> The Procedures set out minimum requirements. Each district branch should comply with any additional or more stringent requirements of state law.

<sup>8</sup> In the case of a minor patient, the ten (10) years will not begin until the patient reaches majority.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- d. Unless (i) the case will be decided solely on the basis of extrinsic evidence obtained entirely from sources other than the respondent, and/or (ii) the complaint is referred to a licensing board or similar authority for initial or final processing, without receiving information from the patient,<sup>9</sup> at the time it notifies respondent of a complaint received, the district branch ethics committee shall obtain and provide the respondent with valid written authorization(s) from the patient(s) involved to provide (i) relevant medical records and other information about the patient, and, if applicable, (ii) psychotherapy notes, to the district branch for the purposes of its investigation.<sup>10</sup>

2. If, after receiving a written complaint, the district branch determines that there are compelling reasons why it would not be the appropriate body to consider the complaint, the district branch shall write to the Chair of the APA Ethics Committee, requesting that it be excused, providing a detailed explanation of the reasons for its request. If the Chair of the APA Ethics Committee determines that the district branch should not be excused, the district branch shall proceed with the complaint. If the Chair of the APA Ethics Committee agrees that the district branch should be excused from considering the complaint, the Chair shall then appoint three (3) Fellows of the APA to serve as an ad hoc investigating committee to conduct the investigation and to render a decision.<sup>11</sup> When possible, these Fellows shall reside in the same Area as the respondent and in no event shall any such Fellow be a member of the APA Ethics Committee or the APA Board of Trustees.

3. If the district branch finds it cannot determine that the complaint warrants investigation under the ethical standards established by *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*, the district branch shall so notify the complainant, requesting additional information when appropriate. If the district branch determines that the charges do not warrant investigation, it shall notify the complainant, stating the basis for the conclusion and informing the complainant that he/she may request a review of this decision no later than sixty (60) days from the Chair of the APA Ethics Committee. If the Chair of the APA Ethics Committee determines that the complaint warrants investigation, he/she will appoint an ad hoc investigating committee as provided for in Paragraph 2 above. When an ad hoc investigating committee is appointed, the district branch shall be so notified by the Chair of the APA Ethics Committee.

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<sup>9</sup> Prior to forwarding a complaint to the licensing board, any other authority or individual, the district branch should obtain the patient's consent to potentially involving the complainant in a procedure s/he did not wish to invoke.

<sup>10</sup> If not provided by the patient/complainant, the district branch shall provide the patient/complainant with an authorization form or forms that comply with federal law (HIPAA) and applicable state law. If investigation reveals that medical information or records and/or psychotherapy notes of a patient who is not the complainant are relevant, the district branch must obtain the authorization of such patient before obtaining such records from a member. Whenever psychotherapy notes are relevant to the case, separate authorizations for medical records and psychotherapy notes will be provided. In extrinsic evidence cases, if the respondent wishes to provide medical information or records and/or psychotherapy notes in connection with the sanction phase of the case, appropriate authorizations shall be obtained.

<sup>11</sup> Unless otherwise indicated, whenever these Procedures refer to activities of a district branch, the same requirements shall apply to the ad hoc investigating committee when it performs an investigation.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

4. If the district branch determines that a complaint warrants investigation under the ethical standards established by *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*, the district branch shall advise the APA Secretary as well as the complainant and the respondent that it will be conducting the investigation. The district branch shall also send a copy of the complaint to the respondent, along with copies of *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* and these Procedures. If the district branch decides to consider the complaint in accordance with the procedures in Part II (Enforcement Option), the respondent shall further be informed that he/she has the right to be represented by counsel; that he/she has the right to a hearing; and that if there is a hearing, at the hearing, he/she will have the rights set out in Paragraph 9 below. The respondent will also be informed of his/her right to appeal an adverse decision to the APA Ethics Committee or, where appropriate, to the APA Ethics Appeals Board in accordance with the provisions of Paragraphs 19–23 below.

5. The district branch investigation shall be comprehensive and fair and conducted as provided herein. The district branch may decide:

- a. to conduct a formal enforcement proceeding, including where appropriate a hearing, pursuant to the Enforcement Option procedures set out in Part II, Paragraphs 6-25 below, or
- b. with the agreement of the respondent, to attempt to consider and resolve the complaint in accordance with the Educational Option procedures set out in Part III, Paragraphs 26-33 below.

In deciding which approach to use, the district branch shall consider factors including the nature and seriousness of the alleged misconduct, prior findings or allegations of unethical conduct, and guidelines developed by the APA Ethics Committee. Any attempt to resolve the matter through the Educational Option shall be without prejudice to the right of the district branch to determine at a later time that resolution pursuant to this option is not possible and to proceed to consider and resolve the complaint pursuant to the Enforcement Option procedures of Part II.

**PART II: ENFORCEMENT OPTION**

6. If the district branch pursues investigation and resolution of a complaint in accordance with the provisions in this Part, a hearing conducted in accordance with the provisions of Paragraph 9 below shall be held unless the respondent has voluntarily waived his/her right to a hearing, or the district branch, prior to the hearing, has determined that there has been no ethics violations. The respondent's waiver of a hearing shall not prevent the district branch from meeting with, and hearing the evidence of, the complainant and other witnesses and reaching a decision in the case.

7. The respondent will be notified of the hearing by certified mail or overnight delivery (signature required) at least thirty (30) days in advance of the hearing. The notice will include the following:



*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- a. The date, time, and place of the hearing;
  - b. A list of witnesses expected to testify;
  - c. Notification of the respondent's right to representation by legal counsel or another individual of his/her choice;
  - d. Notification of the respondent's right to appeal any adverse decision to the APA Ethics Committee; and
  - e. The names of the members of the ethics committee or panel which will conduct the hearing.
8. The initial, information-gathering stages of the investigation, which may include preliminary interviews of the complainant and the respondent, may be conducted by any single member of or a subcommittee of the ethics committee. In all cases in which there may be a decision adverse to the respondent, unless the respondent has waived his/her right to a hearing, there must be a hearing before the district branch ethics committee or a specially constituted panel of at least three (3) members, at least one (1) of whom must be a member of the district branch ethics committee.
9. The hearing shall provide fairness and respect for both the respondent and the complainant. The following procedures shall apply:
- a. The respondent may be represented by counsel or other person. The counsel or other person may answer questions addressed to him/her, advise his/her client, introduce evidence, examine and cross-examine witnesses, and make opening and closing statements. Counsel's participation is subject to the continuing direction and control of the Chair. The Chair shall exercise its discretion so as to prevent the intimidation or harassment of the complainant and/or other witnesses and with regard to the peer review nature of the proceedings. Questions addressed by members of the committee or panel to the respondent shall be answered by the respondent.
  - b. Except when the district branch concludes that it is prepared to proceed solely on the basis of extrinsic evidence,<sup>12</sup> the complainant must be present at the hearing unless excused by the committee or panel Chair. The complainant will be excused only when he/she has so requested and, in the judgment of the Chair, participation would be harmful to him/her.

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<sup>12</sup> For these purposes, "extrinsic evidence" shall mean documents whose validity and accuracy appear to be clear on their face and which do not rely on the assertions or opinions of the complainant and/or his/her witnesses. Examples of such evidence include admissions by the respondent, formal judicial or administrative reports, sworn deposition or trial testimony that was subject to cross-examination, photographs, medical or hospital records, hotel or credit card receipts, and so forth. When the district branch decides to rely solely on such extrinsic evidence, it should take appropriate steps to ensure that members of the hearing panel do not take into account any information from the complainant or other witnesses and base their decision solely on the available extrinsic evidence. Additional information on extrinsic evidence is available from the APA.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- c. Except when the district branch concludes that it is prepared to proceed solely on the basis of extrinsic evidence or the complainant is excused pursuant to Paragraph 9(b) above, the complainant shall testify regarding his/her charges.
- d. The respondent or his/her attorney may challenge material presented by the complainant or the complainant's witnesses: (i) by appropriate direct challenge through cross-examination; or (ii) if the complainant asked to be excused from such direct challenge and the Chair determined that such direct challenge will be harmful to the complainant, by written questions submitted by the respondent and posed to the complainant by the Chair, with answers to be provided orally or in writing as the Chair in his/her discretion determines is appropriate.
- e. The respondent may choose not to be present at the hearing and to present his/her defense through other witnesses and counsel.
- f. The respondent may testify on his/her own behalf, call and examine supporting witnesses, and introduce relevant evidence in support of his/her case. Evidence may not be excluded solely on the grounds that it would be inadmissible in a court of law.
- g. Members of the hearing panel may ask pertinent questions during the hearing.
- h. A stenographic or tape record shall be made of the proceedings, and a copy shall subsequently be made available to the respondent at a reasonable charge.
- i. The respondent may make an oral statement and/or submit a written statement at the close of the hearing.

10. All ethics committee or panel recommendations shall be in writing and shall include a statement of the basis for the recommendation. If the investigation has been conducted by a panel, the panel shall make a recommendation only as to whether there has been an ethics violation, and the district branch ethics committee shall review this recommendation and add its recommendation as to sanction, if any.

11. Upon completion of the investigation and any internal review procedures required by the district branch's governing documents, the district branch shall render a decision—

- a. that the respondent did not act unethically;
- b. that the case should be concluded without a finding; or
- c. that the respondent acted unethically, and what sanction is appropriate.

If the investigation has been conducted by an ad hoc investigating committee, the ad hoc investigating committee shall make the decision. The district branch decision shall be in writing and shall include a statement of the basis of the decision. In all cases, the district branch shall seek to reach a decision as expeditiously as possible. This should usually be within nine (9) months from the time that the complaint was received. All district branch

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

decisions must be reviewed by the APA Ethics Committee in accordance with Paragraph 15 below.

12. The three (3) sanctions in order of severity are as follows:

- a. reprimand;
- b. suspension (for a period not to exceed five [5] years);<sup>13</sup>
- c. expulsion.

13. If the district branch renders a decision that the case should be concluded without a finding, it may issue a letter of concern to the member, which can include suggestions for education. The letter of concern will be signed by the president of the district branch after a draft has been reviewed by the APA Ethics Committee. The APA Ethics Committee must agree that the complaint resulted in an investigation that was comprehensive and fair, and in accordance with the procedures in Paragraphs 6–9 above. In addition to the three (3) sanctions noted in Paragraph 12, the district branch may also, but is not required to, impose certain conditions, such as educational or supervisory requirements, on a suspended member.<sup>14</sup> When such conditions are imposed, the following procedures shall apply:

- a. If the district branch imposes conditions, it shall monitor compliance.
- b. If the ad hoc investigating committee imposes conditions, the Chair of the APA Ethics Committee shall establish a means for monitoring compliance.
- c. If a member fails to satisfy the conditions, the district branch or the APA monitoring body established by the Chair of the APA Ethics Committee may decide to expel the member.
- d. If it is determined that a member should be expelled for noncompliance with conditions, the member may appeal pursuant to the provisions set forth in Paragraphs 19–23 below.
- e. If a member expelled for noncompliance with conditions does not appeal, the APA Board of Trustees shall review the expulsion in accordance with the provisions of Paragraph 18 below.

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<sup>13</sup> A suspended member will be required to pay dues and will be eligible for APA benefits, except that such a member will lose his/her rights to hold office, vote, nominate candidates, propose referenda or amendments to the Bylaws, and serve on any APA committee or component, including the APA Board of Trustees and the APA Assembly. If the suspended member is a Fellow or Life Fellow, the Fellowship will be suspended for the same period of time. Each district branch shall decide which, if any, district branch privileges and benefits shall be denied during the period of suspension.

<sup>14</sup> Personal treatment may be recommended, but not required, and any such recommendation shall be carried out in accordance with the ethical requirements governing confidentiality as set forth in *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*. In appropriate cases, the district branch may in addition refer the psychiatrist in question to a component responsible for considering impaired or physically ill physicians.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

14. After the district branch completes its investigation and arrives at its decision, the decision and any pertinent information concerning the procedures followed or relating to the action taken shall be forwarded to the APA Ethics Committee for review in accordance with the provisions of Paragraphs 15-17 below. If the Chair of the APA Ethics Committee determines that these review functions are best carried out instead by a subcommittee, he/she shall designate such a subcommittee (or subcommittees) that shall include at least three (3) voting members of the APA Ethics Committee and that shall be authorized to undertake these review functions on behalf of the full APA Ethics Committee.

15. In all cases, including those where the district branch finds that an ethics violation has not occurred or that the case should be concluded without a finding, the APA Ethics Committee shall review the information submitted by the district branch to assure that the complaint received an investigation that was comprehensive and fair and in accordance with the procedures in Paragraphs 6-9 above. If the APA Ethics Committee concludes that these requirements were not satisfied, it shall so advise the district branch, and the district branch shall remedy the deficiencies and shall make further reports to the APA Ethics Committee until such time as the APA Ethics Committee is satisfied that these requirements have been met. If, in the view of the APA Ethics Committee, the district branch is either unwilling or unable to complete the investigation in a satisfactory manner, the Chair of the APA Ethics Committee may appoint an ad hoc investigating committee to conduct the investigation and render a decision.

16. In cases where the district branch has found that an ethics violation has occurred, the APA Ethics Committee or subcommittee, after ascertaining that the investigation was comprehensive and fair and in accordance with these procedures, shall consider the appropriateness of the sanction imposed. If the APA Ethics Committee or subcommittee concludes that the sanction is appropriate, it shall so notify the district branch. If the APA Ethics Committee or subcommittee concludes that the sanction should be reconsidered by the district branch, it shall provide a statement of reasons explaining the basis for its opinion, and the district branch shall reconsider the sanction. After reconsideration, the decision of the district branch shall stand, even if the district branch decides to adhere to the original sanction, except that the sanction may be modified as provided for in Paragraphs 18, 22 or 24 below.

17. After the APA Ethics Committee or subcommittee completes the review process, the district branch shall notify the respondent of the decision and sanction, if any, by certified mail or overnight mail (signature required). The respondent shall be provided copies of the district branch ethics committee and/or panel recommendation(s) and the district branch decision. If the decision is that no ethics violation has occurred, the case shall be terminated, and the district branch shall also notify the complainant of this decision. If the decision is that an ethics violation has occurred, the respondent shall be advised that he/she has thirty (30) days to file a written letter of appeal with the Chair of the APA Ethics Committee. In such circumstances, the complainant shall not be advised of any action until after the appeal has been completed or until the APA notifies the district branch that no appeal has been taken or that the procedures provided for in Paragraph 18 below have been completed.

18. If, after review by the APA Ethics Committee or upon a finding of noncompliance with conditions as provided for in Paragraph 13(c) above, the decision is to expel a respondent, and the respondent fails to appeal the decision, the APA Board of Trustees at its next meeting shall

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

review the expulsion on the basis of a presentation by the Chair of the APA Ethics Committee and the documentary record in the case. A decision to affirm an expulsion must be by a vote of two-thirds (2/3) of those Trustees present and voting. A decision to impose a lesser sanction shall be by a majority vote. If necessary, the APA Board of Trustees may request further information from the district branch before voting on the decision to expel.

19. a. All appeals in cases in which the complaint was received by the district branch after January 1, 2003 shall be considered and decided by a panel of three (3) members of the APA Ethics Committee who have not been involved in a review of the case pursuant to Paragraphs 14-17. The Chair of the APA Ethics Committee may appoint a replacement if there are not three members of the Committee who have not been involved in the case who are able to serve.
  - b. In cases in which the complaint was received by the district branch prior to January 1, 2003, the APA Ethics Committee shall decide whether it is appropriate under the circumstances for the appeal to be heard by a panel of the Ethics Committee or by the APA Ethics Appeal Board pursuant to procedures in effect prior to January 1, 2003. In making this decision, the APA Ethics Committee shall consider the availability of an Ethics Committee panel which has not reviewed the case, whether the respondent was notified of his/her right to appeal to the Ethics Appeals Board and whether a respondent informed of an appeal to the Appeals Board will agree to an appeal to a panel of the Ethics Committee.
20. All appeals shall be based on one (1) or more of the following grounds:
- a. that there have been significant procedural irregularities or deficiencies in the case;
  - b. that *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* has been improperly applied;
  - c. that the findings of or sanction imposed by the district branch are not supported by substantial evidence;
  - d. that substantial new evidence has called into question the findings and conclusions of the district branch.
21. a. The respondent's request for an appeal must be received within 30 days of the date the respondent is notified of the district branch decision. Upon receipt of the respondent's request for an appeal, the APA Ethics Committee or Ethics Appeals Board shall request a copy of the district branch file, which shall be made available to the respondent upon request and compliance with any conditions set by the Committee or Appeals Board.
- b. In appeals heard by an Ethics Committee appeals panel, the panel will review, and decide the appeal solely on the basis of, the district branch's documentary record of its investigation and decision and any written appeal statements filed by the respondent and the district branch. The respondent's statement will be provided to the district branch, which may file a written response. Any district branch response will be forwarded to the respondent, who will have the opportunity to respond in writing prior

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

to the Ethics Committee's consideration of the appeal. Filing deadlines and other procedures governing the appeal shall be established by the APA Ethics Committee.

- c. In appeals heard by the Ethics Appeals Board,<sup>15</sup> the respondent shall be entitled to file a written statement with the Appeals Board and may appear before the Board alone or accompanied by counsel. The Appeals Board shall request a representative of the district branch, accompanied by counsel if the district branch so requests, to participate in the appeal by speaker phone. In addition, the Appeals Board may request any information from the district branch and may also request the complainant, accompanied by counsel if he/she so requests, to attend the appeal. The APA counsel and other necessary APA staff may also attend if the Appeals Board so requests. Time limits and other procedures governing the appeal shall be established by the Appeals Board.

22. After reviewing all documents and hearing any oral presentation, the APA Ethics Committee appeals panel or the APA Ethics Appeals Board may take any of the following actions:

- a. affirm the decision, including the sanction imposed by the district branch;
- b. affirm the decision, but alter the sanction imposed by the district branch;
- c. reverse the decision of the district branch and terminate the case;
- d. remand the case to the district branch with specific instructions as to what further information or action is necessary.<sup>16</sup> After the district branch or panel has completed remand proceedings, the case shall be handled in accordance with procedures in Paragraphs 14 through 22.

23. After the APA Ethics Committee appeals panel or Ethics Appeals Board reaches a decision as set forth in Paragraph 22, if the decision is anything other than to expel a member, the Chair of the APA Ethics Committee shall notify the district branch and the respondent simultaneously of the decision and that it is final.

24. If the decision is to expel a member, the APA Board of Trustees at its next meeting shall review the action solely on the basis of the presentation of the APA Secretary (or his/her designee) or the APA Ethics Committee Chair (or designee) and the documentary record in the case. The APA Board of Trustees may affirm the sanction, impose a lesser sanction, or remand

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<sup>15</sup> The Ethics Appeals Board shall be chaired by the APA Secretary and shall include two past Presidents of the APA, a past Speaker of the APA Assembly, the Chair of the APA Ethics Committee and a current chair of a district branch ethics committee. The Secretary and Chair of the APA Ethics Committee shall serve during their respective terms of office. All other members of the Ethics Appeals Board shall be appointed by the President for a three-year term. All members of the Ethics Appeals Board, including the chair, shall be entitled to one vote on all matters. If any of the above cannot serve, the President is authorized to appoint a replacement.

<sup>16</sup> Remands will be employed only in rare cases, such as when new information has been presented on appeal or when there is an indication that important information is available and has not been considered.

to the APA Ethics Committee appeals panel or the Ethics Appeals Board for further action or consideration. A decision to affirm an expulsion must be by a vote of two-thirds (2/3) of those Trustees present and voting. All other actions shall be by majority vote. Members of the APA Board of Trustees who participated as members of the APA Ethics Committee appeals panel or the Ethics Appeals Board shall not vote when the APA Board of Trustees considers the case. Once the APA Board of Trustees has acted or, in a case of a remand, has approved the action taken on remand, the APA Secretary shall notify the district branch of the decision and that it is final.

25. Once a final decision is reached, the district branch shall notify the complainant and the respondent by certified mail or by overnight mail (signature required).

### **PART III: EDUCATIONAL OPTION**

26. If the district branch decides to attempt to resolve the complaint pursuant to the Educational Option procedures in this Part III (Paragraphs 26-33), it shall proceed only after (a) the respondent has been informed (i) that the district branch wishes to proceed in this manner but that he/she is entitled to proceed under Part II enforcement procedures, and (ii) that the district branch reserves the right to begin the investigation again and use formal enforcement procedures in Part II if in its sole discretion it determines that the respondent has not satisfactorily cooperated, (b) the respondent agrees to proceed under Part III rather than Part II, and (c) the complainant has been notified that the district branch has decided to proceed in this manner and has been provided a copy of the Procedures.

27. The district branch's consideration of an ethics complaint under this Part shall provide both the complainant and the respondent the opportunity to address the district branch. The district branch shall determine the procedures to be used, including whether to meet separately or together with the complainant and the respondent, whether to permit the respondent to be accompanied by a person of his or her own choosing, the size and composition of the group(s) meeting with the parties, and other matters involving the form and details of the district branch's consideration of the complaint. However, in determining the procedure it will use, the district branch shall seek to provide a format that will facilitate the respondent's understanding of the ethical issues raised by the complaint, including the reasons for or sources of the complainant's concern, and to permit the district branch to assess the respondent's understanding of these matters.

28. In proceedings under this Part, the district branch shall make no determination as to whether the respondent has violated the *Principles* or otherwise committed an ethics violation.

29. After its consideration of the complaint pursuant to Paragraph 27, the district branch may identify a specific educational program including courses, reading and consultation for the respondent to complete within a specified period. The respondent and the APA Ethics Committee will be notified of the required steps, the time frame in which they must be completed, and that failure to complete them as required will be grounds for being dropped from membership in the APA and the district branch for failure to satisfy educational requirements

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

(see Bylaws, Section 2.5 or for further proceedings pursuant to Part II of these Procedures. The district branch will monitor the respondent's compliance with any such educational requirements.

30. The district branch shall retain records of complaints considered pursuant to this Part and of any education thereafter required of a respondent. The district branch may consider such information in connection with a decision as to how to handle any later complaints involving the respondent.

31. If the district branch at any time determines that the respondent has not cooperated with the district branch's consideration of the complaint, has not otherwise participated in a manner that permits an adequate educational experience or has not satisfied any educational requirements it has imposed, the district branch may so notify the respondent and inform him/her (a) that the complaint will be returned to the district branch ethics committee for its consideration and resolution pursuant to the procedures set out in Part II, above, or (b) that the respondent's name will be presented to the Board of Trustees at its next meeting and the member dropped from membership unless the Board acts to exempt the respondent from the educational requirements. The decision as to whether to proceed under Part II or to recommend that the respondent be dropped from membership in the APA and the district branch will be in the district branch's discretion.

32. If the district branch decides to return the complaint for consideration and resolution pursuant to Part II of the Procedures, any subsequent investigation and hearing under Part II shall be conducted by district branch members who did not conduct the proceedings pursuant to the Educational Option in Part III.

33. If the district branch decides and notifies the respondent that his/her name will be presented to the Board of Trustees for purposes of being dropped from membership, the district branch shall also notify the APA Ethics Committee, which will notify the Office of Membership and the Board of Trustees.

**PART IV: CONFIDENTIALITY**

34. Except as described in Paragraph 35 below, disclosure by APA members of the name of the respondent, the fact that a complaint has been lodged, the substance of the complaint, or the identity of any witnesses shall be limited to persons who need this information to assure the orderly and effective administration of these procedures and/or APA membership action.

35. To assure proper protection of the public, there are times when disclosure of the identity of a respondent and other information may be essential. Such disclosure is authorized in the following instances:<sup>17</sup>

- a. The name of any member who is expelled from the APA for an ethics violation, along with an explanation of the nature of the violation, shall be reported in *Psychiatric News*

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<sup>17</sup> State and/or federal law may impose additional reporting requirements with which district branches or the APA must comply.



and in the district branch newsletter or other usual means of communication with its membership. The name of any member who is expelled from the APA for an ethics violation, along with an explanation of the nature of the violation, shall also be reported to the medical licensing authority in all states in which the member is licensed. In addition, the name of any member who is also a member of a foreign psychiatric society or association and who is expelled shall be reported to the international society or association to which the member belongs.<sup>18</sup> This Paragraph does not apply to those members who are dropped from membership for failure to satisfy educational requirements, pursuant to Paragraph 33, above.

- b. The name of any member who is suspended from the APA for an ethics violation, along with an explanation of the nature of the violation, shall be reported in *Psychiatric News* and in the district branch newsletter or other usual means of communication with its membership. The name of any member who is suspended from the APA for an ethics violation, along with an explanation of the nature of the violation, shall also be reported to the medical licensing authority in all states in which the member is licensed.<sup>19</sup>
- c. The name of any member who resigns from the APA after an ethics complaint against him/her is received and before it is resolved shall be reported in *Psychiatric News* and in the district branch newsletter or other usual means of communication with its membership.
- d. The APA Board of Trustees or, after approval by the APA Ethics Committee, any district branch's governing council may report an ethics charge or a decision finding that a member has engaged in unethical conduct to any medical licensing authority, medical society, hospital, clinic, or other institutions or persons where such disclosure is deemed appropriate to protect the public.<sup>20</sup>

## Addendum 1

### **Guidelines for Ethical Practice in Organized Settings**

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<sup>18</sup> Reporting shall include a press release to the media in the area in which the expelled member lives. If requested by a state licensing board to which the expulsion is reported, the APA and/or district branch may release relevant information from their files.

<sup>19</sup> If requested by a state licensing board to whom the suspension is reported, the APA and/or district branch may release relevant information from their files.

<sup>20</sup> Chapter 7, Sections 1, 2, and 3, Bylaws, American Psychiatric Association, May 2005 edition.

At its meeting of September 13–14, 1997, the APA Ethics Committee voted to make the “Guidelines for Ethical Practice in Organized Settings,” as approved by the Board and the Assembly, an addendum to *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*, to be preceded by introductory historical comments and cross-referenced to the appropriate annotations, as follows:

This addendum to *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* was approved by the Board of Trustees in March 1997 and by the Assembly in May 1997. This addendum contains specific guidelines regarding ethical psychiatric practice in organized settings and is intended to clarify existing ethical standards contained in Sections 1–9.

### **Addendum**

Psychiatrists have a long and valued tradition of being essential participants in organizations that deliver health care. Such organizations can enhance medical effectiveness and protect the standards and values of the psychiatric profession by fostering competent, compassionate medical care in a setting in which informed consent and confidentiality are rigorously preserved, conditions essential for the successful treatment of mental illness. However, some organizations may place the psychiatrist in a position where the clinical needs of the patient, the demands of the community and larger society, and even the professional role of the psychiatrist are in conflict with the interests of the organization.

The psychiatrist must consider the consequences of such role conflicts with respect to patients in his/her care, and strive to resolve these conflicts in a manner that is likely to be of greatest benefit to the patient. Whether during treatment or a review process, a psychiatrist shall respect the autonomy, privacy, and dignity of the patient and his/her family.

These guidelines are intended to clarify existing standards. They are intended to promote the interests of the patient and should not be construed to interfere with the ability of a psychiatrist to practice in an organized setting. The *Principles* and *Annotations* noted in this communication conform to the statement in the preamble to the *Principles of Medical Ethics*. These are not laws but standards of conduct, which define the essentials of honorable behavior for the physician.

#### **1. Appropriateness of Treatment and Treatment Options**

a. A psychiatrist shall not withhold information that the patient needs or reasonably could use to make informed treatment decisions, including options for treatment not provided by the psychiatrist. [Section 1, Annotation 1 (APA); Section 2, Annotation 4 (APA)]

b. A psychiatrist's treatment plan shall be based upon clinical, scientific, or generally accepted standards of treatment. This applies to the treating and the reviewing psychiatrist. [Section 1, Annotation 1 (APA); Section 2 (APA); Section 4 (APA)]

c. A psychiatrist shall strive to provide beneficial treatment that shall not be limited to minimum criteria of medical necessity. [Section 1, Annotation 1 (APA)]

## **2. Financial Arrangements**

When a psychiatrist is aware of financial incentives or penalties that limit the provision of appropriate treatment for that patient, the psychiatrist shall inform the patient and/or designated guardian. [Section 1, Annotation 1 (APA); Section 2 (APA)]

## **3. Review Process**

A psychiatrist shall not conduct reviews or participate in reviews in a manner likely to demean the dignity of the patient by asking for highly personal material not necessary for the conduct of the review. A reviewing psychiatrist shall strive as hard for a patient he or she reviews as for one he or she treats to prevent the disclosure of sensitive patient material to anyone other than for clear, clinical necessity. [Section 1, Annotations 1 and 2 (APA); Section 4, Annotations 1, 2, 4, and 5 (APA)]

## **Addendum 2**

### **Questions & Answers About Procedures for Handling Complaints of Unethical Conduct**

The APA Ethics Committee receives frequent requests for opinions on the Procedures for Handling Complaints of Unethical Conduct (following the Annotations in this edition of the *Principles*; referred to in this Addendum as the Procedures). The questions and answers that follow have been received and developed since 1973.

**1. Question:** Ethics proceedings sometimes involve serious unethical conduct. Under what circumstances should information about ethics cases be disclosed to the membership, government authorities, or other interested organizations and persons?

**Answer:** APA ethics cases are conducted in secrecy. As a general matter, the complainant's charges, the identity of the respondent, and other information are made available only to persons participating directly in the proceedings. Even within the APA and the district branches, information should not be passed on to other components. (October 1976; November 1977)

However, there are times when disclosure of information about an ethics case is necessary to assure proper protection of the public. For example, many states now require reporting to government agencies concerning members who have been found to have engaged in unethical conduct. The timing of such required reports, the amount and specificity of information to be disclosed, and other matters will vary from state to state. District branches should consult applicable state statutes to assure that these requirements are adhered to. The National Practitioner Data Bank requires that the APA report suspensions and expulsions. (March 1985; November 1989)

The Procedures outline in detail the public reporting that is now authorized, including releasing the names of members who are expelled or suspended, reporting to medical licensing authorities, reporting members who resign after an ethics complaint is received, and so forth. It is important to carefully review Paragraph 35 of the Procedures to ensure that you understand what is required. (July 1993)

Apart from these specific guidelines, public safety considerations may justify reporting before completion of formal proceedings. If a complainant, deemed highly credible, alleges unethical conduct on the part of a member that would pose a serious danger to the safety of patients, the district branch could report the allegations to an appropriate state agency, following consultation with legal counsel. (October 1977; March 1985)

**2. Question:** Does an Inactive Member have the responsibility to abide by the *Principles of Medical Ethics*?

**Answer:** These Principles apply to all categories of members living in the United States and in Canada. International Members and Fellows should abide by the ethics of the countries in which they live. (May 2003)

**3. Question:** For the sake of educating members and showing diligence to the public, should the results of ethics hearings be made public? Such results could be printed in the district branch newsletter or in *Psychiatric News*.

**Answer:** Undoubtedly, such publication would accomplish the above goals; but, it might also discourage complainants and district branch ethics committees from proceeding. However, if the penalty is expulsion or suspension, the name is to be published with the offense specified. If a member resigns during an ethics investigation, the name will be published. (See Question and Answer 1 above.) (March 1974; March 1985)

For educational purposes, we also encourage district branch ethics committees to extract the lessons from ethics hearings to illustrate the tensions between ethics principles and member behavior and their resolution. The purpose is to alert members to possible vulnerability to allegations of unethical conduct. (September 1979)

In addition, the APA may publish disguised ethics cases in *Psychiatric News* in order to educate members and the public as to what matters are being reported and how they are being handled. (APA Board of Trustees, December 1981)

**4. Question:** Aren't APA members who participate in ethics hearings or who bring complaints taking a risk of being sued?

**Answer:** Local laws vary, and one should check with local attorneys. In general, if procedures are followed properly and all involved act without malice, there should be no serious risk. In many states, specific immunity has been granted by laws. In fact, the public expects professional organizations to police themselves, and courts have held that professional peers are best qualified to judge the actions of each other. The most a respondent could sue for would be a rehearing, not damages, unless the member can prove malice on the part of those who judged him or her. It should be understood that anyone can file a suit at any time. To date, there has never been a successful suit against the APA and/or its district branches. (April 1976; March 1985)

**5. Question:** What does a complainant have to gain except potential embarrassment and harassment?

**Answer:** Patient complainants may be seeking vindication or revenge. Occasionally they see an ethics procedure as a route to financial reward. There have been complainants who demonstrate a sincere desire to obtain help for the respondent. Colleague complainants are usually seeking to protect the reputation of the profession. As a general statement, the only gain a complainant can expect is the realization that he or she has brought to our profession's attention a possible break

in our ethical standards. From then on, it is up to us. Local laws vary, but in most jurisdictions complainants who bring ethics charges without malice receive legal protection. (June 1976; March 1985)

**6. Question:** In an ethics hearing, should the complainant and respondent be heard together?

**Answer:** The Procedures require that the complainant and the respondent be heard together under most circumstances. Exceptions include cases in which the member has waived his/her right to a hearing, cases in which the committee or panel chair has determined that requiring the complainant and the respondent to appear together would be harmful to the complainant, and cases in which the respondent decides not to appear but to present his/her case through legal counsel and other witnesses. (November 1989)

If the district branch determines that an ethics complaint will be handled under the Educational Option (see Paragraph 27 of the Procedures), both the complainant and the respondent shall have the opportunity to address the district branch. The district branch shall determine the procedures to be used, including whether to meet separately or together with the complainant and the respondent. (May 2003)

**7. Question:** Can various specialty groups within psychiatry develop their own code of ethics?

**Answer:** Because we are members of the medical profession first, we are responsible to the *Principles of Medical Ethics*, formulated by the American Medical Association. The APA added "With Annotations Especially Applicable to Psychiatry." These annotations were additive, and in no case did they subtract from or change any elements of the *Principles of Medical Ethics*. Nothing precludes another psychiatric society from developing a code that addresses the special needs of that group as long as it is additive to *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* and does not subtract or change any elements of the above. To allow anything else would be to create much confusion for our membership and the public and would lead to legal challenges. (July 1976)

**8. Question:** To whom at the district branch should formal complaints be directed?

**Answer:** That is to be determined by each district branch. We recommend complaints be directed to the president of the district branch. We prefer the president to be the initial recipient because of his/her elected status and because there is frequent turnover in the office. Occasionally a chair of an ethics committee remains in that position for several years, and it would be unwise for him or her to be not only the initial recipient of complaints but also the recipient of charges of member harassment or complaint suppression. (October 1976)

**9. Question:** Should a district branch provide an appeal mechanism?

**Answer:** There are ample appeal mechanisms available under the Procedures. Nothing prevents a district branch from setting up an appeal to its local membership as long as the district branch

follows its own procedures as well as those of the APA. We do not recommend it. (January 1977; March 1977)

**10. Question:** Can a former member dropped for ethical reasons be readmitted to membership?

**Answer:** Yes, if he or she demonstrates a return to ethical conduct. We should strongly encourage and reward efforts toward rehabilitation. (March 1977)

**11. Question:** If a member is undergoing legal investigation for an alleged crime or is involved in a malpractice suit and a formal complaint has been received by the district branch, should its ethics committee proceed?

**Answer:** If the ethics committee decides to proceed, the member may object because he or she might fear that information produced at the ethics hearing could be subpoenaed for the trial, although the district branch would be advised to use all legal means to resist the subpoena. For this reason, or others, the district branch might determine it was more prudent to defer the investigation for the time being. However, it is incumbent upon the ethics committee to monitor the investigation and trial so that an ethics hearing can be conducted as soon after their completion as possible. (April 1977; August 1977; November 1977; January 1978; September 1979)

**12. Question:** If a district branch covers a large area, can one of its chapters act on an ethics complaint?

**Answer:** The Procedures would allow the executive council of the district branch to appoint a special hearing body composed of chapter members that would investigate the complaint and make recommendations to the council as long as at least one member of the hearing panel is a member of the district branch ethics committee. However, only the council can make an official decision on the merits of the complaint. (April 1977; October 1989)

**13. Question:** What are the expectations of a complainant in an ethics hearing?

**Answer:** The complainant should be heard, and the complaint be taken seriously even though it may eventually be found to be without merit. While the complainant can be accompanied by an attorney to the hearing and can ask the attorney for advice, the attorney should not be allowed to argue the client's complaint or cross-examine the respondent or his/her witnesses. The complainant can gain nothing from the procedure of a tangible nature. He or she can gain only appreciation for assisting us in maintaining the integrity of our profession. (June 1977)

**14. Question:** What are the "rights" of a member against whom a formal complaint has been filed?

**Answer:** A member complained against has the right to be informed of the complaint, to be notified in advance of any hearing or investigation, to have legal counsel, to bring witnesses in his/her defense, to be allowed to present his/her defense in detail, to expect the hearing panel and

the decision-making body to make a decision that is fair and without malice, and to be notified of the decision and the avenue of appeal. The respondent and/or the respondent's attorney have a right, in most cases, to confront his/her accusers and to cross-examine those accusers and other witnesses against him or her. There is a significant issue here—the member's right of confrontation versus the concern as to the harm this might do to a complainant—so each hearing chairperson will decide the form the cross-examination will take, whether by direct questioning or by written inquiry. (June 1977; October 1989)

If the district branch decides to attempt to resolve the complaint using the Educational Option, the respondent must be informed that the district branch wishes to proceed in this manner, that the respondent is entitled to proceed instead under the Enforcement Option, among other requirements. (See Procedures, Paragraphs 26-33) (May 2003)

**15. Question:** If a component committee, council, or task force of the APA comes across evidence of unethical behavior of a member, should the component make a formal ethics complaint as a matter of routine?

**Answer:** Yes, with one exception. If the component was gathering confidential information for another purpose and had advised the member of this confidentiality, the component should not make a formal complaint unless the unethical behavior is of such magnitude as to constitute a severe and immediate risk to the public or other members. (September 1977)

**16. Question:** Do APA Fellows and Members and International Members and Fellows (who live in other countries) have to follow the ethics principles of the APA?

**Answer:** Yes. The Bylaws make no exception in the requirement to abide by the *Principles of Medical Ethics*. However, the APA is not able to enforce the provisions of its Annotations to the *Principles of Medical Ethics* beyond the geographic boundaries of its district branches (in the United States and Canada). International Fellows and Members, and other Fellows and Members living in other countries are expected to follow the ethics codes of the country where they live or practice. (October 1977; July 1999, APA Board of Trustees)

**17. Question:** Does a patient-complainant have to give permission to a respondent to reveal information about the treatment relationship?

**Answer:** No. To bring a complaint is to consent to an investigation. In such a circumstance, the psychiatrist may ethically reveal only that information relevant to the hearing of the complaint. (November 1977) Although the complainant (patient) may not have to give an informed consent to the respondent to discuss the respondent-complainant's relationship, the complainant does have to sign an informed consent that may be provided to the respondent (if the respondent is the holder of the medical records) to release records for review by the ethics committee. (September 2003)

**18. Question:** If the public press reports the conviction of a member psychiatrist of a crime or the loss of a malpractice suit that raises a very serious question about moral competency to practice, what is the responsibility of the district branch?



**Answer:** If no other member of the district branch nor anyone else makes a formal complaint, it would be appropriate for an officer of the district branch to do so. (January 1978; January 1979)

**19. Question:** Can the district branch send to the APA a code number rather than the name of the respondent? If the member has been found innocent, can the district branch expunge its records of the complaint?

**Answer:** The APA believes that the use of code numbers and initials presents serious administrative problems. This information is kept in a secure place at APA headquarters, so fear of loss of confidentiality is unwarranted. A file is created after the original material is destroyed so that we can maintain a history of ethics issues involving our profession. The district branch can expunge its record if it chooses, but might also wish to maintain such history. (April 1978; June 1978)

**20. Question:** When a member transfers from our district branch to another, can information about a finding of unethical conduct be sent to the second district branch?

**Answer:** With the written permission of the transferring member, the transferring district branch can send information about an ethical charge and the results of the investigation to the new district branch executive council as confidential correspondence. Unless the member is suspended or expelled, he or she remains an APA member and does not lose the right to transfer. However, the receiving district branch has a right to challenge the transfer. (May 1978)

**21. Question:** Our district branch ethics committee is investigating an ethics complaint against one of our members. The member is moving to another district branch. Do we drop the investigation or pass the information on to the new district branch?

**Answer:** This question presents problems. The member might use moving and transferring as a way of avoiding the investigation and possible censure by peers. To pass the information on to the new district branch for continued investigation would create a very difficult problem for the new district branch, the complainant, and witnesses. Further, at this time, the information the first district branch received is to be considered confidential. (April 1978) Therefore, the APA Board of Trustees has made the following addition to the *Operations Manual*:  
A transfer from one district branch to another will be delayed until resolution of any charge of unethical conduct. (May 1978)

**22. Question:** Should a member who is mentally ill and, as a result, has behaved unethically be suspended or expelled?

**Answer:** We would recommend the member be placed on Inactive Status and encouraged to seek treatment under the "impaired physician" act adopted in many states. Because he or she may also have had his or her medical license suspended or revoked, return to active membership would require that the local licensing body had returned his or her medical license. The district branch would want to assure itself that the member had recovered and was again capable of

ethical practice. The ultimate goal of such proceedings is rehabilitation of our colleague. The APA Board of Trustees has made the following addition to the *Operations Manual*:

When a member has had a license suspended or revoked because of physical or mental illness or substance abuse, he or she will not be dropped from membership in the APA, but may be placed on Inactive Status until recovery. This will be handled administratively in the APA Central Office, with the concurrence of the district branch and the Chair of the APA Membership Committee. (May 1978; July 1999)

**23. Question:** What should the composition of a district branch ethics committee be?

**Answer:** That is up to the district branch to decide. The committee should consist of members whose judgment is respected, obviously, but there are no specific requirements. Some district branches use their executive council, but it is more common to establish a standing committee. The APA Ethics Committee membership is defined in the Operations Manual as follows: six members, appointed for 3 years, with one to be a Past President of the APA. (August 1978; May 2003)

**24. Question:** If a complainant refuses to participate in a formal hearing, should the complaint be dropped?

**Answer:** Not necessarily. While not willing to participate in a formal hearing, the complainant might present written information sufficient to proceed or point the way to other evidence that would be relevant. The role of the complainant is not that of a prosecutor but that of a person bringing a potential problem to our attention (see Questions 5, 6, 13, and 14). (February 1979)

**25. Question:** When a member is suspended from membership in the district branch and in the APA, what privileges does he or she lose?

**Answer:** A suspended member will lose privileges cited in the Bylaws. He or she will lose the right to vote, to nominate candidates for office, to propose referenda and amendments to the Bylaws, and to serve on components, including the APA Board of Trustees and the APA Assembly. He or she may not hold elected office and may not initiate referenda to change actions of the Board of Trustees.. If the suspended member is a Fellow or Life Fellow, the Fellowship will be suspended for the same period of time. The suspended member will be expected to pay dues and assessments and will remain eligible for the other benefits of membership. Suspension may also result in the loss of other district branch privileges. (September 1981; March 1985; July 1993; May 2003)

**26. Question (Part A):** On occasion, a member charged with unethical behavior may settle out of court with the complainant in a parallel civil suit. Part of the settlement requires the complainant not to pursue the ethical charge. Should the APA establish a rule that participation by a member in such agreements is unethical in itself?

**Answer:** This "back door exit" from ethical complaints concerns us and, if used to stifle a bona fide complaint, is unethical.

**26. Question (Part B):** Even though the complainant drops the charge, can the process be continued?

**Answer:** If the alleged behavior is known to others, such as district branch officers, and from sources other than that provided by the original complainant, another complaint may be brought by whoever has that information. Obviously, the original complainant would not be available to provide information or to appear at a hearing. (March 1988)

**27. Question (Part A):** For an ethics charge, is there a time limit between the alleged behavior and complaint beyond which the complaint cannot be accepted?

**Answer:** In 2002, the APA Board of Trustees and the APA Assembly adopted a “statute of limitations” for an ethics complaint. The following appears in the Procedures: To be considered, a complaint alleging unethical conduct must be received within ten (10) years of the alleged conduct. In the case of a minor patient, the ten (10) years will not begin until the patient reaches age of majority.) (November 2002)

**27. Question (Part B):** If the district branch determines that the alleged complaint occurred prior to the ten (10) year statute of limitations, can a complainant ask that the APA review this decision?

**Answer:** Yes. However, the review is only to determine that the statute of limitations was applied appropriately. Such a review will be done by the APA Secretary. (November 2002)

**28. Question:** What is the effect of a respondent’s refusal to participate in the investigation or hearing? Is that, in itself, unethical?

**Answer:** The investigation and hearing can proceed with the evidence at hand and reach its conclusion in the absence of the respondent’s participation, although the right of appeal is not lost. A charge of unethical conduct upon this action itself would not be sufficient to constitute a sustainable complaint. (October 1977)

**29. Question:** We have learned from the Board of Medical Examiners that a member has been found guilty of sexual misconduct with a patient. The Board revoked his license, stayed the revocation, suspended his license for 6 months, and gave him 7 years of probation. Can the district branch suspend him without going through all the repetitive procedures?

**Answer:** APA policy does not allow automatic suspension at the time of license suspension, but requires an investigation. Thus, while a fair procedure must be followed, it is likely this will not have to be exhaustive under the circumstances. (January 1988)

**30. Question:** A serious ethical allegation about a member was received shortly after he resigned from our district branch and the APA, presumably because he was aware of the impending complaint. Should we publish that he resigned while under investigation?

**Answer:** The name of any member who resigns from the APA after an ethics complaint against him or her is received shall be reported in *Psychiatric News* and in the district branch newsletter or other usual means of communication with its membership. (July 1993)

**31. Question:** Do you go forward with a complaint alleging unethical behavior by a psychiatrist before he or she was an APA member? (September 2003)

**Answer:** No.

**32. Question:** Our district branch is quite large and has a heavy volume of complaints. Thus, we have divided the ethics committee into several hearing panels, all of whose members belong to the ethics committee. Paragraph 10 of the Procedures gives to a panel only the responsibility to determine if there has been a violation, and the recommendation of the ethics committee is required for the penalty. This would overburden us. Can you clarify?

**Answer:** This requirement for a panel to recommend only the finding of unethical conduct but not the penalty was meant for panels not entirely comprised of ethics committee members. If all of the panel members are on the ethics committee, they may recommend the sanction, too. (April 1990)

**33. Question:** Although we found a member not to have behaved unethically, we feel he is impaired. Can the district branch ethics committee refer him to an impaired physician committee?

**Answer:** While the rules protecting confidentiality in the processing of ethical complaints do not address this, we believe a discreet referral to an impaired physician committee is permissible. (June 1990)

**34. Question:** Should our district branch executive council discuss matters from the ethics committee in executive session? Should minutes be kept and, if so, how complete?

**Answer:** Discussion should be in executive session and complete minutes should be kept, including the reasoning leading to the decision and the vote to reach a decision. (January 1991)

**35. Question:** Are there circumstances in which a reprimand can be published?

**Answer:** No. Publication is limited to suspension or expulsion (see Paragraph 35 of the Procedures). If you feel publication is indicated, you may wish to review your sanction. (February 1991)

**36. Question:** What material should be retained in the district branch file at the conclusion of a case?

**Answer:** The district branch file is the formal record of its investigation, hearing, and/or resolution of a complaint. The file will be produced if the member appeals the decision as well as if there is litigation. As such it should include the following:

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- a. the final district branch decision and report of the case;
- b. any other final reports of the ethics committee, the district branch council, investigators, etc.;
- c. all correspondence to and from the respondent (and legal counsel), the complainant (and his/ her legal counsel), other witnesses and/or potential witnesses, and from the APA;
- d. all other documents and other evidence submitted by the parties or obtained by the ethics committee; and
- e. audio tapes, minutes, or other formal records of interviews or district branch committee or council meetings.

**37. Question (Part A):** There has been a great deal of discussion recently about using “extrinsic evidence” in processing ethics complaints. Could you clarify what this is?

**Answer:** Extrinsic evidence is really just information, often written, but also perhaps photographs. It is carefully defined in the Procedures (see Footnote 10); all aspects of this definition are crucial. First, the information must be “extrinsic” to the ethics proceeding; that is, it comes from some source or exists due to some purpose entirely unrelated to the ethics proceeding. Examples include an independent court or administrative (board) hearing, a medical record or a report from a state licensing board. Written reports made in the course of an ethics investigation are part of the proceeding, and thus, are not extrinsic to it.

Second, validity and accuracy must be clear; the information cannot be merely someone’s assertions. A determination by a court or a licensing board would generally be considered valid and accurate. Sworn testimony subject to cross-examination, receipts, photographs, or medical records also generally meet this requirement. A newspaper article, however, alleging that a member has done certain things, would be “extrinsic,” but is not presumptively valid and accurate, so it could not be used as extrinsic evidence (although it might actually stimulate some inquiry by the district branch). (March 2000)

**37. Question (Part B):** A district branch has a complaint and information that meets the requirements to be considered “extrinsic evidence.” How might this be helpful to the work of the district branch ethics committee?

**Answer:** Extrinsic evidence can be used in two ways. It may be just one more piece of information to be considered with others in the course of a full hearing (photographs, receipts, and medical records are often used in this way); or more importantly, it may be sufficient to eliminate the need for the district branch to conduct a full hearing on whether an ethics violation has occurred. If the document meets all criteria to be extrinsic evidence and, *standing alone*, it is sufficient to make a determination on whether there has been a violation and the nature of the violation, then a full hearing is not required.

When a district branch decides to reply on extrinsic evidence alone, care must be taken that this is the only information considered in determining whether there has been a violation and which

of the *Principles* has been violated. This most commonly occurs when the district branch has detailed information from a court or licensing board. Notice to the respondent and other procedural requirements still apply: the respondent is notified that rather than a hearing, the district branch will consider certain identified extrinsic evidence. The respondent must still be given an opportunity to be heard regarding any sanction but would not be allowed to speak or present any evidence as to whether or not there was a violation of ethics. If the district branch feels that information in addition to the extrinsic evidence is needed in determining the occurrence of a violation, then the district branch should convene a full hearing under all of the requirements listed in the Procedures. (March 2000)

**38 (Part A). Question:** How does the district branch determine that it will proceed using the Educational Option?

**Answer:** The district branch should consider several factors, namely the nature and seriousness of the alleged misconduct, and whether or not there have been previous findings of misconduct. Certainly the Educational Option may be considered for less seriousness instances of ethical misconduct, where the respondent is clearly receptive to education, and where there is a likelihood that education would lead to rehabilitation. If this option is chosen, it must be with the agreement of the respondent. In addition, this does not preclude the district branch from determining at a later date to resolve the complaint using the Enforcement Procedures. (September 2003)

**38 (Part B). Question:** When would a district branch choose the Enforcement Option?

**Answer:** The Enforcement Option should be used when there is egregious behavior, when there has been harm to the patient or to the profession; or when the respondent's behavior manifests a pattern of misconduct. (September 2003)

*Appendix H*

**Policy on the Availability of Support Services**

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*Last Revision: 07-16-2004*

**Scope:** This policy applies to the Delaware Psychiatry Residency Program.

**Policy:** It is the policy of The Delaware Psychiatry Residency Program that all residents have available counseling, medical, psychological, and support services in addition to the provision of an educational training program. The support services are confidential, with any information to be released only with approval of the resident. The residents have the following available services:

A. Counseling:

- For minor problems or issues, the residents have the option to receive help from senior residents, supervision attendings, the Residency Training Director, and/or Medical Director. If the resident wishes not to utilize people within the program, the program can utilize the Employee Assistance Program (EAP.) Information regarding the EAP is provided at the end of this policy.

B. Medical:

- – For relatively minor medical problems, the residents can make appointment to see one of the Delaware Psychiatric Center medical staff physicians. The residents can also access their provided medical insurance and seek care in that manner.

C. Psychological:

- – Residents can seek out help privately or through their medical insurance plan. The Residency Training Director is available to help triage if the resident desires.

D. Support Service:

- – The residency program appreciates the stress inherent in participating in any training program. Attempts are made to reduce unnecessary stress by limiting work hours, frequency of night calls, etc. In addition, residents are provided with assigned supervisors throughout their training who can help guide the resident through the challenges of a training program. In addition, to the above supports, group format support is available during regularly scheduled residents meetings.

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**About HMS**

Human Management Services, Inc. (HMS) began providing Employee Assistance Programs (EAP) in 1979 and was incorporated in July of 1985. Currently HMS services over 450,000 employees and their eligible dependents on a national basis. HMS is able to provide quality EAP services on a local, regional and national level. HMS specializes solely in the design and delivery of employee assistance programming. HMS has gained the necessary expertise to assist in the identification, prevention, and resolution of productivity problems associated with employees, and their eligible dependents, impairment by personal concerns. HMS adheres to the professional guidelines and standards set forth by the Employee Assistance Professionals Association (EAPA).

HMS provides quality consultative services to organizations to help them retain valued employees, promote a healthy work environment, and maximize workplace productivity. To this end, EAP services include: education, evaluation, short-term counseling, referral services, and case management. Employees and eligible dependents who access HMS are never charged a fee and can access the services 24 hours a day.

HMS is a free standing EAP that is not affiliated with any insurance company or managed care corporation. This allows HMS to be very objective when making a level of care determination. If services are needed beyond the EAP, HMS will take into account what is best for the employee, while at the same time working with their insurance benefit to expedite treatment in a cost effective way.

HMS “Core Technology” services include: 24-hour crisis intervention; evaluations and short-term counseling; work/life programs; and referral services; case management, management training; unlimited management consultations; educational workshops and seminars; monthly newsletters; Critical Incident Stress Debriefings (CISD); and many promotional materials.

Our goal is to decrease potential liability in organizations by increasing awareness of EAP services to managers, supervisors and employees. Our mission and commitment has always been to provide the highest quality Employee Assistance Program in order to benefit both employees seeking assistance as well as, employers seeking the cost savings associates with Employee Assistance Programs.

Companies offer and pay for the services of HMS, an integrated counseling and referral service that is designed to assist employees in identifying and resolving personal concerns that may affect job performance, including but not limited to health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issue. HMS services are available to all employees, their spouses and any eligible dependent free of charge.

### **Confidentiality**

Contact with HMS is strictly confidential and is covered under the Federal Privacy Act. Unless HMS has in its possession a signed release form, identifying information about an individual's use of the program cannot be provided.

### **Helpful Links**

#### General Mental Health Information

- National Mental Health Association [www.nmha.org](http://www.nmha.org)
- The American Psychological Association [www.apa.org](http://www.apa.org)
- Internet Mental Health [www.mentalhealth.com](http://www.mentalhealth.com)
- The National Family Caregiver Alliance [www.caregiver.org](http://www.caregiver.org)
- The Alzheimer's Association [www.alz.org](http://www.alz.org)

#### Depression & Anxiety Information

- National Depressive and Manic Depressive Assoc. [www.ndmda.org](http://www.ndmda.org)
- National Alliance for the Mentally Ill [www.nami.org](http://www.nami.org)
- Anxiety Disorder Association of America [www.adaa.org](http://www.adaa.org)
- The American Institute for Stress [www.stress.org](http://www.stress.org)



Drug & Alcohol Information

- Substance Abuse and Mental Health Services Admin. [www.samhsa.gov](http://www.samhsa.gov)
- Alcoholics Anonymous [www.alcoholics-anonymous.org](http://www.alcoholics-anonymous.org)
- Support for Families & Friends of Alcoholics [www.al-anon.org](http://www.al-anon.org)
- Nar-Anon for Families & Friends of an addicted person [www.nar-anon.org](http://www.nar-anon.org)
- Narcotics Anonymous for those with an addiction [www.na.org](http://www.na.org)

**For more information or to set up an appointment, please call (800) 343-2186.**

**In a crisis, emergency help is available 24 hours a day; 7 days a week through our toll free number (800) 343-2186.**

## **Confidential Evaluation, Treatment Referral, and Resident Impairment Policy**

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*Last Revision: 11-10-1997*

**Purpose:** The Delaware Psychiatric Center (DPC) recognizes the significant intellectual, physical, and psychological energies needed to perform the duties of a psychiatric resident. It acknowledges that the need may arise for the resident to seek confidential evaluation or treatment. In addition, The Delaware Psychiatry Residency Program may recommend or require evaluation or treatment of a resident in need. DPC will facilitate the resident gaining access to this treatment.

**A. Resident Request for Referral:**

1. Resident requests for assistance will be handled in a confidential manner. Referrals can be made through a private referral, the Delaware Employee Assistance Program (EAP), or by providing a list of referrals through the Delaware Psychiatric Society. The selection of these options is made by the resident.

**B. Residency Recommendation for Referral:**

1. The Residency Program Director or a concerned faculty member may suggest the need for referral with the options for referral noted above. The resident is not obligated to follow up on the suggestion for referral. The suggestion for referral is handled in a confidential manner.

**C. Resident Impairment:**

1. If a resident has evidenced possible medical, psychiatric, or substance abuse problems which have significantly affected their ability to perform their duties as a resident, the Graduate Medical Education Committee (GMEC) will meet with the resident to evaluate the need for a recommendation for a medical and/or psychiatric evaluation. If the resident either refuses a referral and/or continues to manifest an inability to perform their duties as a resident, the GMEC will refer the resident to the Delaware Physician's Health Program (PHP) and initiate disciplinary procedures. If the resident refuses referral to the PHP, further disciplinary action may be taken, including the reporting of the resident to the Delaware Board of Medical Practice.
2. If the resident accepts referral to the PHP, the PHP's Health Committee will evaluate the resident to see if there is a need for medical and/or psychiatric treatment. If a resident does not follow the provisions of the Health Committee, the Health Committee is under obligation to also report the resident to the Delaware Board of Medical Practice.
3. If a resident needs to take medical leave of absence, the Health Committee must supply DPC with a letter indicating that the resident may return to work. Quarterly, verbal reports are also required from the Health Committee as long as the resident remains under their supervision and/or a letter stating when supervision has ended.
4. Any physician who has been accepted for supervision by the Delaware PHP will be placed on probation by the GMEC under its disciplinary procedure. Probation will

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

include reports from the Delaware PHP, as well as, extra supervision and possible assignment of limited clinical responsibilities as indicated by the resident's performance difficulties. The probationary period gives the resident an opportunity to improve performance under a more structured setting. A resident can be taken off probationary status, according to disciplinary procedure, when no significant performance problems persist.

## **Supervision of Psychiatric Residents Policy**

*Last Revision: 11-01-2007, 04-15-2005*

**Purpose:** This policy outlines the supervision by a Board-certified Attending Psychiatrist of residents participating in the Residency Program.

**Standards:** The Delaware Psychiatric Center (DPC) has a defined process for supervision by Board-certified Psychiatrists with appropriate clinical privileges of each participant in the Residency Program in carrying out patient care responsibilities. The Graduate Medical Education Committee (GMEC) will communicate regularly with the Medical Staff. The GMEC communicate via Medical Staff representation at regularly scheduled Governing Authority meetings. Psychiatric residents are supervised by Board-certified Psychiatrists at each institution at which they rotate as specified by the Accreditation Council for Graduate Medical Education (ACGME) standards.

**Definitions:**

- ***OD*** – On-call Doctor
- ***ACF*** – Acute Care Facility
- ***PGY*** – Postgraduate Year

**Procedures:**

A. Assigned Duties:

1. All DPC patients are covered for emergencies by a resident (on-call doctor) 24 hours a day. The on-call doctor (OD) covers from 4:30pm to 8:00am on weekdays and 8:00am to 8:00am on weekends and public holidays. The OD sees all new admissions and consults within the hospital for all medical or psychiatric events.
2. During the week, the residents assigned to in-patient service do routine patient care in the Acute Care Facility (ACF) under supervision of a Board Certified Attending Psychiatrist. This includes team meetings, weekly individual supervision or supervision for individual patients as needed.

B. Countersignatures:

All documentation in the patient charts is signed by the resident and countersigned by the Attending Psychiatrist according to DPC policy and procedures. This includes progress notes, orders and treatment plans. The resident initials all lab reports upon receipt.

C. Cover for the OD:

The OD is covered throughout the call by a back-up call consisting of a senior resident who is available by telephone. The on-call Psychiatrist and on-call Primary Care Physician are available throughout the call by telephone or pager.

D. Privileges of the Attending Psychiatrists:

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

The OD is covered throughout the call by a back-up call consisting of a senior resident who is available by telephone. The on-call Psychiatrist and on-call Primary Care Physician are available throughout the call by telephone or pager.

E. Duties on the ACF:

1. Each resident is assigned patients as they are admitted. The resident conducts a psychiatric work-up and gathers information from other available sources (e.g. old records, referral notes, family members, outside professionals, etc.). A formulation is made and orders are written.
2. The resident is responsible for the daily care of the patient and for appropriate documentation. On weekends and public holidays, the OD interviews problem cases as identified by the unit staff, the resident in charge of the patient or the previous OD.
3. The OD communicates a report to the Medical Director and/or designee upon completion of his/her tour of duty. The OD is encouraged to utilize medical and psychiatric back-up, as needed.

F. Seclusion and Restraint:

Seclusion or restraint may be ordered by the OD as per Medical Staff bylaws –see DPC policies for details

G. Orientation of a New Resident:

1. On admission to the program, the resident spends the first month of PGY-I in orientation which consists of:
  - a. Daily attendance at Team meetings in the ACF.
  - b. Daily meeting with the Psychiatric staff and Senior Residents for supervision and didactic instructions in common psychiatric illnesses and issues (e.g. schizophrenia, depression, suicide, violence, etc.). Also the resident receives handouts on Psychiatric Assessment, DSM IV, suicide profiles, etc.
  - c. Management of a limited number of patients to include appropriate documentation.
  - d. OD duty begins in a graded fashion. The resident begins with observer status of another resident on duty, moving up to levels of participation, to independent unaccompanied OD duty. The time taken for this process to be completed is decided individually by the Program Director.

H. PGY-II Residents in the ACF:

PGY-II residents in the ACF are considered senior in the unit and have the responsibility of overseeing their juniors where appropriate, bringing relevant information to Team meetings, scheduling attendance of residents at group therapy, scheduling residents to conduct psycho-education groups and maintaining liaison with the Program Director and the Attending Psychiatrist on the ACF.

I. PGY-IV Resident Administrative Elective Rotation:

PGY-IV residents may choose to spend a rotation of two (2) to four (4) months in the ACF acting as assistant to the Attending Psychiatrist, conducting Team Meetings under supervision, instructing junior residents, and managing clinical patients. These duties are determined by the Attending Psychiatrist and Program Director according to the needs of the ACF and the resident.

**Outpatient Supervision: Issues and Guidelines**

*Last Revision: 09-12-1997*

1. Supervisors must take notes in supervisory sessions to record pertinent information regarding the patient and the resident's treatment. This is necessary for protection of patient care. In addition, supervisors must make a note in the supervisor's records that, at the start of supervision, the American Psychiatric Association (APA) Ethical Guidelines were reviewed and acknowledged by the resident.
2. Residents must inform patients that they are receiving supervision from an attending psychiatrist and state in a progress note that the patient was informed and agreed to the arrangement.
3. All residents and supervisors will be provided with the CMHC Policy and Procedure Manual. These policies and procedures must be followed. If exceptions or problems with the policies are found, then the issue needs to be brought to the Program Director's attention who will consult with the CMHC.
4. Supervisors may require the resident to have the patient seen with the supervisor if clinically warranted.
5. Supervisors are encouraged to have residents use process notes, auto tapes, and/or videotaping to assist in their supervision of the residents. (Audio taping and/or videotaping must be approved with a signed written consent.)
6. Residents should not present a single case to multiple supervisors. Consultation requests by the resident to persons other than the supervisor must receive prior approval by the supervisor.

## **Work Environment Policy**

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*Last Revision: 11-30-2007*

**Purpose:** The Division of Substance Abuse and Mental Health is committed to providing a supportive educational and work environment.

**Scope:** This policy applies to the Delaware Psychiatry Residency Program.

**Policy:** The Sponsoring Institution will provide a supportive working and educational environment for residents in compliance with the guidelines established by the ACGME. The institution will provide the following program requirements:

### **Program Requirements:**

- A. Supportive Educational Resources:
  - a. The residency program will provide adequate inpatient and outpatient facilities, clinics, agencies, and other suitable placements where the residents can meet the educational objectives of the program.
  - b. The program will specify the facilities in which the goals and objectives are to be implemented.
  - c. Residents will have offices adequate in size and decor to allow them to interview patients and accomplish their duties in a professional manner.
  - d. The program will provide adequate and specifically designated areas in which residents can perform basic physical examinations and other necessary diagnostic procedures.
  - e. Other educational resources will be provided: audiovisual equipment; teaching material such as films, audio cassettes, videotapes, as well as the capability to record and play back videotapes; a library with a substantial number of current basic textbooks and journals in psychiatry, neurology, and medicine; laboratory services consistent with educational objectives and patient care; MEDLINE and other medical information search programs.
- B. Resident Work Environment:
  - a. Residents may raise and resolve issues without fear of intimidation or retaliation.
  - b. Residents are provided an organized system of communication and exchange of information on their work environment and their ACGME-accredited programs through a resident support group that meets once per month (12 meetings per calendar year).
  - c. The institution will provide a process by which individual residents can address concerns in a confidential and protected manner; for instance, the Medical Director meets individually with residents twice per calendar year (6 month intervals) to conduct program evaluations, whereby discussing strengths and weaknesses of the program and resident concerns. Data is anonymously aggregated and reports are distributed to faculty and administrators for the purpose of program improvement.



*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- d. The institution must provide services and develop systems to minimize the work of residents that is extraneous to their GME program and ensure that the following conditions are met:
  - i. Residents on duty must have access to adequate and appropriate food services 24 hours per day in the institution.
  - ii. Residents must be provided with adequate appropriate sleeping quarters.
  - iii. Medical records system that documents the course of each patient's diagnosis (-es) and care must be available at all times and must be adequate to support quality patient care, the education of residents, quality assurance activities, and provide a resource for scholarly activity.

Appropriate security and personal safety measures must be provided to residents at all locations including but not limited to hospital and institutional grounds, on-call quarters, and related clinical facilities.

## **Attendance Policy: Academic Credit, GMEC guidelines, and Seminar Attendance**

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*Last Revision: 12-31-2007, 7-1-09*

### A. Academic credit

1. Academic credit will be granted for those clinical assignments which the residents have substantially completed. These guidelines acknowledge that unexpected absence due to sickness or bereavement may occur after previously approved time off has been taken and do not override the vacation guidelines below.
2. The Delaware Psychiatry Residency Program is a full-time residency program. If a resident has missed time from the training program which makes it impossible to satisfy the criteria for graduating from the residency program in the allotted time, then the training period may need to be extended. Brief leaves of absences may be accommodated by a shortening of the resident's elective rotations in their PGY-IV. Long leave of absence may result in the resident taking longer than expected to complete the residency program.

### B. GMEC guidelines for vacation time, sick time, conference time and holidays. :

1. The Delaware Psychiatry Residency Program shall provide to the resident:
  - a. 15 paid personal day per year. Personal time can be used towards vacation and sick time as per GMEC guidelines.
  - b. Up to five (5) paid conference days; And
  - c. Holidays: Residents observe holiday schedule of the hospital/institution at which they are rotating.
2. Residents are prohibited from taking more than two (2) weeks off at one time, unless approved by the Residency Program Director. At least ten (10) days of vacation must be scheduled one (1) month prior to the next academic year. Any additional scheduled vacations during the year must be requested at least 2 weeks in advance.
3. This decision to grant vacation will be based on many factors including the rotation length and maximum leave allowance available. Residents are encouraged to request leave in advance.
4. Residents are prohibited from taking any vacation during the last two weeks of June and first two weeks of July, unless approved by the Residency Program Director, due to new resident orientation.
5. It is Resident's responsibility to inform the Rotation Supervision, Chief Resident, and Residency Coordinator, as soon as possible if he/she is unable to attend work for any reason including sickness.
6. **Residents must observe the holiday schedule of the hospital/institution at which they are rotating.** If required to work a holiday, a "comp" day does not accrue.
7. The GMEC has determined that the following guidelines delimit the routine vacation time allowance. These times are distinct from the guidelines for academic credit, which take into account absence for any cause. For the purposes of these guidelines, personal time and conference time are combined for rotations with a duration of 1-5 months:

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

<b>Rotation Length</b>	<b><u>Maximum</u> Leave Allowance</b>
1 month	2 days
2 months	5 days
3 months	7 days
4 months	9 days
5 months	10 days
12 months	15 days of personal time 5 days of conference leave

C. Seminar Attendance:

1. Residents are required to attend a minimum of 70% of their scheduled didactic seminars. This requirement meets the ACGME Psychiatry Residency guidelines.
2. Documentation of attendance is secured by each resident signing to attest to their attendance during the scheduled seminar and completing the seminar evaluation form. A binder for each resident is kept in the Residency Office for this purpose.
3. Resident attendance is reviewed regularly, and any outstanding issues are brought up during the residents' Semi-Annual Review with the Residency Director.
4. Failure to meet the 70% threshold or misrepresenting attendance may jeopardize the resident's standing in the residency program.
5. For the purposes of calculating percent attendance, eligible seminars (the denominator) do not include lectures given during the following rotations and/or circumstances: internal medicine rotation, family medicine rotation, emergency medicine (night float) rotation, on-call duties, and post-call leave of absences.

## **Resident Appointment Eligibility, Selection, Promotion, and Graduation Policy**

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*Last Revision: 11-30-2007; 01-16-1998*

**Purpose:** The Division of Substance Abuse and Mental Health is committed to providing an environment that is conducive to successfully balancing the educational and professional status of residents. The purpose of this policy is to establish a framework for appointment eligibility, selection and promotion of residents in compliance with the ACGME Institutional Requirements.

**Scope:** This policy applies to the Delaware Psychiatry Residency Program.

**Policy:** The Sponsoring Institution will only appointment, select and promote eligible residents in compliance with the criteria and guidelines established by the ACGME; the institution will monitor the program for compliance; and the Program Director and residents will comply with the following program requirements:

### **Program Requirements:**

#### A. Eligibility and Selection of Residents:

1. Resident Eligibility: Applicants with one of the following qualifications are eligible for appointment to an accredited residency program:
  - a. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
  - b. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
  - c. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
    - i. Are permanent residents (Green Card or US citizens) and have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment, or,
    - ii. Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.
2. Resident Selection: The program will provide educational resources adequate to support the number of residents appointed to the program. The Program Director will not appoint more residents to the residency program than approved by the ACGME RRC.
  - a. The Delaware Psychiatry Residency Program does not discriminate with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status.
  - b. The selection of qualified candidates is based upon residency program-related criteria such as resident preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity.
  - c. Before accepting a resident who is transferring from another program, the Program Director will obtain written or electronic verification of previous

educational experiences and a summative competency-based performance evaluation of the transferring resident and will provide the same when requested to do so by another program.

- i. Verification must include evaluation of professional integrity of residents transferring from one program to another.
    - ii. A transferring resident's educational program must be sufficiently individualized so that he/she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation.
  - d. The Program Director will assure that the presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, Ph.D. students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The Program Director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.
  - e. The Delaware Psychiatry Residency Program will provide effective educational experiences for residents that lead to measurable achievements of the educational outcomes in the ACGME competencies as outlined in the Common and specialty/subspecialty specific Program Requirements.
- B. Financial Support for Residents: The sponsoring institution will provide all residents with appropriate financial support and benefits to ensure that they are able to fulfill the responsibilities of their educational program.
- C. Benefits and Conditions of Appointment: Candidates for the residency program will be provided with a copy of the "Applicant Communication Packet" either in writing or via electronic means. The packet includes the terms, conditions and benefits of their appointment, including financial support; vacations; parental, sick, and other leaves of absence; professional liability, hospitalization, health disability and other insurance provided for the residents and their families; and the conditions under which the sponsoring institution provides call rooms, meals, laundry services, or their equivalents.
- D. Promotion of Residents:
  1. Residents will be evaluated according to the Resident Evaluation Policy.
  2. All residents will be evaluated semi-annually and annually to determine measurable achievements comparable to the goals and expectations for their level of training.
  3. The GMEC will promote a resident to the next level of training if he/she has satisfactorily completed each assigned rotation and has achieved the goals and expectations for his/her level of training.
  4. If a resident has not performed at their level of training or at a particular rotation, the GMEC will treat the matter under the Remediation, Dismissal and Due Process Policy.
    - a. If the resident's performance fails to improve upon verbal and written warnings, the resident may be placed on probation.

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

- b. If the resident is placed on probation, he/she may receive less than full credit in the event that clinical responsibilities are reduced or if a rotation needs to be repeated.
  - c. Upon receiving reduced credit, the resident may not be promoted into the next graduate training year until the required full credit is earned.
5. The GMEC will evaluate each resident placed on probation for sufficient improvement to be promoted or a lack of performance improvement, which may result in the termination of the resident's contract.
- E. Resident Graduation: Residents will be eligible to graduate from the residency program once they have substantially achieved the goals and objectives by training year and rotation. Eligibility for graduation will consist of the results of the resident's clinical exams and his/her evaluations (semi-annual and annual reviews) reviewed by the Program Director.

## **Evaluation Policy**

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*Last Revision: 11-30-2007; 01-19-1998*

### **A. Rotation/Supervisor Evaluation:**

1. Each resident is required to fill out, anonymously, an “Evaluation of Rotation and Supervisor” form at the end of every rotation. The following areas are rated:
  - a. Whether written objectives for the rotation were met;
  - b. Whether there was a sufficient variety of clinical material;
  - c. If structured, clinical supervision was provided adequately;
  - d. If the clinical supervision was found useful by the resident;
  - e. Whether or not a multi-disciplinary staff was available for consultation and collaboration;
  - f. If the clinical responsibilities overwhelmed the resident’s academic activities;
  - g. How the rotation compared with other rotations the resident has had;
  - h. What were the general strengths of the rotation; and
  - i. What were the rotation’s areas to be strengthened (if applicable)
2. The Program Director and each resident participate in a semi-annual and annual review every year. During the meeting, residents are given the opportunity to give additional feedback relating to rotations and supervisors. Concerns of the residents voiced in the meeting and/or through written evaluation given anonymously to the Residency Office are communicated to the residents’ supervisors in order to help improve the rotation. In addition, “Rotation/Supervisor Evaluations” are reviewed in a semi-annual meeting of the Graduate Medical Education Committee (GMEC). If a rotation or supervisor receives less than satisfactory evaluations, the GMEC will make recommendations to correct any deficiencies including the suitability of continuing a particular rotation or supervisor in that capacity.

### **B. Seminar/Instructor Evaluation:**

1. A “Seminar/Instructor Evaluation” form is filled out by each resident in order to assess whether a seminar has fulfilled the seminar objectives and goals, as well as to give any suggestions for improvement. The following areas are rated:
  - a. Whether the amount of time spent to cover the material was adequate;
  - b. Whether the course material was well-organized and presented clearly;
  - c. Whether questions were answered satisfactorily;
  - d. Whether the handouts (if applicable) were helpful;
  - e. Whether examples and illustrations helped clarify ideas presented;
  - f. Whether the presentation made the subject interesting;
  - g. Whether the lecturer assess that the material was understood;
  - h. Whether the course met the goals and objectives given out at the beginning of the course;
  - i. What were the general strengths of the seminar; and
  - j. What were the seminar’s areas to be strengthened (if applicable.)

*Division of Substance Abuse and Mental Health  
The Delaware Psychiatry Residency Program*

2. The Program Director and each resident participate in a semi-annual and annual review every year. During the meeting, residents are given the opportunity to give additional feedback relating to seminars and instructors. Concerns of the residents voiced in the meeting and/or through written evaluation given anonymously to the Residency Office are communicated to the residents' seminar instructors in order to help improve the lectures. In addition, Seminar/Instructor Evaluations are reviewed in a semi-annual meeting of the Graduate Medical Education Committee (GMEC). If a seminar or instructor receives less than satisfactory evaluations, the GMEC will make recommendations to correct any deficiencies including the suitability of continuing a particular instructor in that capacity.

C. Residency Program Evaluation:

1. The Program Director meets with the residents, at least, every month to discuss their concerns and share information. In addition, there is a semi-annual residents' meeting scheduled to discuss the residency program as a whole. The residents' concerns are reviewed in a semi-annual meeting of the GMEC. In addition, the residency is reviewed in regard to policies and procedures, its relationship to sponsoring and participating hospitals, and the surrounding medical and psychiatric community and changing health care needs.
2. Subcommittees will be established with members from the faculty or appropriate outside parties to address issues of particular need. The task forces will report back to the GMEC with findings and recommendations, and the GMEC will decide on any actions.