

DEPARTMENT OF PSYCHIATRY
RESIDENCY TRAINING MANUAL



2016-2017

DEPARTMENT OF PSYCHIATRY RESIDENCY PROGRAM

MISSION STATEMENT

The purpose of the Department of Psychiatry Residency Training Program at the University of Florida is to provide an educational and scholarly environment that will train qualified and competent individuals in the field of psychiatry and enable them to become certified by the American Board of Psychiatry and Neurology, Inc. Training the next generation of academic and community psychiatrists is our major mission.

INTRODUCTION

The Department of Psychiatry at the University of Florida is committed to achieving excellence in its target missions of patient care, education, research and advocacy. It is the goal of the Department to provide a training model that spans from laboratory bench to the clinical bedside, integrating new findings in basic and clinical neuroscience into the highest quality of care for individuals with psychiatric illness or other illness affected by psychosocial factors. This includes the development of professional competence and inculcation of the professional attitudes to be a successful physician. The training includes education in the basic sciences, the cognitive and technical skills necessary to practice general psychiatry, and the development of clinical knowledge and maturity so that clinical judgment can be appropriately applied in the care of patients.

The overall objective of our training program is to develop highly skilled psychiatrists to fill leadership roles in the various areas of psychiatry. A partial list of such arenas includes academic psychiatry, community and public psychiatry, clinical practice, consultation services, forensic psychiatry, geriatric psychiatry, substance abuse/addiction medicine, and child psychiatry. Each resident is expected to become proficient in the diagnostic and therapeutic techniques required of competent clinicians, to be skilled in working with, and coordinating the activities of other mental health professionals, and to develop the necessary skills to critically evaluate relevant research findings in the clinical literature. Every attempt is made to provide a core educational experience as well as tailoring specific training to the special needs and interests of the resident.

Professional attitudes highly valued by this program include complete dedication to patient care, the ability to make sound ethical and scientific judgments in the care of patients, a scholarly mind set and dedication to life long learning, the ability to work well with others and to become part of a team, and the capacity for hard work with a positive attitude and flexibility. The residents in this program are expected to teach and share knowledge with colleagues, students and other health care providers. Critical thinking based on a thorough reading of the available literature and respect of the cultural, religious, and individual preference of the patient and family will be the basis for decisions made that affect the lives of patients. The well-trained psychiatrist must be aware of the cost and societal implications of their decisions and be able to adapt to the evolving health care system in this country. It is anticipated that the behavior learned in the psychiatry residency will make the individual a leader and valued member of the medical community in whichever setting that individual wishes to practice.

Jacqueline A. Hobbs, MD, PhD

Jacqueline A. Hobbs, MD, PhD, DFAPA
Program Director

Robert Averbuch, MD

Robert Averbuch, MD
Associate Program Director

Psychiatry Faculty		
Name	Job Title	Division
Averbuch, Robert, MD	Assoc Prof & Assoc Prog Director	Adult/Education
Blotner, Adrian, MD	Chief & Assoc Prof	Pain/Psychiatry
Brown, Jody, MD	Asst Prof & Prg Director	Child
Brown, Martha, MD	Assoc Pro	Addiction
Bruijnzeel, Adriaan, PhD	Assoc Pro	Addiction
Bruijnzeel, Dawn, MD	Asst Prof	Adult (VA)
Bussing, Regina, MD	Prof and Chair	Child
Camacho-Duran, Angela, MD	Chief & Asst Prof	Adult
Carr, Brent, MD	Chief & Asst Pro	Adult
Chen, Hong, MD	Asst Prof	Adult SMH
Cheong, Josepha, MD	Prof	Adult
Cooke, Brian K, MD	Asst Prof	Adult / Forensic
Creelman, Wayne, MD	Chief & Cln Eminent Scholar	Comm Psych
D'Alli, Richard, MD	Assoc Prof	Child
Febo, Marcelo, PhD	Asst Prof	Addiction
Fernandes, Joel, MD	Asst Prof	Adult (VA)
Flores, Cindi, PhD	Asst Professor	Child
Giles, Donna, PhD	Professor	Animal Research
Ginory, Laura, MD	Asst Prof	Adult(SMH)
Gold, Peter, Psy.D.	Asst Prof	Comm Psych
Gooch, Erik, DO	Asst Prof	Adult (SMH)
Gower, Michael, MD	Asst Prof	Adult (VA)
Greene, Lisa (Merlo), PhD	Asst Prof	Addiction *Chief
Greene, William, MD	Asst Prof	Addiction
Hancock-Smith, Anyaliese PhD	Asst Prof	Med Psychology
Hobbs, Jacqueline, MD, PhD, FAPA	Vice Chair, Assoc Prof & Prg Director	Animal Resch/Education
Holbert, Richard, MD	Chief & Asst Prof	Adult(Vista)
Hollifield, William, MD	Asst Prof	Addiction
Huckaby, Timothy, MD	Asst Prof	Addiction
Jacobs-Elliott, Michelle, MD	Asst Dean & Asst Professor	Adult (SMH) *Chief
Kanter, Gary, MD	Assoc Prof, Prog Dir AOPC	Adult
Khurshid, Khurshid, MD	Assoc Prof & Chief	Adult
Korah, Tessy, MD	Asst Prof	Adult(Vista)
Lewis, Mark, PhD	Prof & Assoc Chair *Chief	Animal Research
Lewis, Carol, PhD	Assoc Prof	Med Psych
Liu, Yijun, PhD	Assoc Prof	Addiction
Logan, Daniel, MD	Asst Prof	Addiction

Name	Job Title	Division
Mayberry, Kohl, DO	Asst Prof	Child
McNamara, Joseph, PhD	Asst Professor	Med Psychology
Miller, Brooke, PhD	Asst Prof	Addiction
Morgan, Drake, PhD	Asst Prof	Addiction
Muehlmann, Amber, PhD	Asst Prof	Adult
Nallapula, Kishan, MD	Asst Prof	Child
Nelson, Melanie, PhD	Assoc Prof	Med Psychology
Nias, Michael, F	Asst Prof	Addiction/Child
Nixon, Sara Jo, PhD	Chief & Professor	Addiction
Olsen, Brian, PhD	Asst Prof	Med Psychology
Orlando, Ann-Marie, PhD	Asst Prof	Child
Phalin, Benjamin, PhD	Asst Prof	Research
Rahmani, Mariam, MD	Asst Prof	Child
Razafsha, Mahdi, MD	Asst Prof	Adult
Reid, Czerne PhD	Lecturer	Education
Reisfield, Gary, MD	Chief & Asst Pro	Addiction
Rodriguez, Julie, MD	Asst Prof	Adult (SMH)
Rodriguez, Leonardo, MD	Asst Prof	Adult (VA)
Setlow, Barry, PhD	Assoc Prof	Addiction
Shapiro, Michael, MD	Asst Professor	Child
Silberberg, Joel, MD	Chief & Professor	Forensics
Smolen, Jamie, MD	Assoc Prof	Addiction
Snodgrass, Natalie, MD	Asst Prof	Adult (Clinic)
Solomon, Louis, MD	Asst Prof	Adult
Suryadevara, Uma, MD	Asst Prof	Adult (SMH)
Sutton, Jill, PhD	Asst. Prof	Med Psych
Svetlov, Stanislav, MD, PhD	Assoc Prof	Addiction
Tandon, Rajiv, MD	Professor & Chief	Adult (VA)
Teitelbaum, Scott, MD	Professor & Prg Director *Chief	Addiction
Thornton, Josph, MD	Asst Prof	Adult (VA)
Turner, Ana, MD	Asst Prof	Adult (VA)
Tucker, Daniel, MD	Chief & Assoc Prof	Child
Valcante, Gary, PhD	Director CARD	CARD
Wang,Ka (Kevin), PhD	Associate Prof	Addiction
Ward, Herbert,Jr., MD	Assoc Prof & Vice Chair	Adult
Welch, Stephen, MD	Asst. Prof	Adult (VA)
Yergen, Cara, MD	Asst Prof	Community Psychology
Yvorchuk, William, MD	Asst Prof	Addiction

Psychiatry Residents 2016-2017

PGY-1's	
Jonathan Browning, MD	University of Florida College of Medicine
Danielle Epstein, DO	Nova Southeastern University
Matthew Harnach, MD	Florida State University College of Medicine
Jessica (Kincheloe) Khan, MD	University of Iowa Carver College of Medicine
Tarik Ksaibati, DO	Lake Erie College of Osteopathic Medicine, Erie
Nicholas Martinezv	Charles E. Schmidt COM at Florida Atlantic University
Hannah Morrissey, DO	A.T. Still Univ Missouri Sch. of Dentistry & Oral Health
Meghan Newberry, DO	Nova Southeastern University
Phuong Tam Nguyen (Tammy) , MD	Howard University College of Medicine
Joshua Proemsey, MD	University of Central Florida College of Medicine
Ashely Bindshedler, DO	Lake Erie College of Osteopathic Medicine, Erie
Ye Zhong (Susan) , MD	University of South Alabama College of Medicine
PGY-2's	
Sheldon Brown, MD	Florida State University College of Medicine
Kathleen Burns, MD	Florida State University College of Medicine
Maanasi Chandarana, DO	Nova Southeastern University
Fei Chen, DO	Lake Erie College of Osteopathic Medicine
Eric Downes, MD	Charles E. Schmidt College of Med at FAU
Brett Flanagan, MD	Medical College of Wisconsin
Joseph Matassini, DO	Lake Erie College of Osteopathic Medicine
Jaison Nainaparampil, MD	Univ of Cincinnati College of Medicine
Jerett Watnick, DO	Lake Erie College of Osteopathic Medicine
PGY-3's	
Bruce Bassi, MD	University of Michigan Medical School
Sarah Bolis, MD	St. Mathew's University School of Medicine
Natasha Clark, MD	University of Illinois College of Medicine
Jennifer Davis, DO	William Carey University of Osteopathic Medicine
Yarelis Guzman-Quinones, MD	San Juan Bautista School of Medicine
Avjola Hoxha, MD	University of South Carolina School of Medicine
Elyse Huey, MD	University of South Carolina School of Medicine
Camilo Leal, MD	Morehouse School of Medicine
Wagdy Khalil, MD	Ain Shams University
Ahmed Qureshi, MD	USF Health Morsani College of Medicine
Daniel Pietras, MD	Univ of Cincinnati College of Medicine
Yarelis Soto, MD	Ponce Health Sciences University
PGY-4's	
Christopher Ong, MD	University of Florida College of Medicine
Andrew Pierce, MD	East Tennessee State University
Krista Pinard, MD	University of Florida College of Medicine
Laura Rodriguez-Roman, MD	University Central del Caribe
Daniel Witter, MD	University of Florida College of Medicine

EDUCATIONAL PROGRAM

Graduated Levels of Responsibility

Graduate medical education is based on the principle of progressively increasing levels of responsibility in caring for patients, under the supervision of the faculty. Faculty members closely monitor the progress of each resident in acquiring the skills necessary for advancement to the next level of training. In their evaluation of a resident's progress, faculty members consider such factors as clinical experience, fund of knowledge, diagnostic abilities, clinical judgment, interpersonal and communication skills, professionalism, and the application of various treatment modalities. Each level of training, or postgraduate year (PGY), is defined by a set of competencies that the resident is expected to master. Upon achieving these standards, residents are afforded greater degrees of independence in patient care, at the discretion of the faculty. At all times, however, faculty remains ultimately responsible for all aspects of patient care. Examples of expected competencies and responsibilities for each level follow.

PGY1 - During their PGY1 year, faculty and senior level residents closely supervise residents. Time is equally divided between a rotating internship and psychiatry. Through their experiences in primary care, residents sharpen their skills in performing a history and physical, generating a differential diagnosis, ordering and conducting appropriate tests, analyzing test results, conducting emergency assessments, and considering interventions.

After completing their Neurology rotations, residents are expected to be able to perform a complete neurologic examination, generate a differential diagnosis, order and conduct appropriate tests, analyze results, and develop a plan of treatment.

During their six months of psychiatry, residents gain experience in two different settings, the psychiatry consult liaison service and on the inpatient psychiatry services. As a PGY 1 resident on the consult liaison service, the resident is introduced to the concept of the interaction between being a psychiatric consultant and interfacing with physicians and other health care providers on medical and surgical services. Under close supervision by faculty and senior residents, the PGY 1 resident is introduced to the variety of psychiatric symptoms that may result from medical illnesses, complications arising from surgical procedures, and the cognitive and behavioral disturbances created by medications and substance abuse. As a consultant, the resident learns how to gather medical information from multiple sources, assess cognitive functioning, communicate with members of the health care team, order appropriate diagnostic studies, and utilize both pharmacologic and psychotherapeutic interventions to enhance patient care.

When assigned to the psychiatric inpatient services, residents learn to manage patients from a biopsychosocial perspective. Residents learn to perform complete psychiatric assessments with particular attention to underlying comorbid medical conditions. Residents are expected to generate a differential diagnosis, propose and institute a thorough patient evaluation, and develop a plan of treatment all under the supervision of the attending psychiatrist.

As members of a multi-modal and multi-disciplinary treatment team, residents learn the importance of collaboration in patient care. Residents participate in group and family therapy sessions, as well as active learning in psychotherapy modules. The resident should be able to communicate with patients and families about the psychiatric condition under treatment and the plan of care as outlined by the attending physician. Residents must demonstrate good clinical judgment in their assessment of crises, and understand when to ask for help. Appropriate communication of clinical data to both patients and colleagues is emphasized. Residents are expected to exhibit a dedication to the principles of professional preparation that emphasizes primacy of the patient as the focus for care. In conjunction with the structured didactic teaching program, the first year trainee must develop and implement a plan for study, reading, and research of selected topics that promotes personal and professional growth and be able to demonstrate successful use of the literature in dealing with patients. At all levels, the resident is expected to demonstrate an understanding of the socioeconomic, cultural, and managerial factors inherent in providing cost-effective care.

In 2011, the ACGME implemented new supervisory requirements for residents at all levels, with the PGY 1 level having particularly stringent requirements of direct supervision. The Psychiatry RRC has further delineated the criteria by which a PGY-1 resident may progress to indirect with direct supervision available. The competencies that must be obtained by PGY 1 residents are as follows:

1. the ability and willingness to ask for help when indicated;
2. gathering an appropriate history;
3. the ability to perform an emergent psychiatric assessment; and,
4. presenting patient findings and data accurately to a supervisor who has not seen the patient.

All incoming residents receive a rigorous assessment process to ascertain that these competencies are achieved, including an Objective Structured Clinical Examination (OSCE), during Orientation and the month of July. A second OSCE occurs approximately 9 months later in the intern year to assess overall progression of skills.

PGY2 - Individuals in the second year of training are expected to perform the duties learned in the first year more independently and may supervise the routine activities of medical students and interns. On the inpatient services, residents are given greater autonomy and encouraged to assume a leadership role in the treatment team under the supervision of an attending. Residents are encouraged to teach trainees and medical students as a means of stimulating their own academic progress. As a psychiatric consultant, the PGY2 resident learns the elements of an appropriate response to consultation in conjunction with a faculty supervisor. The second year trainee draws upon his/her experiences and knowledge to assist other services in the management of psychiatric patients. Residents at this level are also given supervisory responsibilities with trainees on call. It is expected that the second year resident will utilize the literature and routinely demonstrate the ability to research selected topics and present these to the team. In the outpatient setting (half-day per week), residents learn to apply psychotherapy techniques learned in PGY1 didactics and hone their psychopharmacology skills through experience.

In the emergency setting, residents develop greater skills in rapid assessment and disposition of patients. While on call, residents are afforded greater autonomy and develop confidence in their acute management of psychiatric patients. Through the supervision of medical students, residents develop greater teaching skills. The second-year trainee should be able to incorporate ethical concepts into patient care and discuss these with the patient, family, and other members of the health care team. Upon completion of the second year, residents should have a mastery of the basics of patient care in the inpatient, consultation, and outpatient settings.

PGY3 – Third-year residents are full-time in the outpatient setting. Here, residents learn the importance of the therapeutic alliance and begin to develop long-term relationships with their patients. Third-year trainees are afforded greater autonomy in their assessment and treatment of patients.

Residents develop psychotherapy skills through both didactics and case supervision. Understanding of the concepts of transference and counter-transference is emphasized. Trainees build upon their psychopharmacology skills with more advanced didactics and direct applications to patient care. Residents are expected to demonstrate and utilize knowledge acquired from independent reading and study.

Residents complete a yearlong didactic and clinical experience (half-day per week) in Child Psychiatry. Residents learn to communicate effectively with children and their families and the importance of multi-modal assessment.

By the end of the third year, residents should be capable of managing the full spectrum of psychiatric disorders with both biological and psychotherapeutic modalities. Residents should demonstrate continued sophistication in the acquisition of knowledge and skills as well as further ability to function independently in evaluating patient problems and developing a plan for patient care. PGY-3 residents should be capable of assuming the role of clinical chief on selected services.

PGY4 - Individuals in the fourth post-graduate year assume an increased level of responsibility as the chief or senior resident on selected services. Residents at this level may assume greater administrative responsibilities and pursue selectives/electives in areas of sub-specialization. The senior resident can apply a full range of psychiatric treatments and should continue to develop an individual style of practice. The fourth year is one of senior leadership and the resident should be able to assume responsibility for organizing their service and supervising junior residents and students. The resident should have mastery of the information contained in standard texts and be facile in using the literature to solve specific problems. The resident may be responsible for presentations at conferences and for teaching junior residents and students on a routine basis. During the final year of training, the resident has the opportunity to demonstrate the mature ethical, judgment, and clinical skills needed for independent practice. The PGY4 should have some understanding of the role of the practitioner in an integrated health care delivery system and be aware of the issues in health care management facing patients and physicians.

ALL YEARS — Residents at every level are expected to treat all members of the health care team with respect, and to recognize the value of contributions from others involved in the care of patients and their families. The highest level of professionalism is expected at all times. It is expected that residents will treat others with the same respect and consideration they afford superiors and colleagues. Personality conflicts and selfish pursuit of goals are not conducive to good patient care. Long hours and the stress of practice can precipitate conflict; the resident should be aware of the situations where this is likely to happen and compensate by not escalating the situation.

The resident is expected to develop a personal program of reading. Besides the general reading in the specialty of psychiatry, residents should do directed reading daily with regard to problems that they encounter in patient care. Residents are expected to attend all conferences at the service and program level. The conference program is designed to provide a didactic forum to augment the resident’s reading and clinical experience.

Milestones

Residents are evaluated by the Clinical Competency Committee (CCC) on a semi-annual basis according to the ACGME Psychiatry Milestones. The CCC is a committee made up of program faculty who are very invested in residency education. The Milestones can be found at: <https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf>.

Block Schedule Diagram

Year 1

Block	1	2	3	4	5	6	7	8	9	10	11	12
Institution	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	2	2	2	2	2	2
Rotation	Inpt	Inpt	Inpt	C/L	C/L	C/L	IM	IM	IM	IM	Neuro	Neuro
% outpatient	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%	0%	0%
% Research	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Emergency Psychiatry experience at Sites 1 and 2.

Year 2

Block	1	2	3	4	5	6	7	8	9	10	11	12
Institution	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2
Rotation	Inpt	Inpt	Inpt	Inpt	Inpt	Ger	C/L	C/L	C/L	C/L	C/L	C/L
% outpatient	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
% Research	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Emergency Psychiatry experience at Sites 1 and 2.

Year 3

Block	1	2	3	4	5	6	7	8	9	10	11	12
Institution	1	1	1	1	1	1	1	1	1	1	1	1
Rotation	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt
% outpatient	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% Research	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Full-time continuous outpatient experience includes 80% Adult and 20% Child.

Year 4

Block	1	2	3	4	5	6	7	8	9	10	11	12
Institution	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2
Rotation	Add	C&A	Geri	C/L	Comm	Comm	E1	E2	E3	E4	E5	E6
% outpatient	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%
% Research	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Possible electives (E1-E6): CBT, DBS, Eating Disorders, ECT/TMS, Forensics, Junior Attending, Research, State Hospital, Teaching Resident.

Institution Site 1=Shands Hospital at the University of Florida-Gainesville

Institution Site 2=North Florida/South Georgia Veterans Health System

Inpt=Psychiatry Inpatient

Geri=Geriatric Psychiatry

IM=Internal Medicine

Neuro=Neurology

C/L=Consult/Liaison Psychiatry

Outpt=Continuous Outpatient Psychiatry

Add=Addiction

C&A=Child and Adolescent Psychiatry

Comm=Community

Vacation time taken at any time throughout the year each year upon approval from supervisors and Program Director.

Clinical Service Description:

a. Primary Care/Internal Medicine/Pediatrics/Family Practice

- b. 4 month, required rotation, PG-1 year; residents are required to complete 2 of the 4 months on a VA inpatient internal medicine, family practice, or pediatric service. Residents spend 2 months in an outpatient setting at the VA Urgent Care Clinic, the Family Practice Clinic or the Pediatric Clinic.
- c. Both outpatient and inpatient clinical services are staffed by faculty from the corresponding departments at the University of Florida (i.e. Internal Medicine, Pediatrics, or Family Medicine). Full-time attending faculty and senior residents staff inpatient services. Two outpatient attendings work specifically with our residents and are full time faculty.
- d. While on service, residents participate in the teaching rounds and conferences of these departments. Residents also learn through daily patient management, case presentations, and on-site teaching from faculty and senior residents. Additionally, while on inpatient services, residents take overnight call with the team on a regular basis, including cross-coverage. Learning also occurs through the instruction of medical students on service.

- e. Clinical populations vary with the particular service. The VA Medical Services are predominantly male and Caucasian, with a significant minority of African Americans and smaller representations (under 10%) of other minorities. Patients encountered at Shands Hospital are more diverse in ethnicity, with a more equal distribution between sexes and larger African American and Hispanic populations. In all settings, residents are exposed to a wide range of medical pathology including primary care and tertiary referrals.
- f. Psychiatry residents maintain similar caseloads to their internal medicine, family practice and pediatric counterparts while on service. Average inpatient caseloads run between five and seven. In all of the outpatient experiences residents see on average 6 and a maximum of 8 patients daily.
- g. Supervision is provided in both individual and group settings by the departmental faculty of the individual service. Psychiatry residents receive the same supervision as that provided to residents on the individual services.
- h. Psychiatry residents on medicine services attend Psychiatry block didactic sessions.

a. **VA Inpatient Psychiatry – Mood, Anxiety, and Dementia Adult Psychiatry Team**

- b. Residents spend up to 2-4 months on this rotation during the PG-1 year, and sometimes the PG-3/4 year. This rotation is often required in the PG-1 year.
- c. Faculty consists of 1 board certified psychiatrist who is full-time. When on approved leave (vacation, conference attendance, sick), faculty from the other VA inpatient units (Psychosis, Addiction Psychiatry), Consult-Liaison, as well as the Chief of Psychiatry cross-cover).
- d. Residents spend 5-10 hours in rounds with the attending, 3-5 hours in seminars and case conferences, including a 1 hr. weekly teaching session with the attending psychiatrist on service.
- e. The patient population is predominantly lower middle class with about 95% male and 5% female. Approximately 80% are white, 15% black, and 5% others. The average age of the patient population is 50. Diagnostically, about 35% have a primary mood disorder, 30% have Post Traumatic Stress Disorder or another primary anxiety disorder, 15% have an adjustment disorder, 12% have a primary cognitive disorder, and 8% others. A number of the patients have co-morbid personality disorders. Residents are exposed to psychological and neuropsychological testing. Treatment modalities include psychopharmacology, electroconvulsive therapy, group therapy, case management, and psychosocial rehabilitation.
- f. The average case load is 8-10 patients with a maximum of 12 patients.
- g. The residents have clinical teaching and supervision with the attending psychiatrist on a daily basis as part of morning rounds. Residents participate in all aspects of treatment and are taught by an attending faculty member as well as social workers, case managers, pharmacists, and other allied health care professionals.
- h. The residents see a wide range of psychiatric diagnoses in a VA setting allowing them to observe health care in a unique system of care (exemplary EMR, rural setting, intensive longitudinal outpatient care, peer review process, risk management, interdisciplinary teams, unique patient population, and emphasis on research).

a. **VA Inpatient Addiction**

- b. Residents may spend 1 month on this rotation usually during the PG-3 year, occasionally during the PG-1 year. One month of training in addiction is required (and accomplished either on the VA or Vista Service) and electives are also available in the PG-4 year.
- c. The faculty consists of 1 full-time psychiatrist with significant experience in addiction medicine/psychiatry. When on approved leave (vacation, conference attendance, sick), faculty from the other VA inpatient units (Psychosis, Mood), Consult-Liaison, as well as the Chief of Psychiatry cross-cover). Residents also interact with VA licensed therapists who partake in individual and group therapy.
- d. Residents spend 1-4 hours per week in seminars and case conferences in addition to 2-4 hours daily in rounds with the faculty. The faculty supervises the residents on all cases. A broad range of addiction diagnoses is seen.
- e. The patient population is predominantly lower middle class with about 95% male and 5% female. Approximately 80% are white, 15% black, and 5% others. The average age of the patient population is mid-40s. The approximate breakdown of the substance-related diagnoses are 60% alcohol, 15% opioid, 7% cocaine, 1% sedative-hypnotic, and 17% other. About 50% of patients have major psychiatric comorbidities: 45% anxiety/PTSD, 30% major depression, 15% bipolar disorders, 5% schizoaffective disorders, 1% cognitive disorders, and 0.5% schizophrenia. Personality disorders occur in about 20% of admissions including approximately 3% Cluster A, 90% Cluster B, and 2% Cluster C. Treatment modalities include medical detoxification; pharmacotherapy for relapse prevention (FDA approved) including disulfiram, acamprosate, naltrexone, vivitrol, buprenorphine, nicotine replacement, varenicline, and wellbutrin; psychopharmacologic management of comorbid psychiatric disorders; individual and group psychotherapy including motivational interviewing, motivation enhancement therapy, rational emotive behavior therapy; psychoeducational classes; nutrition; and recreational and occupational therapy.
- f. The normal case load is 8-12 patients with a maximum of 12 patients. The resident takes part in all aspects of treatment.
- g. The residents have two hours of required individual supervision weekly. Clinical teaching occurs daily during rounds. Also, residents may take part in the group therapy component and work with the addiction therapists.
- h. The resident is exposed to a variety of treatment modalities and participates in all aspects of treatment planning and implementation. Medical/Physician Assistant student teaching is a major emphasis of the resident experience on this service.

a. **VA Inpatient Red Team (Psychosis)**

- b. Most residents will spend 2 months (total) on this rotation in their PG-1, PG-3, or PG-4 year.
- c. Faculty consists of one board-certified psychiatrist who is part-time. When on approved leave (vacation, conference attendance, sick), faculty from the other VA inpatient units (Psychosis, Addiction Psychiatry), Consult-Liaison, as well as the Chief of Psychiatry cross-cover).
- d. Residents spend 5-6 hours per week in seminars and conferences in addition to 1-3 hours daily in rounds with the faculty. The faculty interview all patients with the residents and supervise them on all cases.

- e. The patient population is predominantly lower and lower-middle class. About 95% of the patients are male with 75% white, 20% black, and 5% others. The average age of the patients is approximately 40-45. The most common diagnoses include Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Substance-Induced Psychotic Disorder, Psychotic Disorder due to a General Medical condition and Major Depressive Episode with psychotic features. Post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), and treatment-resistant depression are also common. Not infrequently, patients have co-morbid substance use disorders. Residents are exposed to psychological/neuropsychological testing. Treatment modalities include psychopharmacology, electroconvulsive therapy (ECT), individual psychotherapy including crisis intervention and cognitive-behavioral, family and group therapy, case management, and psychosocial rehabilitation.
- f. The caseload ranges from 6-12 patients with a maximum of 12 patients. The resident participates in the evaluation process, treatment planning, discharge process, and chart documentation. Residents also have the opportunity to testify at civil commitment hearings.
- g. The residents have 2 hours of required individual supervision weekly. Clinical teaching occurs daily in rounds. Residents participate in all aspects of treatment and the experience is enriched through the contributions of social workers, case managers, and other allied health care professionals.
- h. The residents work primarily with a severely mentally ill population and obtain intense training in the biopsychosocial assessment and treatment. The residents see a wide range of psychiatric diagnoses in a unique setting. Medical/Physician Assistant student teaching is a major emphasis of the resident experience on this service.

a. **Inpatient Neurology**

- b. 2-month required rotation, PG-1 year; 2 months spent at the VAMC on inpatient/consultation services.
- c. Rotations are staffed by full-time faculty of various sub-specialties from the Department of Neurology. Faculty attendings rotate every two weeks, which allows psychiatry residents to be exposed to at least three to four different stylistic approaches to a neurological case and to varying areas of expertise.
- d. Residents participate fully in the teaching rounds and attend the noon conferences and Grand Rounds of the Neurology services. The majority of learning occurs through observation and active participation in patient cases with feedback and instruction from supervising faculty and senior level residents. Residents also learn by teaching medical students on service.
- e. Clinical populations are predominantly male and Caucasian with a significant minority of African Americans and smaller representation (under 10%) of other minorities. The experience at the VAMC covers the full breadth of commonly encountered neurological disorders such as dementias, delirium, epilepsy, tumor, stroke, CNS infections, and demyelinating and degenerative illness. While on consultation service, residents frequently interface with the Psychiatry inpatient services, gaining experience in the interplay between the two disciplines. State-of-the-art treatment techniques are employed in both a clinical and research setting.
- f. Psychiatry residents maintain similar caseloads and patient care responsibilities to their PG-1 neurology counterparts. Inpatient responsibilities may include a caseload of 3 to 5

patients, while consultation volume may vary greatly from day to day (on average 1 to 3 cases).

- g. Neurology faculty and senior residents provide daily supervision on rounds and less formal clinical support on other occasions. Senior residents closely follow PG-1 progress and provide regular and on-the-spot feedback and teaching.
- h. UF psychiatry residents are fortunate to be exposed to a number of Neurology faculty whose specialization is in behavioral neurology. This affords greater exposure to the intricacies of higher cortical functions and greater interplay with psychiatric pathology.

a. **Shands Brain Stimulation Unit Inpatient Geropsychiatry**

- b. Residents spend 2 months on this rotation during the PG-3/4 years. Occasionally, a PG-1 may rotate on this service. This rotation is required.
- c. Faculty consists of 1 board certified psychiatrist who is full-time. When on approved leave (vacation, conference attendance, sick), faculty from Shands Consult-Liaison as well as the Vice Chair for Clinical Affairs cross-cover.
- d. Residents spend 4-6 hours per week in seminars and conferences in addition to 2-4 hours per week in rounds with the faculty. The faculty interview all patients with the residents and supervise them on all cases.
- e. The patient population is predominantly middle class but patients from all socioeconomic classes are encountered. About 60% of the patients are female and 40% male, 80% white, 15% black, and 5% other ethnicities. The average age of the patients is approximately 60. Diagnostically, about 15% have a primary cognitive disorder, 75% have a primary mood disorder, 10% have a psychiatric disorder due to a general medical condition or substance induced psychiatric disorder, 5-8% have a primary psychotic disorder, and 2-5% others. Most of the patients have co-morbid medical conditions. Residents are exposed to psychological and neuropsychological testing. Treatment modalities include psychopharmacology, electroconvulsive therapy, psychotherapy (including brief, crisis intervention, cognitive-behavioral, family and group therapy), case management, and psychosocial rehabilitation. The resident also has the opportunity to testify at civil commitment hearings.
- f. The average caseload ranges from 7-9 patients with a maximum of 10 patients. The resident participates in the evaluation process, treatment planning, discharge process, and chart documentation. Residents also have the opportunity to testify at civil commitment hearings.
- g. The residents have required individual supervision twice weekly for 1 hour. Clinical teaching occurs daily in rounds. Residents participate in all aspects of treatment and are taught by social workers, case managers, a psychologist, and other allied health care professionals.
- h. The residents see a broad range of disorders. A number of the patients have co-morbid medical conditions highlighting the interplay between psychiatric and medical illness. The unit is primarily a geriatric psychiatry and medical-psychiatry unit. Residents teach medical and PA students on this rotation. Inpatient and outpatient ECT (1800+ cases per year) is provided on this unit.

a. **Adult Outpatient Psychiatry**

- b. Required 12-month rotation in the PG-2 year.

- c. Clinic faculty consist of 13 full-time psychiatrists and 5 part-time psychiatrist.
- d. Residents spend approximately 5 hours weekly in didactics including seminars, case conferences, and training modules; additionally, residents spend 2 hours weekly in individual supervision with faculty discussing their cases; residents have approximately 25 patient contact hours/week, all of which are directly staffed by an on-site attending; residents are observed interviewing new patients and emphasis is placed on mastery of the biopsychosocial formulation; therapy cases are both staffed on-site, and discussed in more detail later in individual supervision.
- e. The outpatient population is diverse in diagnoses, age, and socioeconomic status. Approximately 60% of patients are female; ages range from 18 to 95, with the majority falling between 30 and 50. While a majority of patients are in the lower middle class, residents are exposed to a large number of indigent cases in government sponsored programs as well as affluent tertiary referrals. Residents get additional experience in such tertiary services as refractory mood and anxiety disorders, and more complex neuropsychiatric patients with a variety of movement disorders and pain management. The majority of patients are Caucasian (approximately 60%), with 30% African American, and 10% Asian or Hispanic; approximately 60% of cases involve depression or anxiety, 30% include some component of psychosis, another 15-30% have some component of substance abuse, 30% have personality disorders or traits, and 10-15% have elements of a psychiatric disorder due to a general medical condition with a significant representation of neurological disorders. A majority of patients receive some component of psychopharmacologic treatment, alone or in concert with psychotherapy; residents spend approximately 15-25% of their clinical time performing psychotherapy; residents also have experiences in couples and group therapies during their PG-2 year.
- f. Average caseload consists of 10-20 patients in some form of psychotherapy and 50-100 patients in medication management.
- g. All PGY-2 residents have required individual supervision 2 hours/week with faculty members specifically qualified to instruct on psychotherapy. Additionally, PGY 2 residents are now divided into 2 cohorts, each meeting 1-15 hours weekly for a group supervision/process group. An attending psychiatrist performs on-sight supervision of psychopharmacology management. Additional supervision in clinical issues, research initiatives, and career mentoring is available on an optional basis.

a. **Consult-Liaison Psychiatry**

- b. 2-4 month rotation during the PG-1 year; 4 months on this rotation in the PG-3/4 year.
- c. Faculty consists of one full-time psychiatrist and one part-time psychiatrist (who is board-certified in psychosomatic medicine) with additional departmental psychiatrists to provide back up. Departmental and hospital social work assistance is also present.
- d. Residents spend 1-3 hours daily in rounds. The psychiatric faculty supervises all cases. Residents have 3-6 hours of didactics per week. Residents give presentations on various subjects pertinent to clinical cases.
- e. The patient population consists of approximately 25% mood disorders, 25% substance disorders, 5% adjustment disorders, 25% dementia and delirium, 6% substance-induced psychiatric disorders or psychiatric disorders due to a general medical condition, 10% primary psychotic disorders, 8-10% anxiety disorders and 6-8% somatoform disorders (percentages do not total 100% due to co-morbidities). Residents are responsible for thorough evaluations and providing opinions on civil commitment cases. A number of treatment modalities are experienced including ECT, psychopharmacotherapy, crisis intervention, brief therapy, cognitive-behavioral therapy, and psychosocial rehabilitation.

Part of the educational experience is also to effectively interface with other medical teams to provide care for a patient in a treatment team approach.

- f. Residents see approximately 9-10 new cases per week plus follow-ups as needed. The residents cover the emergency rooms at Shands Hospital and the Gainesville VA Hospital from 8 am to 4 pm. Coverage is provided by on call residents and faculty from 4 pm to 8 am. In addition, children and adolescents are seen in the ER and in the Children's Hospital on this service.
- g. The psychiatric faculty supervise all cases. Residents receive supervision daily in rounds. There are also case discussions and formal lectures on C/L subjects scheduled throughout the week.
- h. All of the faculty, many of which have sub-specialties, are available to the consultant with difficult cases.

a. **Child and Adolescent Outpatient Psychiatry**

- b. Required 12-month rotation in the PG-2 year, ½ day per week.
- c. Clinic faculty consists of 5 full-time child psychiatrists and one advanced registered nurse practitioner.
- d. PG-2 residents are supervised in their clinical experience by on-site faculty and participate in a comprehensive child/adolescent psychiatry orientation before engaging in direct patient care. PG-2 residents also attend a weekly Child seminar for the full academic year, have exposure to child psychiatry-focused case conferences, and have the ability to interact with child and adolescent psychiatry fellows.
- e. The clinic population is comprised of children and adolescents in the age range of 6 to 17 years. The clinic director enhances diagnostic diversity through the periodic review of PGY-2 caseloads. The majority of patients fall within the middle class, and there is exposure to both low and high socioeconomic status families. Patients are predominately Caucasian with a substantial minority of African American, Hispanic and Asian-American descent. A majority of patients receive some component of psychopharmacologic treatment, alone or in combination with various psychotherapy modalities. Other patients are seen for therapy modalities alone.
- f. PGY-2 residents carry an average caseload of 20-40 patients over the course of the academic year.
- g. All PGY-2 residents have new evaluations staffed and seen by a child psychiatry attending physician, and an attending Child Psychiatrist performs on-site supervision and is available for all case discussions.

a. **Child and Adolescent Inpatient Psychiatry**

- b. Required 1 month rotation in PG-3 or 4 year.
- c. Faculty and staff consist of one full-time child psychiatrist, one consulting child psychologist, one full-time social worker (LCSW) functioning as therapist/case manager, and one occupational therapist. When the child psychiatrist is on approved leave (vacation, conference attendance, sick), faculty from the child division cross-cover.
- d. Residents learn through active participation in daily rounds with on-site supervision by faculty and discussion of key diagnostic and treatment issues. The therapies center on a mindfulness based cognitive behavioral therapy model integrated with a token economy.

Residents also gain exposure to and participate in group and family therapies on the unit. Finally, residents learn through their instruction of medical students on service.

- e. The program consists of an average of seven inpatients and one partial hospital program patient daily. Boys comprise approximately 55% of the patient population and girls 45% of the population. Both middle and lower middle class socioeconomic status patients are represented. In addition, children of lower socioeconomic status with co-occurring major medical illnesses are treated in this program. Average length of stay is 5 to 7 days. The patient mix consists of approximately 80% Caucasian, 14% African American, and 6% of various other racial/ethnic backgrounds. The main problems requiring admission are affective disorders including depression and bipolar spectrum diagnoses. Post traumatic stress disorder is the most common of the anxiety disorders requiring hospitalization although the full range of anxiety disorders are represented. Conduct disorder and substance use disorders are common comorbidities. Psychotic disorders including schizophrenia and pervasive developmental disorders such as Autism and other developmental delays are represented. Eating Disorders and emerging Personality Disorders are also seen.
- f. Average caseloads range from 4 to 6 inpatients. Most cases are representative of the demographics/diagnoses listed above.
- g. Residents are supervised daily in team rounds and case discussions. They have multiple opportunities for supervision regarding mindfulness based CBT in action whether in the classroom, working with the structured therapeutic workbook, or in direct supervision during family or group.

a. **UF Health Psychiatric Hospital Inpatient Addiction**

- b. Residents may spend 1 month on this rotation during the 3rd or 4th year. One month of training in addiction is required (and accomplished either on the VA or Vista Service). Electives are also available.
- c. Primary full-time faculty consist of 2 addiction specialists (one board certified in Adult Psychiatry and Addiction Medicine; one board certified in Emergency Medicine and Addiction Medicine). Additional Vista faculty consist of 5 psychiatrists who are not addiction specialists. Residents also interact with VA licensed therapists/counselors who perform individual and group therapy.
- d. Residents spend 3-5 hours per week in seminars (including *Principles of Addiction Medicine* didactic) and case conferences in addition to 3-4 hours daily in rounds with the faculty. The faculty interviews all patients with the residents and supervises them on all cases. A broad range of addiction diagnoses is seen.
- e. The clinical population spans a broad range of socioeconomic classes from the poor to the affluent. Approximately 62% of the patients are male and 38% female, 91% white, 6% black, and 1% Hispanic. The average age at time of discharge is 40. Diagnostically, approximately 50% have a primary alcohol or sedative use disorder, 19% have opioid use disorders, 10% cocaine use disorders and 35% have a polysubstance use disorder. A number of patients have a substance-induced psychiatric disorder or a primary psychiatric disorder. Residents are exposed to the treatment of withdrawal syndromes, substance-induced psychiatric syndromes, primary psychiatric syndromes in conjunction with addiction disorders, and the psychosocial treatments of addictive disorders including the 12-step programs and psychosocial rehabilitation.
- f. The normal case load is 3-10 patients with a maximum of 10 patients. The residents partake in all aspects of treatment.

- g. The residents have required individual supervision twice weekly for 1 hour. Clinical teaching occurs during daily rounds. Also, residents take part in the group therapy component and work with the addiction therapists.

a. **UF Health Psychiatric Hospital Inpatient**

- b. Required 2-month rotation in the PG-3 and PG-4 years; additionally most PG-1's do a 2 month rotation on this service.
- c. Faculty consists of 4 full-time board-certified psychiatrists. One is also board-certified in internal medicine. Another is additionally board-certified in geriatric psychiatry.
- d. Residents spend 1-3 hours daily in rounds with the faculty. They are in seminars 3-5 hours weekly. The faculty interviews all patients with the residents and supervises them on all cases.
- e. The patient population spans the breadth of socioeconomic classes. Approximately 78% are white, 18% black, and 2.5% Hispanic and 1.5% others. Diagnostically, about 35% have a primary mood disorder 33% primary psychotic disorder, 6% adjustment disorder, 10% primary cognitive disorders. A number of the patients have co-morbid personality disorders and substance use disorders. Treatment modalities include psychopharmacology, individual psychotherapy including brief, crisis intervention, and cognitive-behavioral, family and group therapy, case management, and psychosocial rehabilitation. Residents are exposed to psychological and neuropsychological testing. Residents also have the opportunity to testify at civil commitment hearings.
- f. The average caseload ranges from 8-10 patients. The resident participates in the evaluation, treatment, discharge planning, and chart documentation.
- g. The residents have 2 hours of required individual supervision weekly. Clinical teaching occurs daily in rounds. Residents participate in all aspects of treatment and are taught by an attending faculty as well as social workers and other allied health care professionals.
- h. The residents see a broad range of psychiatric diagnoses in a community setting.

a. **VA Community Psychiatry: Mental Health Intensive Case Management (MHICM) and Healthcare for the Homeless Veterans (HCHV); Helping Hands Psychiatry Clinic**

- b. Residents spend 1-2 months on this service during the PG-3 and 4 year and this rotation is required.
- c. Faculty consists of 1 full-time psychiatrist.
- d. Residents spend 3-5 hours weekly in didactics and 1-3 hours daily in clinical rounds with the faculty.
- e. The Community Psychiatry rotation at the VA has 2 components. Residents primarily care for patients in the intensive case management service in which there are approximately 130 patients with severe mental illnesses, primarily schizophrenia as well as major mood disorders such as bipolar disorder. The age of the patients ranges from 20s-70s. Treatment modalities include psychopharmacology, crisis intervention, group therapy, case management, and psychosocial rehabilitation. At MHICM, residents have the opportunity to learn more about clozapine management and participate in the clozapine group.

Residents also rotate with HCHV at the new VA domiciliary to provide treatment for the homeless program that provides resource education and needs-based care to homeless veterans. Residents evaluate and treat veterans with psychiatric and dual diagnoses.

Treatment modalities include psychopharmacology, crisis intervention, and supportive therapy. Residents also help engage veterans in the wider VA system by providing consults.

In addition, the resident on the MHICM rotation are expected to participate in at least 2 Helping Hands clinics per month while on rotation. Helping Hands is a medical and psychiatry clinic for the homeless and nearly homeless of Gainesville.

- f. The residents are expected to participate in all aspects of the Community Psychiatry Program. The residents participate with the faculty member in the treatment of approximately 150-200 patients. On average, the resident will see 5-10 patients per day. Flexibility is required in the management of these patients. At times the severity of illness dictates the frequency of visits, including crisis interventions to avert exacerbations.
- g. Clinical teaching occurs daily in rounds and during clinic times as appropriate. The attending is always available for consultation. Residents participate in all aspects of treatment and learn from case managers, nurses, and social workers.
- h. Residents are exposed to patients with severe psychiatric illness and are given the opportunity to learn about community psychiatry in 2 distinct programs. Emphasis is placed on the importance of the biopsychosocial model in the evaluation and treatment of patients. The residents are also given administrative duties that often are closely tied to community resources and outreach programs. Additionally, residents, at times, provide education relevant to Community Psychiatry to the MHICM staff.

a. Forensic Psychiatry

- b. 1 month, elective, usually completed in the PG-3 or -4 year.
- c. 2 full-time board-certified forensic psychiatrists.
- d. Residents observe and participate in (as appropriate/at the discretion of the attending) forensic evaluations performed by the attendings and forensic fellows. Residents are required to write a forensic report. Readings pertaining to forensic psychiatry are assigned and discussed with the attendings/fellows. Residents continue to have 2 hours of individual supervision weekly. Residents continue to attend didactics 3-5 hours per week. Residents also continue their continuity clinics during their elective time unless otherwise arranged.
- e. Residents are exposed to patients and forensic work in various settings including the general forensic outpatient office, prisons, depositions, and the courtroom. Capacity and fitness to stand trial evaluations are commonly observed.
- f. An average case load would consist of 12-18 inmates per rotation at each correctional facility and one to two forensic evaluations per week either civil or criminal.
- g. All residents have required individual supervision once weekly and following each evaluation with the attending supervisor.
- h. Satisfies the forensic experience requirement. Allows residents to explore forensic psychiatry as a fellowship and career option.

a. Addiction Psychiatry/Florida Recovery Center (FRC)

- b. 1 month, elective, usually completed in the PG-3 or -4 year.

- c. Faculty consists of 1 full-time board-certified psychiatrist who is also certified in addiction medicine and 2 full-time board-certified addiction medicine specialists. In addition, there are 1 full-time clinical psychologist and 6 full-time certified addiction counselors.
- d. Residents attend weekly 1-hour didactic sessions reviewing chapters in *Principles of Addiction Medicine*. Residents are given additional specific reading assignments designed to enhance their knowledge of addiction medicine that are discussed with the attending physicians. Residents continue to have 2 hours of individual supervision weekly. Residents remain in their usual PGY-specific didactics/conferences 3-5 hours per week. Residents also continue their continuity clinics during their elective time unless otherwise arranged.
- e. The patient population is adults ages 18 and up, with the majority aged 21-50; approximately 80% of patients are Caucasians, approximately 60% male/40% female. Patients are enrolled in a partial hospitalization program for addiction treatment. The program specializes in the treatment of healthcare professionals, so a sizable and variable percentage of the patients are licensed physicians, nurses, etc. Virtually all patients have a diagnosis of substance dependence, and approximately 50% also have significant comorbid psychiatric conditions, most commonly mood disorders and anxiety disorders. Residents spend the majority of their time making clinical rounds with the attending physician(s), actively participating in a variety of group therapy sessions, and participating in outpatient forensic evaluations of patients suspected of having substance use disorders.
- f. The typical census in the partial hospitalization program is approximately 40-45 patients. Residents are assigned specific patients, not to exceed 10. At the discretion of the attending physician(s), residents may take more of a broad role in the overall treatment administration process, rather than taking individual patient responsibilities.
- g. Residents are continuously supervised by the addiction medicine faculty, one of whom is present during all direct patient interactions, with the exception of occasional outpatient forensic evaluations, where the resident may first see a patient alone, then discuss with the attending physician who will see the patient immediately following. Residents continue to have their usual 2 hours per week of individual supervision of their psychotherapy cases.
- h. This rotation allows residents to experience first-hand the world of addiction treatment at a leading institution in the field. The FRC is the training site of the University of Florida's acclaimed addiction medicine training program that has trained more fellows in addiction medicine than any other institution in the United States.

a. **Shands Consults Junior Attending**

- b. 1 month rotation, elective, usually completed in PG-3 or -4 year.
- c. Faculty consists of one full-time psychiatrist and one part-time psychiatrist (who is board-certified in psychomatic medicine) with additional departmental psychiatrists to provide back up. Departmental and hospital social work assistance is also present.
- d. Residents spend 1-3 hours daily in rounds. The psychiatric faculty supervises all cases. Residents have 3-6 hours of didactics per week. The junior attending teaches junior residents and medical students with oversight and review by the attending.
- e. The patient population consists of approximately 25% mood disorders, 25% substance disorders, 5% adjustment disorders, 25% dementia and delirium, 6% substance-induced psychiatric disorders or psychiatric disorders due to a general medical condition, 10% primary psychotic disorders, 8-10% anxiety disorders and 6-8% somatoform disorders (percentages do not total 100% due to co-morbidities). Residents are responsible for thorough evaluations and providing opinions on civil commitment cases. A number of

treatment modalities are experienced including ECT, psychopharmacotherapy, crisis intervention, brief therapy, cognitive-behavioral therapy, and psychosocial rehabilitation. Part of the educational experience is also to effectively interface with other medical teams to provide care for a patient in a treatment team approach.

- f. The junior attending's main role is to receive consults and delegate cases to more junior residents. The junior attending may opt (with attending input) to see and follow certain consult patients (e.g. more complicated or rare cases) that are deemed to enhance the junior attending's learning. Maximum caseload is 3.
- g. The psychiatric faculty supervise all cases. Residents receive supervision daily in rounds. There are also case discussions and formal lectures on C/L subjects scheduled throughout the week.
- h. All of the faculty, many of which have sub-specialties, are available to the consultant with difficult cases. The junior attending may take the opportunity to learn more specialized subject matter such as billing in preparation for transition to a faculty role.

a. **Shands Brain Stimulation Unit Inpatient Geropsychiatry Junior Attending**

- b. 1 month rotation, elective, usually completed in PG-3 or -4 year.
- c. Faculty consists of 1 board certified psychiatrist who is full-time. When on approved leave (vacation, conference attendance, sick), faculty from Shands Consult-Liaison as well as the Vice Chair for Clinical Affairs cross-cover.
- d. Residents spend 4-6 hours per week in seminars and conferences in addition to 2-4 hours per week in rounds with the faculty. The faculty interview all patients with the residents and supervise them on all cases.
- e. The patient population is predominantly middle class but patients from all socioeconomic classes are encountered. About 60% of the patients are female and 40% male, 80% white, 15% black, and 5% other ethnicities. The average age of the patients is approximately 60. Diagnostically, about 15% have a primary cognitive disorder, 75% have a primary mood disorder, 10% have a psychiatric disorder due to a general medical condition or substance induced psychiatric disorder, 5-8% have a primary psychotic disorder, and 2-5% others. Most of the patients have co-morbid medical conditions. Residents are exposed to psychological and neuropsychological testing. Treatment modalities include psychopharmacology, electroconvulsive therapy, psychotherapy (including brief, crisis intervention, cognitive-behavioral, family and group therapy), case management, and psychosocial rehabilitation. The resident also has the opportunity to testify at civil commitment hearings.
- f. Maximum caseload is 3. The main role of the junior attending is to oversee the junior resident on the service. The resident participates in the evaluation process, treatment planning, discharge process, and chart documentation. Residents also have the opportunity to testify at civil commitment hearings.
- g. The residents have required individual supervision twice weekly for 1 hour. Clinical teaching occurs daily in rounds. Residents participate in all aspects of treatment and are taught by social workers, case managers, a psychologist, and other allied health care professionals.
- h. The residents see a broad range of disorders. A number of the patients have co-morbid medical conditions highlighting the interplay between psychiatric and medical illness. The unit is primarily a geriatric psychiatry and medical-psychiatry unit. The junior attending

takes a lead role in teaching medical and PA students on this rotation. Inpatient and outpatient ECT (1800+ cases per year) is provided on this unit.

a. Electroconvulsive Therapy (ECT; Shands or VA)

- b. 1 month, elective, usually completed in PG-3 or -4 year.
- c. Faculty consists of 2 board-certified psychiatrists; one is full-time, and one is part-time. When on approved leave (vacation, conference attendance, sick), faculty from the Shands or VA inpatient/outpatient services provide cross-coverage.
- d. Residents spend approximately 3-4 hours every Monday, Wednesday, and Friday morning in the ECT suite performing ECT alongside the faculty member. Residents are encouraged to attend rounds on the inpatients receiving ECT. Residents spend 3-5 hours per week in seminars and conferences.
- e. The patient population is predominantly middle class but patients from all socioeconomic classes are encountered. About 60% of the patients are female and 40% male, 80% white, 15% black, and 5% other ethnicities. The average age of the patients is approximately 60. Diagnostically, about 15% have a primary cognitive disorder, 75% have a primary mood disorder, 10% have a psychiatric disorder due to a general medical condition or substance induced psychiatric disorder, 5-8% have a primary psychotic disorder, and 2-5% others. Most of the patients have co-morbid medical conditions. Treatment modalities include ECT and psychopharmacology.
- f. The average caseload ranges from 7-9 patients with a maximum of 10 patients. The resident participates in the evaluation process, treatment planning, discharge process, and chart documentation.
- g. The residents have required individual supervision twice weekly for 1 hour. Clinical teaching occurs daily in the ECT suite.
- h. The residents see a broad range of disorders. A number of the patients have co-morbid medical conditions highlighting the interplay between psychiatric and medical illness. Residents teach medical students on this rotation. Inpatient and outpatient ECT (1800+ cases per year) is provided on this unit.

a. Transcranial Magnetic Stimulation (TMS)

- b. 1 month, elective, usually completed in PG-3 or -4 year.
- c. Faculty consists of 2 full-time board-certified psychiatrists with specialized training in TMS.
- d. Educational methods include assigned reading, observation, and performing the TMS procedure under the supervision of the faculty attending. The resident also learns about clinician administered depression scales and patient self-rating scales.
- e. All patients have a primary mood disorder. Patients consist of males and females from the ages of 18-80. All socioeconomic levels are seen but most patients are in the middle to high economic level. The ethnic mix is The majority of patients are Caucasian (approximately 60%), with 30% African American, and 10% Asian or Hispanic; approximately 60% of cases involve depression or anxiety, 30% include some component of psychosis, another 15-30% have some component of substance abuse, 30% have personality disorders or traits, and 10-15% have elements of a psychiatric disorder due to a general medical condition with a significant representation of neurological disorders.
- f. Average caseload is 2 with the maximum of 6.

- g. The resident meets daily with the TMS faculty member to discuss each case.
- h. This rotation allows the resident to learn the latest in device-medicated treatment of mental illness.

a. Northeast Florida State Hospital (NEFSH)

- b. 1 month (more if desired), elective, usually completed in PG-3 or -4 year.
- c. Faculty consists of 1 full-time board-certified psychiatrist. When on approved leave (vacation, conference attendance, sick), other facility faculty provide cross-coverage.
- d. Residents spend approximately 20 hours per week at NEFSH during this rotation. They round with the attending psychiatrist/treatment team (approximately 3-5 hours), attend group therapy sessions, and spend time in supportive therapy with the patients. Residents spend 3-5 hours per week in didactics/conferences.

In addition, the resident on the NEFSH rotation are expected to participate in at least 2 Helping Hands clinics per month while on rotation. Helping Hands is a medical and psychiatry clinic for the homeless and nearly homeless of Gainesville.

- e. The patient population is predominantly lower socioeconomic class but patients from all socioeconomic classes are encountered. About 35% of the patients are female and 65% male; 65% white, 35% black/other ethnicities. The average age of the patients is approximately 70 (ward where residents work) but can range from 20 to 90 plus at the hospital in general. Diagnostically, 86% have a schizophrenia/schizoaffective disorder, 4% have dementia, and 10% have other Axis I disorders. Approximately 30% have a personality disorder and 49% have a substance abuse diagnosis. Approximately 75% have a least one serious medical condition. Treatment modalities include psychopharmacology, ECT (off grounds), individual/group psychotherapy, work/vocational programs, and recovery center classes. Residents also have access to observing forensic evaluation by a forensic psychologist.
- f. The average caseload ranges from 7-9 patients with a maximum of 10 patients. The resident participates in the evaluation process, treatment planning, discharge process, and chart documentation.
- g. The residents have required individual supervision twice weekly for 1 hour. Clinical teaching occurs daily on rounds.
- h. Provides residents experience in the treatment of patients with severe, chronic mental illnesses who are mostly involuntarily committed to a state hospital system. May count towards the Community Psychiatry experience.

a. Student Mental Health

- b. 1 month (more if desired), elective, usually completed in the PG-3 or -4 year.
- c. Clinic faculty consists of 2 full-time and 2 part-time board certified psychiatrists.
- d. Residents continue to attend 3-5 hours of scheduled didactics/conferences as well as 2 hours of individual supervision each week. Residents see new and follow up patients for evaluation, diagnosis, and treatment in the outpatient setting. Although psychopharmacology is the main treatment modality, the resident can recommend and/or provide individual psychotherapy.

- e. Most patients treated during this rotation are college-age adolescents or young adults. The clinic population consists of about 40% males and 60% females; 80% are Caucasian, 5-10% African American and about 15% Hispanic. Ages can range from 17 to some nontraditional students in their 60's. However, the majority are 18-24 years of age. Approximately 50-60% are treated for depressive disorders and/or anxiety disorders, 20-25% have a primary or co-morbid ADHD diagnosis, 5% with bipolar disorders and/or psychotic disorders, 5-10% with personality disorders, and 5-10% with adjustment disorders. Residents learn pharmacotherapy and various therapy modalities within the outpatient clinic setting.
- f. An average case load would consist of 20-30 patients for medication management and 3 patients in individual psychotherapy.
- g. Supervision is provided by the assigned supervisor (a board certified psychiatrist) who is present on-site. This is typically one hour face to face supervision to discuss cases the resident has seen throughout the day. The supervisor is also available throughout the day for consultation regarding any complicated issues. Faculty are also available by phone to provide back up. Additional supervision can be arranged by mutual understanding.
- h. Provides resident experience in comprehensive psychiatric evaluations and medication management for adolescents/young adults. Residents may also gain experience working in conjunction with assigned therapists, or they may provide psychotherapy in their own sessions.

a. VA Teaching

- b. 1-2 months, elective, usually completed in PG-3 or -4 year
- c. 2 full-time board-certified psychiatrists.
- d. The VA Teaching resident prepares and presents lectures, journal clubs, and case conferences for other residents rotating at the VA. They provide approximately 2 sessions per week. The VA Teaching resident is responsible for maintaining attendance records for the lectures.
- e. N/A.
- f. N/A.
- g. Peers and faculty attend the VA Teaching resident conferences and provide feedback to the Teaching resident both verbally and electronically. The Teaching resident continues to have two hours of individual supervision weekly as well as didactics/conferences 3-5 hours per week. Continuity clinics are continued during this elective unless otherwise arranged.
- h. Allows resident to work independently, develop and practice teaching style and techniques, develop a teaching portfolio, and review for PRITE and ABPN exam.

a. Research

- b. 1-2 months (more possible), elective, usually completed in PG-3 or -4 year
- c. Varies depending on research interest of resident. May be psychiatrist, psychologist, basic scientist; full- or part-time.
- d. Laboratory and/or clinical research. Instruction in research methodology, ethical conduct of research, IRB, other regulatory issues, grantsmanship, publication, peer review, and critical appraisal of the literature included.

- e. N/A.
- f. N/A.
- g. Scheduled supervision is per the research mentor. It is recommended that at a minimum the resident and mentor meet weekly to discuss progress and provide instruction. The resident continues to have two hours of individual supervision weekly as well as didactics/conferences 3-5 hours per week. Continuity clinics are continued during this elective unless otherwise arranged.
- h. Allows residents to develop or continue their interest in research. It is expected that some measure of productivity be required by the research mentor such as a publication-quality manuscript, grant application, and/or abstract submission to a meeting.

**University of Florida Psychiatry Residency:
Program Goals and Objectives**

Overall Goals:

1. To provide qualified physicians with a well-rounded educational training environment, diverse in both didactics and clinical experience.
2. To foster the development of prerequisite knowledge, skills, and attitudes in accordance with the professional guidelines set forth by the Psychiatry Residency Review Committee of the American College of Graduate Medical Education, and the American Board of Psychiatry and Neurology, Inc.
3. To prepare qualified physicians for the independent practice of psychiatry and to expose them to the wide range of career opportunities available in the area of academics, research, clinical practice, and the various psychiatric subspecialties.
4. To provide a solid educational background that prepares residents to successfully pass the certification examination in psychiatry by the American Board of Psychiatry and Neurology.

Goals and Objectives PGY 1

Overall Goals for PGY 1

I. Medical Knowledge

- A. Build a foundation in general adult medical knowledge that includes neurological conditions as well as medical illnesses.

II. Patient Care

- A. To diagnose common medical and surgical disorders and to provide the appropriate treatment or management of the patient.
- B. To diagnose common neurological disorders and to provide appropriate management for them.
- C. To understand the need for consultation and the appropriate use of consultative services.
- D. To learn the skills necessary to perform a medical and neurologic examination.
- E. To learn skills necessary in performing a thorough psychiatric evaluation.
- F. To understand the interaction between medical and psychiatric disorders.
- G. To understand the interaction of pharmacologic agents in the treatment of medical and psychiatric conditions.

- III. Interpersonal and Communication Skills**
 - A. To develop communication skills that enables the psychiatrist to elicit a thorough history and develop therapeutic relationships.
- IV. Professionalism**
 - A. To become confident in the new role as a physician.
 - B. To begin the process of becoming a psychiatrist.
 - C. To acquire the sense of responsibility and autonomy necessary to practice medicine.
 - D. To behave respectfully and collaboratively with treatment team members.
 - E. To dress appropriately for professional/clinical activities.
- V. Practice Based Learning and Improvement**
 - A. To establish a philosophy of continual lifelong learning.
- VI. Systems Based Practice**
 - A. To work effectively as a member of a multidisciplinary team.

PGY 1 Objectives by Clinical Rotation

1. Internal Medicine: 4 Months PG1 year

Overall goal: Provide the psychiatry resident with a foundation to understand the medical problems often present in the psychiatric patient.

- I. Medical Knowledge**
 - A. Recognize general medical illness in adult patients.
 - B. List medical disorders likely to present with psychiatric symptoms, and psychiatric disorders likely to present with medical symptoms.
 - C. Select laboratory, imaging, radiographic, and diagnostic studies depending on patient presentation.
 - D. Interpret chest x-rays, interpret ECGs, and laboratory studies.
- II. Patient Care**
 - A. Complete a medical history and perform a physical examination and each patient.
 - B. Demonstrate the ability to synthesize data from the history and physical findings.
 - C. Order appropriate laboratory, imaging, radiographic, and diagnostic studies.
 - D. Formulate a differential diagnosis and treatment plan.
- III. Interpersonal and Communication Skills**
 - A. Develop communication skills that will enable the resident to elicit a through history and forge a therapeutic relationship.
 - B. Demonstrate sound communication with patients, physicians and other health care staff members.
- IV. Professionalism**
 - A. Recite the basic tenets of ethics in medicine.
 - B. Demonstrate appropriate dress reflecting the professional position of a physician.
 - C. Report to all assignments punctually and as required.
 - D. Keep records up to date and sign off on charts in a timely fashion.
 - E. Avoid banned abbreviations in medical records.
- V. Practice Based Learning and Improvement**
 - A. Read current scientific literature and medical texts germane to patient care.
 - B. Apply evidenced based data to optimize patient care.
 - C. Utilize feedback from attending physicians and senior residents to identify strengths and knowledge deficiencies, and use this information to improve patient care.

VI. Systems Based Practice

- A. Collaborate as a member of the medical health care team.
- B. Use all resources appropriately to enhance patient care and safety.
- C. Differentiate the role of ancillary staff such as respiratory therapists, physical therapists, occupational therapists, discharge planners and social workers.
- D. Prepare an adequate discharge summary and plan for follow up medical care.

2. Neurology: 2 Months PG1 year (or possibly 1 month PG1 year and 1 month PG2 year)

Overall Goal: Develop foundational knowledge and clinical skills in neurology.

I. Medical Knowledge

- A. State the signs, symptoms and other manifestations of neurologic illness.
- B. Cite the neurologic disorders that display symptoms largely regarded as psychiatric in nature.
- C. Identify the psychiatric conditions that present primarily with neurological symptoms.
- D. Discuss the appropriate selection of diagnostic laboratory, radiographic, imaging, and encephalographic studies depending on patient presentation.

II. Patient Care

- A. Perform a thorough neurologic examination and history.
- B. Interpret diagnostic studies including CNS MRI and CT imaging studies to facilitate patient care.
- C. Describe the basic interpretation of EEGs.

III. Interpersonal and Communication Skills

- A. Present a patient's case to a neurologist using proper terminology.
- B. Complete comprehensive, timely, and legible medical records.

IV. Professionalism

- A. State the basic tenets of ethics in medicine.
- B. Demonstrate appropriate dress reflecting the professional position of the physician.
- C. Report punctually and as required to all assignments.

V. Practice Based Learning and Improvement

- A. Apply current scientific information and evidenced based principles to the care of the neurologic patient.
- B. Utilize feedback from attending neurologists and senior residents to improve their knowledge base and optimize patient care.

VI. Systems Based Practice

- A. Demonstrate appropriate referral of patients for neurologic consultation.
- B. Prepare an adequate discharge summary and plan for follow up care.

3. Consult Liaison Psychiatry: Up to 3 Months PG1 year

Overall Goal: Introduce the concepts of interaction between psychiatric consultants with other physicians and health care professionals, and initiate the process of becoming a psychiatric consultant.

I. Medical Knowledge

- A. List the diagnostic criteria for psychiatric illnesses commonly encountered in emergency departments, and in hospitalized medically and surgically ill patients.
- B. Recognize the impact of illness, hospitalization and medical and surgical care on the psychological functioning of patients.
- C. Determine psychiatric diagnoses on all patients seen on the consult liaison service.
- D. Construct a comprehensive formulation regarding psychiatric diagnosis in medical and surgical patients.

- E. Recognize the typical signs of psychiatric disorders, including substance abuse, in medical and surgical patients.

II. Patient Care

- A. Perform a thorough psychiatric assessment of the patient.
- B. Evaluate cognitive ability in medically and surgically ill patients.
- C. Order the appropriate diagnostic studies based on patient presentation.
- D. Gather data from appropriate sources including patient chart, family, hospital staff, and other relevant individuals.
- E. Write pertinent and useful consultation notes.

III. Interpersonal and Communication Skills

- A. Communicate information effectively
- B. Demonstrate caring and respectful behaviors when interacting with patients and their families.
- C. Communicate effectively with physicians and other professionals.
- D. Demonstrate increasing comfort and confidence interviewing patients in various clinical settings.

IV. Professionalism

- A. Report on time and attend all assignments.
- B. Demonstrate respect, compassion, and integrity in interactions with patients, family, and other health care providers.

V. Practice Based Learning and Improvement

- A. Seek feedback from supervisors, attending physicians and other health care providers and utilize this feedback to improve performance.
- B. Use online resources and evidenced based data in the role as a consultant.

VI. Systems Based Practice

- A. Work as a consultant member of a team that provides patient care.

4. Inpatient Psychiatry VA and Vista: Up to 6 Months PG1 year

Overall goal: The overall goal of the first year inpatient psychiatry rotations is to provide the resident the experience necessary to enable building a foundation for the care of the psychiatrically ill inpatient.

I. Medical Knowledge

- A. List the diagnostic criteria for the major psychiatric disorders, their epidemiology, presentation, and differential diagnosis.
- B. Name the signs and symptoms of psychiatric disorders typically seen in the inpatient setting.
- C. Review basic psychopharmacology including mechanisms of action, indications for use, dosing, side effects and drug interactions.
- D. Describe the basic concepts, indications for the use of, complications, and contraindications for electroconvulsive therapy.

II. Patient Care

- A. Residents are expected to become adept at obtaining a psychiatric history, and
- B. Demonstrate performance of a medical and neurologic examination.
- C. Formulate an appropriate differential diagnosis depending on the patient presentation and appropriate laboratory studies.
- D. Design a biopsychosocial formulation from the information obtained in the history, physical and neurological examinations, and laboratory, imaging, and radiographic studies.

- E. Practice psychotherapeutic techniques commonly employed on inpatient psychiatric units including supportive therapy, crisis intervention, cognitive-behavioral techniques, group therapy, and family therapy.
- F. Demonstrate skills in selecting appropriate laboratory, radiographic, imaging, and encephalographic studies depending on the patient presentation.
- G. Define clearly in the medical record the history, physical, mental status examination, ancillary information, and the thought making process in arriving at the diagnosis and the formation of the treatment plan.

III. Interpersonal and Communication Skills

- A. Obtain informed consent, and identify when a patient is unable to provide informed consent.
- B. Communicate with patients, family and other health care providers in a non-judgmental and professional fashion.
- C. Maintain comprehensive, timely, and legible medical records.

IV. Professionalism

- A. Dress professionally, report punctually and as required for all assignments.
- B. Demonstrate respect and compassion for patients and their family members.

V. Practice Based Learning and Improvement

- A. Apply information technology and evidence based data to enhance patient care.
- B. Read current scientific information daily to build their medical knowledge base.

VI. Systems Based Practice

- A. Work within a multidisciplinary team, and begin the process of developing skills that will develop team leadership skills.
- B. Demonstrate advocacy for quality patient care and cost-effective treatment.
- C. Prepare an adequate discharge summary and treatment plan for follow up care.

5. Brain Stimulation Unit (BSU): Up to 2 Months PG1 year (but usually PG-2 and above)

The overall goal for this rotation is the management of the psychiatrically ill inpatient who also presents with comorbid medical illness, especially the geriatric patient.

I. Medical Knowledge

- A. Recognize medical illnesses found commonly comorbid in psychiatric inpatients.
- B. Describe psychiatric disorders that typically occur in the elderly.
- C. Review the differential diagnosis and management of cognitive decline often seen in the degenerative disorders of the central nervous system.
- D. Describe the patterns of normal aging, and recognize abnormal aging processes.
- E. Discuss the unique pharmacokinetic and pharmacodynamic considerations encountered in the elderly patient, including drug interactions.
- F. Discuss the theory for the proposed mechanism of action of electroconvulsive therapy.

II. Patient Care

- A. Demonstrate the ability to use all available data such as history, family information, chart data, physical and neurological examinations, and laboratory and imaging data to formulate a differential diagnosis and appropriate treatment plan.
- B. Use neuropsychological testing in assessing cognitive functioning in the elderly.
- C. Demonstrate ability to manage psychiatric disorders in the patient with comorbid medical conditions.
- D. Recognize medical conditions that commonly influence psychiatric symptoms such as HIV, AIDS, CNS lesions, and endocrine diseases.
- E. Manage the patient who presents with poly-pharmacy induced psychiatric symptoms.
- F. Cite the indications, contraindications, adverse effects, and the procedure for the administration of electroconvulsive therapy.

- III. Interpersonal and Communication Skills**
 - A. Communicate appropriately with consultants to aid in the diagnosis and management of medically complicated patients.
 - B. Demonstrate ability to work cooperatively as a member of a health care team.
 - C. Maintain comprehensive, timely, and legible medical records.
- IV. Professionalism**
 - A. Demonstrate compassion, integrity and respect for patients and their families.
 - B. Apply legal and ethical principles appropriately to patient care including informed consent, confidentiality, advanced directives, involuntary commitment, and the right to refuse treatment.
- V. Practice Based Learning and Improvement**
 - A. Utilize information technology to optimize the care of the patient.
 - B. Demonstrate the ability to appropriately educate patients, their family members, students, and other health care professionals avoiding medical jargon.
- VI. Systems Based Practice**
 - A. Collaborate with team nurses, therapists, social workers, and other health care providers to enhance patient care.
 - B. Advocate for quality patient care and cost-effective treatment.
 - C. Prepare an adequate discharge summary and treatment plan for follow up care.

Goals and Objectives PGY 2

Overall Goals for PGY 2

- I. Medical Knowledge**
 - A. Demonstrate sound knowledge base in medical, neurological and psychiatric patient care situations.
- II. Patient Care**
 - A. Manage the full spectrum of psychiatric disorders using both psychopharmacologic and psychotherapeutic modalities.
 - B. Manage patients on inpatient psychiatry units.
 - C. Apply basic techniques in using psychotherapy and hone psychopharmacology skills through experience.
- III. Interpersonal and Communication Skills**
 - A. Continue development of excellent communication skills.
 - B. Further develop skills in consult-liaison psychiatry.
- IV. Professionalism**
 - A. Demonstrate compassion, respect, and tolerance in all interpersonal interactions.
 - B. Act as role model for junior residents.
- V. Practice Based Learning and Improvement**
 - A. Demonstrate continued sophistication in the acquisition of knowledge and skills, as well as further their ability to function independently in evaluating patient problems and developing a treatment plan.
- VI. Systems Based Practice**
 - A. Throughout the year, demonstrate leadership roles on multidisciplinary teams.
 - B. Demonstrate the ability to perform as effective teachers and supervisors of PGY 1 as well as of medical students.

PGY 2 Objectives by Clinical Rotation

1. Consult Liaison Psychiatry: 6 Months PG 2 year

The overall goal is to master the concepts of interaction between psychiatric consultants and other health care professionals, and become proficient as a psychiatric consultant.

I. Medical Knowledge

- A. Demonstrate comprehension of medical illnesses that often present with psychiatric symptoms, and psychiatric disorders presenting with medical symptoms.
- B. Generate a complete DSM differential diagnosis on all patients evaluated.
- C. Demonstrate knowledge of suicidality, including epidemiology, risk factors, patient assessment, treatment, and prevention methods.
- D. Demonstrate knowledge of the epidemiology, differential diagnosis, and treatment of aggression and agitation.
- E. Describe the connection between psychiatric symptoms and the treatment of medical and surgical conditions.
- F. Demonstrate an understanding of the behavioral responses to medical illness.

II. Patient Care

- A. Develop a therapeutic alliance with medically and surgically ill patients.
- B. List the indications, contraindications, and adverse effects of electroconvulsive therapy.
- C. Demonstrate mastery at obtaining a psychiatric history including a thorough cognitive evaluation, and performing basic medical and neurologic examinations.
- D. Demonstrate mastery in formulating biopsychosocial diagnoses from the information obtained in the history, chart review, mental status, and physical examination.
- E. Select appropriate laboratory, radiographic, imaging, and encephalographic studies depending on the patient presentation.
- F. Develop expertise at interpreting the results of laboratory, radiographic, imaging, and encephalographic tests.
- G. Demonstrate mastery at treating the disorders seen by a psychiatric consultant including somatoform disorders, delirium and dementia, substance-related disorders, and medical symptoms caused by medication side effects.

III. Interpersonal and Communication Skills

- A. Demonstrate the ability to communicate with, and provide treatment recommendations to, other health care providers concerning psychiatric disorders commonly encountered by psychiatric consultants in general hospital settings, clinic settings, and the emergency room.
- B. Dictates and/or writes pertinent and useful consultation notes.

IV. Professionalism

- A. Demonstrate mastery of knowledge of legal and ethical issues involving patient care including confidentiality, informed consent, the right to refuse treatment, competency in health care decision making, advanced directives, voluntary and involuntary hospitalization, and be adept at managing these issues in the consult liaison setting.
- B. Demonstrates respect and compassion, and acts with integrity when interacting with patients and their families.

V. Practice Based Learning and Improvement

- A. Demonstrate proficiency in teaching other physicians, residents and medical students about psychiatric issues in the consult liaison setting.
- B. Use feedback from attending physicians and/or senior residents to improve their performance as a psychiatric consultant.
- C. Utilizes online medical resources and evidence based medicine to optimize patient care.

VI. Systems Based Practice

- A. Demonstrate mastery at working with physicians and other health care workers to provide optimal care for patients.
- B. Demonstrates the ability to practice cost-effective health care and resource allocation that does not compromise quality of care.

2. Inpatient Psychiatry VA Psychotic Disorders Team: up to 2 Months PG 2 year

The overall goal for the rotation is to provide the upper level resident a concentrated educational experience in the management of seriously ill psychiatric patients.

I. Medical Knowledge

- A. Review the diagnostic criteria for the DSM psychotic disorders, and demonstrate the ability to recognize the signs and symptoms of psychotic disorders commonly encountered in the inpatient setting.
- B. State the current scientific data concerning epidemiology, etiology, and treatment of the psychotic disorders.
- C. Demonstrate the knowledge of psychiatric and medical conditions that may be comorbid in patients with psychotic disorders.
- D. Demonstrate knowledge of psychopharmacologic medications used to treat the psychotic patient including their indications, contraindications, and adverse effects.

II. Patient Care

- A. Articulate a biopsychosocial formulation of a patient with psychosis, and utilize this information to formulate a treatment plan.
- B. Demonstrate psychotherapeutic techniques utilized in the treatment of the psychotic disorders.
- C. Demonstrate the clinical ability to utilize psychopharmacologic treatments effectively for the patient with psychosis.
- D. Demonstrate skill in obtaining a complete psychiatric history, and performing a medical and neurologic examination in a psychotic patient.
- E. Demonstrate the ability to differentiate primary psychotic disorders from medication or substance induced psychotic disorders, or psychosis precipitated by medical illnesses.
- F. Demonstrate skill in selecting appropriate laboratory, radiographic, imaging and encephalographic studies to aid in the diagnosis and treatment plan.
- G. Demonstrate knowledge of the rating scales utilized to assess either the signs and symptoms of patients with psychosis, or the adverse effects of pharmacotherapy.

III. Interpersonal and Communication Skills

- A. Demonstrate skill in obtaining informed consent and demonstrate understanding when a patient is unable to provide informed consent for treatment.
- B. Assess acuity of psychopathology on the inpatient unit, managing the potentially aggressive patient and effectively communicate the need for intervention to other team members.

IV. Professionalism

- A. Treat all patients, their families, team members and staff with respect and compassion.
- B. Dress appropriately, be punctual and present for all assignments.

V. Practice Based Learning and Improvement

- A. Use information technology and evidence based data to enhance patient care.
- B. Expand knowledge base by reading current scientific information regularly.
- C. Demonstrate the ability to apply current research findings in the care of the patient with psychosis.

VI. Systems Based Practice

- A. Collaborate with team nurses, therapists, social workers, and other health care providers to enhance patient care.

- B. Advocate for quality patient care and cost-effective treatment.
- C. Prepare an adequate discharge summary and treatment plan for follow up care.

3. UF Health Psychiatric Hospital Inpatient Psychiatry: up to 5 Months PG 2 year

The overall goal for this rotation is to continue the assignment on a psychiatric unit that began in year one, but to demonstrate progress toward greater autonomy and responsibility for the care of the patient admitted to a general psychiatric hospital service.

I. Medical Knowledge

- A. Demonstrate knowledge about the neurobiological and psychological underpinnings of mental illness and will apply this knowledge to patient care.
- B. Demonstrate knowledge of the diagnosis, prevalence, treatment, and prevention of psychiatric disorders most likely to affect psychiatric inpatients.
- C. Demonstrate understanding of the psychopharmacologic treatment of mental illness, including the indications, contraindications, and adverse effects of medications, treatment algorithms, augmentation strategies, and combination therapies.
- D. Demonstrate understanding of the indications for and limitations of psychological testing and neuropsychological testing in a psychiatric inpatient setting.

II. Patient Care

- A. Gather accurate and complete information about their patients from multiple sources including the patient, the patient's family, friends, health care providers, and the patient's medical record.
- B. Develop a comprehensive biopsychosocial assessment and differential diagnosis that incorporates genetic predisposition, developmental issues, comorbid medical conditions, substance use and abuse, ethnic, cultural, and spiritual factors, economic issues, current relationships, and psychosocial stressors.
- C. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and sound clinical judgment.
- D. Develop an understanding of the use of specific psychotherapeutic strategies appropriate for an inpatient setting, including supportive techniques, cognitive-behavioral interventions, group and family psychotherapy.
- E. Demonstrate knowledge about electroconvulsive therapy (ECT) including appropriate patient selection, the indications, contraindications, and adverse effects of ECT and is able to educate patients and their families about the risks and benefits of, and alternatives to ECT, and understands the necessity of obtaining informed consent for the procedure.
- F. Demonstrate competence in the management of agitated patients, including verbal and behavioral de-escalation techniques and psychopharmacologic interventions.
- G. Describe and utilize psychotherapeutic techniques that can be helpful in an inpatient group setting, including goal-setting, relaxation strategies, developing & utilizing social support, crisis intervention and safety planning, reducing emotional lability, and cognitive reframing.

III. Interpersonal and Communication Skills

- A. Demonstrates effective communication skills with patients, their families, and other health care professionals.
- B. Demonstrate the ability to effectively communicate with various health care team members, and work as a member of that team.
- C. Create and sustain a therapeutic and ethically sound relationship with patients, including the use of open and honest communication, the maintenance of empathy, and the establishment of appropriate boundaries.
- D. Demonstrate proficiency in conveying sensitive information to patients and their families.
- E. Maintain the medical record appropriately, including an admission history and physical examination, daily progress notes, consent forms, and a dictated discharge summary.

IV. Professionalism

- A. Demonstrate respect, compassion and integrity in all interactions with patients, families, team members, and other health care providers.
- B. Demonstrate accountability to patients, other health care providers and to the medical profession, and is responsive to the needs of patients that supersedes self interest.
- C. Appreciate the ethical issues that can arise in an inpatient psychiatric setting including patient autonomy, involuntary treatment, decisional capacity to accept or refuse psychiatric care, informed consent, confidentiality of patient information, and the potential for violation of appropriate boundaries.
- D. Demonstrate sensitivity and responsiveness to patients regardless of cultural background, age, gender, or disabilities.

V. Practice Based Learning and Improvement

- A. Use information technology to support patient care decisions and patient education, including on-line literature searches, evidence based data, and other computer-based resources.
- B. Use constructive feedback from attending physicians and senior residents concerning patient care practices, and incorporate this information to improve clinical care of patients.
- C. Use information technology to enhance education.
- D. Apply knowledge of study design, statistical methods, and evidence-based medicine to the appraisal of clinical studies.

VI. Systems Based Practice

- A. Work effectively with mental health professionals of other disciplines and with physicians from other specialty services to provide patient focused care.
- B. Demonstrate an understanding of the mental health care system and available community resources and use this knowledge to participate in discharge planning and the development of appropriate aftercare plans.
- C. Facilitate the learning of medical students and other health care providers.
- D. Practice cost-effective health care that does not compromise quality of care.
- E. Prepare an adequate discharge summary and treatment plan for follow up care.

Goals and Objectives PGY 3

Overall Goals for PGY 3

I. Medical Knowledge

- A. State the DSM5 criteria for psychiatric disorders.
- B. Differentiate the various modalities of psychotherapy including cognitive-behavioral, psychodynamic, supportive, brief, couples, group, and combined psychotherapy and psychopharmacology.

II. Patient Care

- A. Manage common child and adolescent behavioral disturbances and psychiatric disorders seen in the outpatient setting.
- B. Demonstrate expanded and enhanced skills in psychopharmacology.

III. Interpersonal and Communication Skills

- A. Develop an appreciation of the importance of the therapeutic alliance and begin to develop long-term relationships with patients.
- B. Demonstrate enhanced communication skills with children, adolescents, adults and their family members.

- IV. Professionalism**
 - A. Establish a unique identity as an ambulatory psychiatrist.
- V. Practice Based Learning and Improvement**
 - A. Demonstrate increased autonomy as a clinician at both the diagnosis and management of common psychiatric conditions.
- VI. Systems Based Practice**
 - A. Demonstrate integration of community-based services and health care systems into the overall management of outpatients.
 - B. Demonstrate greater confidence in the role of teacher of medical students, and act as a mentor to junior residents.

PGY 3 Objectives by Clinical Rotation

- 1. Adult Outpatient Psychiatry (AOPC, Psychiatry Specialty Clinics, and Student Mental Health Service), and Child & Adolescent Outpatient Psychiatry: 12 Months PG 3 year**
 - I. Medical Knowledge**
 - A. Identify the wide range of behavioral disturbances and psychiatric disorders commonly encountered in the outpatient setting among children, adolescents, and adults.
 - B. State the available somatic/pharmacological therapies and their use in the outpatient setting.
 - C. Recite the risks, benefits, side effects, dosing, drug interactions, and contraindications of these treatments and modalities.
 - C. Recognize the more advanced applications of somatic therapies, including off-label uses of medications in children, adolescents, and adults.
 - II. Patient Care**
 - A. List the biopsychosocial factors contributing to the presentation and treatment of common psychiatric disorders seen in children, adolescents, and adults in the outpatient setting.
 - B. Demonstrate the ability to use various modalities of psychotherapy, including brief, cognitive-behavioral, psychodynamic, supportive, combined psychotherapy and psychopharmacology, couples or group therapy, play therapy, and family therapy.
 - C. Demonstrate the ability to recognize transference and countertransference as it appears in establishing the doctor-patient relationship, and how it affects the therapeutic process.
 - D. Demonstrate the ability to perform a thorough initial assessment and formulate a case summary from a biopsychosocial perspective.
 - III. Interpersonal and Communication Skills**
 - A. Demonstrate the ability to use communication skills to initiate and maintain therapeutic alliances with patients and/or their family members.
 - B. Demonstrate the ability to educate patients and their family members about the risks and benefits of pharmacologic treatment options.
 - C. Demonstrate the ability to obtain informed consent for psychotherapeutic treatment, as well as the use of psychopharmacologic interventions in children, adolescents, and adults.
 - D. Maintain comprehensive, timely, and legible medical records.
 - IV. Professionalism**
 - A. Demonstrate punctuality, dress professionally and attend all assignments.
 - B. Demonstrate respect for patients regardless of age, gender, cultural background, race, religion, sexual preferences, or socioeconomic status.
 - C. Maintain confidentiality of medical information obtained through the psychotherapeutic relationship.

- D. Describe medical-legal and ethical issues, including informed consent, criteria for involuntary hospitalization, confidentiality, patient autonomy, and competency to consent for treatment in children, adolescents, and adults.

V. Practice Based Learning and Improvement

- A. Utilize the current scientific literature, recent reports of adverse drug reactions of pharmacologic agents, and evidence based data to optimize the treatment of children, adolescents, and adult patients seen in the outpatient setting.
- B. Integrate knowledge and skills learned in supervision to enhance and improve patient care.
- C. Participate in the education of patients, and their family members appropriately.

VI. Systems Based Practice

- A. Demonstrate knowledge of and utilize the various community support services that are available to provide comprehensive care to the child, adolescent, and adult patient.
- B. Demonstrate an understanding of the manner in which insurance and managed care company policies, and state and federal regulations, affect the delivery of health care services in the outpatient setting.
- C. Collaborate with psychologists, social workers, and nurses to deliver quality patient care to children, adolescents, and adults.
- D. Advocate for quality patient care of children, adolescents, and adults given cost considerations and risk-benefit analysis of potential treatment options.

4. PGY2/4 Outpatient Psychiatry

The overall goal of this longitudinal two-year experience is to build on the foundation of the psychotherapy outpatient rotation begun in year two. The goals and objectives are identical except the upper level resident is expected to accept greater patient responsibility and work toward autonomy as a psychotherapist.

I. Medical Knowledge

- A. Demonstrate mastery of the concepts from PGY 2 year

II. Patient Care

- A. Demonstrate the ability to apply advanced psychotherapy concepts and skills to the treatment of outpatients.
- B. Use advanced psychopharmacology skills, including the off-label use of medications.

III. Interpersonal and Communication Skills

- A. Be adept at recognizing and managing transference and countertransference in long-term therapeutic relationships.
- B. Be adept at dealing with termination issues in long-term psychotherapy relationships.

IV. Professionalism

- A. Maintain patient confidentiality and preserve patient autonomy over a longitudinal experience.
- B. Demonstrate sensitivity to diversity in patients.

V. Practice Based Learning and Improvement

- A. Incorporate knowledge and skills learned in supervision to enhance expertise at psychotherapy.

VI. Systems Based Practice

- A. Be knowledgeable of the limitations imposed by modern health care delivery systems on resources, and how it affects patient care.
- B. Be cognizant of the dual role of the psychiatrist as patient care provider and business administrator.

Goals and Objectives PGY 4

Overall Goals for PGY 4

Residents matriculating into the PGY 4 level must have completed all the requirements for PGY 1-3 levels. The overall goal of the fourth year is to build on the foundation of the first three years, to demonstrate mature ethical judgment and skills necessary for the independent practice as a psychiatrist, and to achieve competency and proficiency in all aspects of psychiatric care so that upon graduation residents are able to practice without direct supervision.

I. Medical Knowledge

A. Fourth year residents are expected to have a superior knowledge base in psychiatry, and solid neurological and general medical skills.

II. Patient Care

A. Fourth year residents should demonstrate an outstanding ability to evaluate and manage the patient with psychiatric illness.

III. Interpersonal and Communication Skills

A. By the fourth year, residents are expected to be expert in communication skills.

IV. Professionalism

A. Fourth year residents are expected to be accountable to the profession and society at large and demonstrate compassion, integrity and respect for others.

V. Practice Based Learning and Improvement

A. Residents will demonstrate expertise at utilizing current scientific data to optimize patient care and continuously improve their own practice of medicine.

VI. Systems Based Practice

A. Residents will understand the various components of the health care system and use resources appropriately to optimize patient care.

PGY 4 Objectives by Clinical Rotation

I. Vista Adult Inpatient Psychiatry: 2 Months PGY 4 year

The overall goal for this rotation is to build on the experience gained on prior inpatient psychiatry rotations and to master the art of inpatient psychiatric care. Prerequisite to the fourth year, the resident must have successfully completed the goals for the lower level rotations in inpatient psychiatry.

I. Medical Knowledge

A. Demonstrate mastery of the signs and symptoms of psychiatric disorders in DSM nomenclature.

B. Demonstrate advanced knowledge of psychopharmacology including mechanisms of action, indications, contraindications, side effects, dosing, drug interactions and off label use of medications.

C. Demonstrate a thorough knowledge of electroconvulsive therapy including appropriate technique, and demonstrate the ability to handle complications arising from the procedure.

II. Patient Care

A. Use advanced psychotherapeutic techniques commonly employed on inpatient psychiatric units including brief psychotherapy, group and family therapies.

B. Demonstrate competence in the biopsychosocial formulation and utilize this information to design a thorough treatment plan.

- C. Demonstrate competence in selecting appropriate laboratory, radiographic, imaging, and encephalographic studies depending upon patient presentation.

III. Interpersonal and Communication Skills

- A. Demonstrate excellence in communication skills with the patient, his family, and other health care team members.
- B. Demonstrate effectiveness as a member of the health care team.
- C. Demonstrate competence in obtaining informed consent, and understand the limitations concerning the ability of the patient to provide informed consent.

IV. Professionalism

- A. Demonstrate respect for patient privacy and autonomy.
- B. Abide by ethical principles in the treatment of patients across differences in gender, age, cultural and religious beliefs.

V. Practice Based Learning and Improvement

- A. Be proficient at teaching medical students and physician Assistant students rotating on the inpatient psychiatry service.
- B. Be proficient at teaching and mentoring junior psychiatry residents.

VI. Systems Based Practice

- A. Describe the administrative aspects of psychiatry including information on insurance companies, ancillary staff and their importance, and the importance of the physician-hospital relationship.
- B. Be adept at working within a multidisciplinary team and becoming the leader of a multidisciplinary team.

2. Vista Inpatient Child & Adolescent Psychiatry: 1 Month PG 4 year

Overall goal: This rotation is designed to provide the upper level resident with an experience in child and adolescent psychiatry geared toward inpatient evaluation and management.

I. Medical Knowledge

- A. Demonstrate knowledge of the typical signs and symptoms of psychiatric disorders presenting in childhood and adolescence.
- B. Work toward mastery of the DSM criteria for disorders found in childhood and adolescence.
- C. Be adept at applying psychopharmacologic medications in child and adolescent psychiatry, including off-label uses.

II. Patient Care

- A. Demonstrate the ability to use the biopsychosocial formulation and understand its importance in developing a treatment plan for the patient and family alike.
- B. Be adept at performing a comprehensive inpatient evaluation including appropriate use of the history and collateral information, physical and neurological examinations, diagnostic tests, and consultations as indicated.
- C. Demonstrate the commonly used psychotherapies applied in the inpatient setting including group therapy, family therapy, and play therapy.

III. Interpersonal and Communication Skills

- A. Demonstrate competence in the collection of medical information from all sources such as the patient, his/her family, pediatrician, and school officials.
- B. Excel at communicating ideas to other members of the treatment team.

IV. Professionalism

- A. Indicate the legal and ethical issues inherent to the treatment of children and adolescents.

- B. Demonstrate compassion and respect for the child and adolescent patient, and their family members.

V. Practice Based Learning and Improvement

- A. Express the utility of the inpatient ward as a therapeutic setting.
- B. Demonstrate competence at teaching medical students and junior residents.
- C. Use evidence based medicine to optimize the care of the child and adolescent patient.

VI. Systems Based Practice

- A. Utilize available community resources to manage more complex issues of patient disposition.
- B. Become adept at providing a leadership role in a multidisciplinary treatment team.

3. Inpatient Addiction Psychiatry (VA or Vista): 1 Block PGY 4 year

Overall goal: The overall goal of this rotation is to provide the resident with the necessary clinical experience to evaluate and manage patients with substance use and/or dependence.

I. Medical Knowledge

- A. Identify the signs and symptoms of the DSM substance related disorders.
- B. State the psychiatric and medical comorbidities typically found in patients with substance related disorders.
- C. Recognize the biological and psychosocial underpinnings of substance related disorders.
- D. Cite the epidemiology of the substance related disorders.
- E. Name the pharmacologic interventions utilized in the detoxification and maintenance treatment of patients with substance related disorders.

II. Patient Care

- A. Obtain a complete history and performing a medical and neurologic examination.
- B. Formulate a biopsychosocial diagnosis and treatment plan from the information obtained in the history, neurologic and physical examinations.
- C. Select appropriate laboratory, radiographic/imaging, and encephalographic studies depending on the patient presentation.
- D. Discuss group psychosocial treatments utilized in substance related disorders including alcoholics anonymous and narcotics anonymous.
- E. Demonstrate the ability to detoxify, manage overdoses, and treat characteristic intoxication and withdrawal syndromes to minimize morbidity and mortality.
- F. Use rating scales used to assess and manage withdrawal states such as the CIWA.

III. Interpersonal and Communication Skills

- A. Effectively communicate with patients with substance disorders, and be able to appropriately educate their family members.
- B. Act in the role of consultant to other health care providers who are treating patients with substance abuse disorders.

IV. Professionalism

- A. Treat patients with substance abuse disorders with respect in a non-judgmental fashion.
- B. Apply legal and ethical principles including informed consent, advanced directives, involuntary commitments, and the right to refuse treatment.

V. Practice Based Learning and Improvement

- A. Apply current scientific information and evidence based data to the diagnosis and management of patients with substance use disorders.
- B. Incorporate feedback from attending physicians and other health care team members to improve their treatment of patients with substance abuse disorders.

VI. Systems Based Practice

- A. Recognize the importance and value the contributions of other health care providers involved in the collaborative treatment of the patient with a substance related disorder.
- B. Work within a multidisciplinary team and learning to become the leader of that multidisciplinary team.

4. Community Psychiatry (MHICM): Up to 2 Months PGY 4 year

Overall goal: The overall goal of this rotation is to expose the resident to the psychiatric patient who is persistently and chronically ill, and is usually treated in the public sector.

I. Medical Knowledge

- A. Know the signs and symptoms of psychiatric illness seen in patients with chronic psychiatric conditions.
- B. Demonstrate knowledge of the indications, contraindications, and adverse effects of psychopharmacologic agents utilized in the treatment of the persistently mentally ill.

II. Patient Care

- A. Know the psychotherapeutic techniques commonly employed in community psychiatry including supportive therapy, crisis intervention, cognitive-behavioral techniques, group therapy, family therapy, and psychosocial rehabilitation.

III. Interpersonal and Communication Skills

- A. Become expert at communicating with patients with chronic psychiatric illness.
- B. Use expert communication skills in collaborating with other health care professionals, consultants, and community based resources.

IV. Professionalism

- A. Be expert at managing the legal and ethical issues including informed consent, advanced directives, involuntary commitments, and right to refuse treatment.
- B. Treat the chronically mentally ill patient and their family members with compassion, integrity, and respect.

V. Practice Based Learning and Improvement

- A. Use current scientific information and evidence base data in caring for the chronically mentally ill patient.
- B. Facilitate the education of patients, family members and other health professionals in patient management issues.

VI. Systems Based Practice

- A. Understand the administrative aspects of psychiatry including information on insurance companies, ancillary staff and their importance, and the nature of the physician-hospital relationship.
- B. Become knowledgeable of and utilize the community resources available in the care of chronically mentally ill patients.
- C. Become expert at working with limited resources while not compromising patient care of the chronically mentally ill.
- D. Be expert at working within a multidisciplinary team and becoming the leader of a multidisciplinary team.
- E. Provide consultation to other health care professionals caring for the chronically mentally ill patient including telephone consultation to VA Satellite Clinics.

5. Electives: 6 Months PGY 4 Year

Overall Goal: The overall goals for electives are to enrich the educational experience of residents in meeting their needs, interests and future professional plans. Currently, the Department has five standing electives that residents may choose among. Residents may also design their own

elective provided they comply with ACGME guidelines. These guidelines state that electives:

- A. Must be well constructed, purposeful, and lead to effective learning experiences.
- B. The choice of electives must be made with the advice and approval of the Program Director and the appropriate preceptor.
- C. Electives must have written goals and objectives in the format of the six core competencies (medical knowledge, patient care, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice).
- D. The specific goals and objectives are dependent upon the elective(s) chosen by the resident. The resident and his/her preceptor bear the responsibility for collaboratively generating the specific goals and objectives for each chosen elective. In addition, they must be approved by the Program Director prior to beginning an elective rotation.

1. Forensic Psychiatry Elective Rotation 1 Month PGY-4

Overall Goals

1. To provide qualified residents of accredited programs in general psychiatry with a well-rounded training environment, diverse in both didactics and clinical experience in forensic psychiatry; and specifically to provide comprehensive exposure to the following:
 - forensic evaluation of a variety of persons of both genders, spanning a broad range of civil and criminal contexts
 - consultation to general psychiatric services on issues related to the legal regulation of psychiatric practice
 - psychiatric treatment of persons involved in the criminal justice system
2. To foster the development of prerequisite knowledge, skills, clinical judgment, and professional attitudes essential to the practice of forensic psychiatry
3. To prepare and expose residents to the practice of forensic psychiatry and to the wide range of career opportunities available in the areas of academics, clinical practice, and the variety of interfaces between psychiatry and the law
4. Our goals and objectives have been developed in response to the requirement by the ACGME that training programs operationalize the measurement of general competency attainment. The general competencies, referring primarily to educational outcomes, aim to allow a measurement of the degree to which program purposes and objectives are or are not being attained, and thus whether we are achieving satisfactory learning by potential graduates of our accredited forensic psychiatry residency education program. Achievement of learning is the ultimate purpose of any well-structured residency program, and this is the goal here at UF.

I. Patient Care

The resident will be able to:

- A. Obtain a comprehensive history, establish rapport, and direct an evaluation in response to specific questions.
- B. Assess criminal responsibility, competence to stand trial, competence to enter a plea, competence to be executed, testimonial capacity, voluntariness of confessions, diminished capacity, amnesia, testamentary capacity, civil competency and dangerousness.
- C. Assess the accused sexual offender and provide treatment recommendations and prognosis for recidivism.
- D. Assess/interpret the eyewitness testimony of adults and children.
- E. Review written records, including clinical and legal documents.
- F. Generate a differential diagnosis and ordering appropriate diagnostics, as well as obtaining additional information.
- G. Evaluate incarcerated individuals and formulate a plan of treatment unique to the individual, but based upon the current standard of care.
- H. Apply the common psychotherapy modalities in the correctional setting.
- I. Apply somatic therapies including psychopharmacology in the correctional setting.
- J. Provide care through a multidisciplinary treatment team.

- K. Provide continuous care in various forensic treatment settings and modalities.
- L. Make rapid forensic assessment and treatment decisions in the acute care setting.

II. Medical Knowledge

The resident will demonstrate knowledge of:

- A. The basic principles of civil and criminal law, including the structure of the federal and state court systems, fundamentals of laws, statutes, and administrative regulations, and basic civil and criminal procedure.
- B. Key legal concepts including jurisdiction, responsibility, tort law, theory and practice of sentencing convicted offenders, and children's rights.
- C. Important civil law concepts including conservators and guardianships, psychiatric malpractice, abandonment law, developmental disability law, testamentary capacity, psychiatric disability, personal injury, child abuse, child custody, and parental competence.
- D. Past and current case law and its impact on the practice of forensic psychiatry.
- E. Contributions of various schools of thought, theoretical viewpoints, and historical figures to the current state of the art (e.g., history of forensic psychiatry).
- F. Roles and responsibilities of forensic psychiatrists.
- G. Common biological/somatic therapies, socio-cultural treatments, and various psychotherapeutic modalities and their efficacies/application to different treatment populations in the legal setting.
- H. Contributions of clinical research to the evidence-based practice of forensic psychiatry.
- I. Relevance of various legal documents, police reports, and court testimony in the assessment of forensic cases.
- J. Diagnostic tools encountered in forensic psychiatry including the use of hypnosis, polygraphy, neuroimaging, neuropsychological and psychological testing, narcoanalysis, and other relevant procedures.
- K. Pertinent ethical, administrative, and legal issues in forensic psychiatry.
- L. Legal regulation of psychiatric practice.
- M. Principles of providing consultation to general psychiatric and medical services in the management of forensic issues.

III. Practice-Based Learning and Improvement

The resident will demonstrate the ability to:

- A. Make use of professional literature while critically appraising material for scientific integrity.
- B. Remain scholarly and stay abreast of the latest developments in the field utilizing information technology to optimize learning.
- C. Incorporate feedback from attending psychiatrists to enhance their assessment and treatment of patients with forensic issues.

IV. Interpersonal and Communication Skills

The resident will demonstrate the ability to:

- A. Prepare clearly written, comprehensive, quality forensic reports in a timely manner for the court or other relevant third parties.
- B. Provide testimony in a variety of civil and criminal settings/cases, including domestic and sexual abuse, personal injury, sentencing of criminal offenders, civil commitment, right to treatment, right to refuse treatment, informed consent, and professional liability.
- C. Communicate findings and opinions thru appropriate documentation and collaboration with colleagues in both legal and psychiatric settings.
- D. Provide consultation to general psychiatric services in the management of forensic issues including decision-making capacity, refusal of treatment, civil commitment, guardianship, dangerousness, and confidentiality.
- E. Teach medical students, residents, and colleagues, as well as educate those in the legal profession about psychiatric issues.

V. Professionalism

The resident will demonstrate the ability to:

- A. Show compassion and respect for patients/clients in all settings without exception.
- B. Be conscientious in performing the duties of a physician and upholding the principles of the legal system.
- C. Respect and recognize the contributions of colleagues, consultants, and other professionals in the provision of patient care.
- D. Maintain the degree of professional integrity expected of all physicians.
- E. Adhere to the moral and ethical principles set forth by our profession, including autonomy, confidentiality, informed consent, and beneficence.
- F. Educate our colleagues and engage them in the evaluative process.
- G. Promote public awareness of mental health issues in the legal system thru community teaching, education of students, and our professional colleagues.
- H. Teach prevention and promote early intervention.

VI. System-Based Practice

The resident will demonstrate knowledge of:

- A. Cost-effective health care yet advocate for quality patient care.
- B. How correctional facilities balance resource allocation with patient advocacy.
- C. The modern health care delivery system, including financial, regulatory and legal implications for the provision of care in the correctional setting.

2. Outpatient Addiction Psychiatry Experience at Florida Recovery Center:

Overall goal

The overall goal of this rotation is to provide the resident with the necessary clinical experience to evaluate and manage patients with substance use disorders in an ambulatory setting.

I. Medical Knowledge

- A. Master the subtleties of diagnosing DSM-5 substance use disorders, including modifiers and specifiers.
- B. Know the psychiatric and medical comorbidities typically found in patients with substance related disorders.
- C. Understand the biological and psychosocial underpinnings of substance related disorders.
- D. Know the epidemiology of the substance related disorders.
- E. Know the pharmacologic interventions utilized in the detoxification and maintenance treatment of patients with substance related disorders.
- F. Gain mastery of the American Society of Addiction Medicine multidimensional assessment and patient placement criteria.
- G. Learn how to recognize and address defense mechanisms common in this patient population including denial, minimization, rationalization, and justification.

VII. Patient Care

- A. Gain mastery of the medical management of an outpatient substance treatment program.
- B. Become adept at the forensic evaluation of impaired professionals via comprehensive outpatient evaluations.
- C. Become expert at obtaining a complete history and performing a medical and neurologic examination.
- D. Become expert at formulating a biopsychosocial diagnosis and treatment plan from the information obtained in the history, neurologic and physical examinations.
- E. Become expert at selecting appropriate laboratory, radiographic/imaging, and encephalographic studies depending on the patient presentation.
- F. Gain working knowledge of the various group psychosocial treatments utilized in substance related disorders including Alcoholics Anonymous and Narcotics Anonymous.

G. Gain experience in the administration of group therapy for addiction.

VIII. Interpersonal and Communication Skills

- A. Effectively communicate with patients with substance disorders, and be able to appropriately educate their family members.
- B. Act in the role of consultant to other health care providers who are treating patients with substance abuse disorders.
- C. Learn how to effectively obtain substance-related collateral information from significant others, families, employers, healthcare providers, pharmacies, etc.

IX. Professionalism

- A. Treat patients with substance abuse disorders with respect in a non-judgmental fashion.
- B. Be expert at applying legal and ethical principles including informed consent, advanced directives, involuntary commitments, and the right to refuse treatment.

X. Practice Based Learning and Improvement

- A. Apply current scientific information and evidence based data to the diagnosis and management of patients with substance use disorders.
- B. Incorporate feedback from attending physicians and other health care team members to improve their treatment of patients with substance use disorders.

XI. Systems Based Practice

- A. Understand the importance and value the contributions of other health care providers involved in the collaborative treatment of the patient with a substance related disorder.
- B. Be expert at working within a multidisciplinary team and learning to become the leader of that multidisciplinary team.

3. Shands and VA Consults Jr. Attending

I. Medical Knowledge

- A. Master the DSM-5 criteria for psychiatric disorders as well as advanced treatment modalities utilized in consult-liaison psychiatry.
- B. Become familiar with the various modalities of psychotherapy and how they might be used in consult-liaison psychiatry including cognitive-behavioral, brief psychodynamic, supportive, and combined psychotherapy and psychopharmacology.
- C. Master knowledge of neurologic conditions and considerations as they apply to psychiatric patients in consult-liaison psychiatry.
- D. Increase knowledge of consult-liaison psychiatry areas of specialized emphasis: oncology, transplant, women's health, etc.

II. Patient Care

- A. Demonstrate proficient skills in managing team rounds and patient treatment options in a consult/liaison setting.
- B. Thoroughly understand drug-drug interactions, particularly of psychiatric with non-psychiatric medications.
- C. Demonstrate a thorough understanding of the biopsychosocial factors contributing to the presentation and treatment of psychiatric disorders commonly encountered in the consult-liaison setting.
- D. Facilitate transfer of patients from medical/surgical to psychiatric treatment services.

III. Interpersonal and Communication Skills

- A. Demonstrate mastery of the ability to communicate with other medical/surgical services as well as with fellow residents.
- B. Gain further experience in teaching and mentoring junior residents and medical students.
- C. Facilitate members of the medical/surgical teams in the understanding of

transference/countertransference issues with patients to enhance patient care.

IV. Professionalism

- A. Be punctual, dress professionally, and attend all assignments.
- B. Be respectful of patients and learners regardless of age, gender, cultural background, race, religion, sexual preferences, or socioeconomic status.
- C. Maintain confidentiality of all medical information.
- D. Uphold the highest ethical standards in interactions with patients and other members of the treatment team.
- E. Demonstrate a good work ethic.

V. Practice Based Learning and Improvement

- A. Become more autonomous as a clinician at both the diagnosis and management of common and uncommon psychiatric conditions encountered in the consult-liaison setting.
- B. Demonstrate motivation for self study.
- C. Demonstrate effective utilization of the current scientific literature and evidence-based data to optimize treatment of patients in the consult-liaison setting.
- D. Demonstrate an understanding of the need for continuing education in consult-liaison psychiatry.

VI. Systems Based Practice

- A. Collaborate with other members of the treatment team to deliver quality and safe patient care.
- B. Gain greater confidence in the role as a team leader.
- C. Collaborate with medical/surgical services in the comprehensive care of patients.
- D. Better understand the continuum of psychiatric care from outpatient to inpatient and how consult-liaison psychiatry fits into that continuum of care.

4. BSU Gero ECT Chief Elective

The overall goal for this rotation is to provide senior resident leadership to the NPEU service. This Unit serves the most medically/surgically and psychiatrically challenging patients, particularly geriatric patients, and complex diagnoses and treatment planning must be done after compiling information from numerous sources, testing, and exams.

I. Medical Knowledge

- A. Demonstrate an expert knowledge base of and be able to teach junior residents and students about medical illnesses found commonly comorbid in psychiatric inpatients.
- B. Demonstrate an expert knowledge base of and be able to teach junior residents and students about psychiatric disorders that typically occur in the elderly.
- C. Demonstrate familiarity with and be able to teach junior residents and students about the differential diagnosis and management of cognitive decline often seen in the degenerative disorders of the central nervous system.
- D. Know and be able to teach junior residents and students about the patterns of normal ageing, and recognize abnormal ageing processes.
- E. Understand and be able to teach junior residents and students about the unique pharmacokinetic and pharmacodynamic considerations encountered in the elderly patient, including drug interactions.
- F. Know and be able to teach junior residents and students the theory for the proposed mechanism of action of electroconvulsive therapy.

II. Patient Care

- A. Be familiar with the medical and psychiatric disorders of all patients on the unit and use this information to optimize the healthcare provided by junior residents.
- B. Co-lead (with the psychiatry attending) daily rounds on the unit.

- C. Testify at Baker Act hearings for patients who may be candidates for involuntary hospitalization and treatment.
- D. Provide sign-out to covering after-hours unit physicians and oversee junior residents' and students' signouts.
- E. Assist junior residents and students in synthesizing all available data such as history, family information, chart data, physical and neurological examinations, and laboratory and imaging data to formulate a differential diagnosis and appropriate treatment plan.
- F. Teach junior residents and students the utility of utilizing neuropsychological testing in assessing cognitive functioning in the elderly.
- G. Assist junior residents and students in the management of psychiatric disorders in patients with comorbid medical conditions.
- H. Teach junior residents and students how to recognize medical conditions that commonly influence psychiatric symptoms such as HIV, AIDS, CNS lesions, and endocrine diseases.
- I. Assist junior residents and students in the management of the patient who presents with poly-pharmacy induced psychiatric symptoms.
- J. Educate junior residents and students on the indications, contraindications, adverse effects, and the procedure for the administration of electroconvulsive therapy.

III. Interpersonal and Communication Skills

- A. Serve as a mentor to junior residents and students on how to appropriately communicate with consultants to aid in the diagnosis and management of medically complicated patients.
- B. Utilize expert communication skills to facilitate transfers and management of patients from other hospital services including the emergency department.
- C. Demonstrate to junior residents and students the ability to work cooperatively and serve as a leader of a health care team.
- D. Model good communication skills for junior residents and students.
- E. Teach junior residents and students how to maintain comprehensive, timely, and legible medical records.

IV. Professionalism

- A. Serve as a role model to junior residents and students in demonstrating compassion, integrity and respect for patients and their families.
- B. Appropriately apply legal and ethical principles to patient care including informed consent, confidentiality, advanced directives, involuntary commitment, the right to refuse treatment, and serve as a role model to junior residents and students in this regard.

V. Practice-Based Learning and Improvement

- A. Utilize information technology to optimize the care of the patient and teach junior residents and students about available information technology and evidence based medicine to enhance patient care.
- B. Demonstrate the ability, and model for junior residents and students, how to appropriately educate patients, their family members, and other health care professionals avoiding the use of medical jargon.

VI. Systems-Based Practice

- A. Serve as a team leader, collaborating with team nurses, therapists, social workers, and other health care providers to identify areas in need of improvement for the enhancement of patient care and safety.
- B. Advocate for quality patient care and safety and cost-effective treatment.
- C. Assist junior residents in the preparation of an adequate discharge summary and treatment plan for follow up care.

5. ECT Elective; Shands at UF or VA Hospital:

The overall goal for this rotation is to provide the junior or senior resident with an intensive training experience in electroconvulsive therapy. Residents who participate in this elective may choose to do their ECT elective working with patients being evaluated and treated at Shands at UF (attending is Rich Holbert, MD) or at the VA Hospital (attending is Dawn Bruijnzeel, MD).

I. Medical Knowledge

- A. The resident should know the theory for the proposed mechanism of action(s) of electroconvulsive therapy (ECT).
- B. Know the psychiatric indications, medical and psychiatric contraindications, adverse effects, and the general procedure for the administration of electroconvulsive therapy.
- C. Demonstrate a thorough knowledge of electroconvulsive therapy including appropriate techniques, and demonstrate the ability to manage complications arising from the procedure.
- D. Demonstrate an expert knowledge base of and be able to teach junior residents and medical students about the psychiatric disorders that ECT is generally effective for.
- E. Know and be able to teach junior residents and medical students the theory for the proposed mechanism of action(s) of electroconvulsive therapy.

II. Patient Care

- A. Demonstrate knowledge about electroconvulsive therapy including appropriate patient selection, the indications, contraindications, and adverse effects of ECT and be able to educate patients and their families about the risks and benefits of, and alternatives to ECT, and understands the necessity of obtaining informed consent for the procedure.
- B. Demonstrate appropriate techniques for the administration of both nondominant unilateral and bilateral ECT.
- C. Demonstrate the ability to formulate and institute maintenance therapy for a patient who has received an acute series of ECT treatments, which may include pharmacotherapy, maintenance ECT, or their combination when indicated.

III. Interpersonal and Communication Skills

- A. Demonstrate how to appropriately communicate with both medical and psychiatric referral sources to aid in the evaluation and management of patients in need of ECT treatment.
- B. Utilize expert communication skills to facilitate transfers and management of patients from other hospital services to the appropriate psychiatric setting for those patients who require ECT.
- C. Demonstrate the ability to work cooperatively and serve as a leader of a health care team that is responsible for treating patients with ECT.
- D. Model for junior residents and students how to maintain comprehensive, timely, and legible medical records for patients receiving ECT treatment.

IV. Professionalism

- A. Demonstrating compassion, integrity and respect for patients who are receiving ECT as well as their family members.
- B. Appropriately apply legal and ethical principles to patient care including informed consent, confidentiality, advanced directives, and the right to refuse treatment.

V. Practice-Based Learning and Improvement

- A. Utilize information technology to optimize the care of the ECT patient and teach junior residents and students about available information technology and evidence based medicine to enhance safe and effective ECT administration.
- B. Demonstrate the ability, and model for junior residents and students, how to appropriately educate patients, their family members, and other health care professionals about ECT avoiding the use of medical jargon.

VI. Systems-Based Practice

- A. Serve as the ECT team leader, collaborating with the attending psychiatrist, team nurses, therapists, social workers, and other health care providers to identify areas needing improvement for the safe and effective administration of ECT.
- B. Advocate for quality patient care and safety and cost-effective ECT treatment.
- C. Model and assist junior residents in the preparation of an adequate discharge summary and treatment plan for patients who have received ECT.

6. Northeast Florida State Hospital Community Psychiatry Elective

The overall goal for this rotation is the management of the chronically psychiatrically ill patient in the state hospital setting.

I. Medical Knowledge

- A. Demonstrate an in depth understanding of severe chronic mental illness and psychiatric work at a state facility.
- B. Demonstrate an in depth knowledge of biopsychosocial assessment and treatment.
- C. Demonstrate an in depth knowledge of the psychopharmacology of clozapine in the treatment of refractory schizophrenia and bipolar disorder.
- D. Demonstrate an understanding of the involuntary continued commitment process.
- E. Demonstrate an understanding of various treatment modalities: psychopharmacology, electroconvulsive therapy, individual psychotherapy including crisis intervention, cognitive-behavioral therapy, group therapy, case management, and psychosocial rehabilitation.

II. Patient Care

- A. Demonstrate the ability to use all available data such as history, family information, chart data, physical and neurological examinations, and laboratory and imaging data to formulate a differential diagnosis and appropriate treatment plan.
- B. Demonstrate the ability to prescribe clozapine for the treatment of refractory schizophrenia.
- C. Demonstrate the ability to use psychopharmacology along or in combination with psychotherapy for the treatment of chronic mental illness.
- D. Participate/testify, with judiciary approval, in civil commitment hearings.

III. Interpersonal and Communication Skills

- A. Communicate appropriately with primary care consultants to aid in the diagnosis and management of medical illness in the chronically mentally ill patient population.
- B. Demonstrate ability to work cooperatively as a member as well as the leader of a health care team.
- C. Demonstrate an ability to lead a multi-disciplinary team meeting.
- D. Maintain comprehensive, timely, and legible medical records.

IV. Professionalism

- A. Demonstrate compassion, integrity and respect for patients and their families.
- B. The resident will appropriately apply legal and ethical principles to patient care including informed consent, confidentiality, advanced directives, involuntary commitment, and the right to refuse treatment.

V. Practice Based Learning and Improvement

- A. Utilize information technology to optimize the care of the patient.
- B. Demonstrate the ability to appropriately educate patients, their family members, students, and other health care professionals avoiding medical jargon.

VI. Systems Based Practice

- A. Learn about how community providers interact with the state system in providing care and resources to the patient.

- B. Collaborate with team nurses, therapists, social workers, case managers, and other health care providers to enhance patient care.
- C. Advocate for quality patient care and cost-effective treatment.
- D. Prepare an adequate discharge summary and treatment plan for follow up care.

7. University of Florida Student Mental Health Outpatient Psychiatry Elective:

I. Medical Knowledge

- A. Demonstrate mastery of knowledge of the wide range of behavioral disturbances and psychiatric disorders commonly encountered in the outpatient setting among adolescents and adults at the University of Florida Student Mental Health Clinic.
- B. Demonstrate an in depth understanding of the available somatic/pharmacological therapies and their use in the outpatient setting; as well as, know the risks, benefits, side effects, dosing, drug interactions, and contraindications of these treatments and modalities.
- C. Utilize the most advanced applications of somatic therapies, including off-label use of medications, in adolescents and adults at the University of Florida Student Mental Health Clinic.

II. Patient Care

- A. Demonstrate a thorough understanding of the biopsychosocial factors contributing to the presentation and treatment of common and rare psychiatric disorders seen in adolescents and adults at the University of Florida Student Mental Health Clinic.
- B. Demonstrate the ability to use all modalities of psychotherapy, including brief, cognitive-behavioral, psychodynamic, supportive, combined psychotherapy and psychopharmacology, couples or group therapy, and family therapy.
- C. Demonstrate the ability to recognize transference and countertransference as it appears in establishing the doctor-patient relationship, and use this knowledge to aid the therapeutic process.
- D. Demonstrate the ability to perform a complete initial assessment and formulate a case summary from a biopsychosocial perspective.

III. Interpersonal and Communication Skills

- A. Demonstrate the ability to use communication skills to initiate and maintain therapeutic alliances with patients and/or their family members.
- B. Demonstrate expertise at educating patients and their family members about the risks and benefits of pharmacologic treatment options.
- C. Demonstrate expertise in obtaining informed consent for psychotherapeutic treatment, as well as the use of psychopharmacologic interventions, in adolescents and adults at the University of Florida Student Mental Health Clinic.
- D. The resident will maintain comprehensive, timely, and legible medical records.

IV. Professionalism

- A. The resident will be punctual, dress professionally, and attend all assignments.
- B. The resident will be respectful of patients regardless of age, gender, cultural background, race, religion, sexual preferences, or socioeconomic status.
- C. The resident will maintain confidentiality of all medical information obtained through the psychotherapeutic relationship.
- D. The resident will demonstrate expert knowledge of medical-legal and ethical issues, including informed consent, criteria for involuntary hospitalization, confidentiality, patient autonomy, and competency to consent for treatment in adolescents and adults seen at the University of Florida Student Mental Health Clinic.

V. Practice-Based Learning and Improvement

- A. The resident is expected to demonstrate an expert utilization of the current scientific literature, recent reports of adverse drug reactions of pharmacologic agents, and

evidence based data to optimize treatment of adolescents and adults seen at the University of Florida Student Mental Health Clinic.

- B. The resident is expected to become proficient at incorporating knowledge and skills learned in supervision to enhance and improve their patient care.
- C. The resident is expected to demonstrate expertise in the education of patients and their family members appropriately.
- D. The resident will demonstrate a leadership role in the health care team discussions with fellow psychiatrists, case managers, psychologists, and primary care physicians who provide care to patients seen at the Student Mental Health Clinic.
- E. The resident is expected to demonstrate expertise in Clinical Skills Assessment examinations utilizing patients seen at the University of Florida Student Mental Health Center.

VI. Systems-Based Practice

- A. Demonstrate mastery of knowledge of and utilize the various community support services that are available to provide comprehensive care to the adolescent and adult patient seen at the University of Florida Student Mental Health Clinic.
- B. Demonstrate expert understanding of the manner in which insurance and managed care company policies, and state and federal regulations affect the delivery of health care services at the University of Florida Student Mental Health Clinic.
- C. The resident will collaborate with psychologists, social workers, and nurses to deliver quality patient care to adolescents and adults at the University of Florida Student Mental Health Clinic.
- D. The resident will advocate for quality patient care of adolescents and adults at The University of Florida Student Mental Health Clinic given cost considerations and risk-benefit analysis of potential treatment options.

8. VA Teaching Resident

I. Medical Knowledge

- A. Review and master DSM-5 criteria for psychiatric disorders and appropriate treatments.
- B. Become well acquainted with common PRITE, psychiatry board and medical student shelf examination material, and convey such material to residents, students and faculty in a structured and unstructured fashion.

II. Patient Care

- A. Become familiar with oral board structure for Psychiatry boards and Medical student oral examination and provide demonstrations and evaluation of mock oral exams.
- B. Provide a VA case conference on a weekly basis for residents and medical students.

III. Interpersonal and Communication Skills

- A. Develop an appreciation of the importance of education of colleagues via hands on and conference style teaching.
- B. Enhance communication skills with fellow residents, medical students and faculty.
- C. Develop a teaching portfolio consisting of PowerPoint presentations, handouts, and other teaching materials.

IV. Professionalism

- A. Be punctual and dress professionally.
- B. Be respectful of all learners.
- C. Establish a unique identity as an educator.
- E. Uphold the highest ethical standards in interactions with learners at all levels.

V. Practice Based Learning and Improvement

- A. Become more aware of literature regarding treatment measures for patients and disorders presented during case conference.

- B. Present a residency wide M&M or case conference when indicated based on evaluation of patient care during rotations.
- C. Resident will demonstrate an understanding of the need for continuing medical education.

VI. Systems Based Practice

- A. Integrate medical student, resident and faculty education into the study of psychiatry.
- B. Gain greater confidence in the role of teacher of medical students and fellow residents, and act as a mentor to PGY-1 residents.

9. Shands and VA Research Elective

Overall goal: The overall goal of this rotation is to facilitate the interested resident to learn about and participate in research activities, tailor research experiences to individual resident's interests and future career, and to enhance the training and education during the residency.

I. Medical Knowledge

- A. Understand the biomedical and social-behavioral knowledge needed by a competent psychiatric researcher.
- B. Meet regularly with the research mentor, generate clinical research questions based on interesting patient cases, and conduct a suitable research project.
- C. Know how to search literature efficiently to assess what has already been studied and what questions have been asked.
- D. Identify and select the appropriate type of study to best answer the question.
- E. Demonstrate the ability to acquire, critically interpret and apply this knowledge in patient care.

II. Patient Care

- A. Develop research question based on one's experiences from patient care.
- B. Know the indications for IRB approval if the study involves human subjects, their medical records and other data that can compromise confidentiality.
- C. Continue continuity clinics during research months; be an expert at obtaining a complete history, formulating a biopsychosocial diagnosis and treatment plan; Know the psychotherapeutic techniques commonly used in community psychiatry.

III. Interpersonal and Communication Skills

- A. Effectively communicate with a mentor to develop a research topic and plan a study design.
- B. Discuss project with appropriate consultants including statisticians and other specialists if needed for conducting research.
- C. Be expert at working within a multidisciplinary research team and learning to become the leader of that multidisciplinary research team.
- D. Write an abstract for potential submission to a national meeting if an experimental study is proposed.
- E. Attend the annual meetings, such as the Biological Psychiatry and APA conferences for career networking and being updated on the newest findings in the area of interest.
- F. Try to write a review article to summarize one particular research topic.

IV. Professionalism

- A. Be punctual, dress professionally, and attend all required meetings.
- B. Maintain the patients' privacy involved in research.
- C. Know the ethics of research, including subject recruitment, obtaining informed consent, and working with IRB for the subject's protection.
- D. Be accurate in presenting research data, include the names of collaborators on the research proposal and manuscripts for publication.
- E. Be responsible for all research activities.

V. Practice-Based Learning and Improvement

- A. Compare the study results to the currently available scientific information and evidence-based data.
- B. The resident will incorporate feedback from the research mentor and collaborators.
- C. Be familiar with the history and current research findings in the particular field of interest.
- D. Examine the potential application of research results to daily patient care.
- E. Set up and accomplish at least one clinical skills assessment per month.
- F. The resident is expected to demonstrate effective utilization of the current scientific literature and evidence-based data to optimize treatment of patients.
- G. The resident is expected to demonstrate competence in the education of patients and their family members on the latest findings from psychiatric research.
- H. The resident will demonstrate an understanding of the need for continuing education in psychiatric research.

VI. Systems Based Practice

- A. Know the cost and other constraints in doing research during the residency and in general.
- B. Know the best methods of performing research to answer the proposed questions.
- C. Understand the pros and cons of the proposed research.
- D. Understand the importance and value of the contributions of research in advancing our understandings of various mental disorders.
- E. Advocate for research during residency to attract more colleagues to be involved in research.

University of Florida Psychiatry Residency:
Psychotherapy Competencies

I. Brief Psychotherapy

A. Knowledge

- 1. The resident will demonstrate understanding of at least one theoretical model of brief psychotherapy.
- 2. The resident will demonstrate understanding of the use of a focus and time limit as therapeutic tools, and with the patient, will collaboratively set goals for the therapy.
- 3. The resident will know the indications and contraindications for brief psychotherapy.
- 4. The resident will demonstrate how the use of brief psychotherapy is effective in meeting the overall treatment needs of the patient.
- 5. The resident will demonstrate the ability to maintain focus throughout the course of brief psychotherapy.
- 6. The resident will demonstrate understanding that competence at brief psychotherapy is contingent upon continued education and practice.

B. Skills

- 1. The resident will be able to utilize at least one well defined model of brief psychotherapy.
- 2. The resident will be able to select appropriate patients for the particular model chosen for brief psychotherapy.
- 3. The resident will be able to establish and maintain a focus and time limit.
- 4. The resident will be able to establish and maintain a therapeutic alliance.
- 5. The resident will demonstrate their ability to educate the patient about the goals, objectives, and time frame of brief psychotherapy.

6. The resident will demonstrate their ability to develop a formulation using the brief psychotherapy model selected.
7. The resident will demonstrate their ability to seek appropriate consultation and or referral for specialized treatment.

C. Attitudes

1. The resident will demonstrate empathy, respect, collaboration with, and an open and nonjudgmental approach toward the patient in brief psychotherapy.
2. The resident will demonstrate the ability to tolerate ambiguity and display confidence in the efficacy of a least one model of brief psychotherapy.
3. The resident will demonstrate sensitivity to the sociocultural, socioeconomic, and educational issues that arise in the therapeutic relationship during brief psychotherapy.
4. The resident will be open to constructive feedback from supervisors by permitting review of audio or videotapes, or direct observation of brief psychotherapy sessions.

II. Cognitive Behavioral Therapy

A. Knowledge

1. The resident will demonstrate understanding of the basic principles of cognitive behavioral therapy including the relationship of thoughts to emotion, behavior, and physiology.
2. The resident will demonstrate an understanding of the concept of automatic thoughts and cognitive distortions, common cognitive errors, and the significance and origin of core beliefs to dysfunctional thoughts and psychopathology.
3. The resident will demonstrate the indications and contraindications for cognitive behavior therapy.
4. The resident will demonstrate the ability to structure a cognitive behavior therapy session with a focus on active, collaborative problem solving.
5. The resident will demonstrate the ability to perform psychoeducation and skill training during therapy, and relapse prevention as termination approaches.
6. The resident will utilize basic behavioral techniques including activity scheduling, exposure and response prevention, relaxation training, graded task assignment, and exposure hierarchies for systematic desensitization.
7. The resident will utilize basic cognitive techniques including identifying automatic thoughts, cognitive restructuring, problem solving, examining the evidence, thought recording, and modification of core beliefs.
8. The resident will demonstrate appreciation that rating scales are an integral part of cognitive behavioral therapy.
9. The resident will acknowledge that competence at cognitive behavior therapy is obtained by continued education and skill development.

B. Skills

1. The resident will be able to establish and maintain a therapeutic alliance with the patient in cognitive behavioral therapy.
2. The resident will educate the patient about the centrality of core beliefs and cognitive schemas, and the responsibility of the patient in actively engaging in treatment.
3. The resident will educate the patient about core beliefs and cognitive schemas most relevant to the presenting problem, and help the patient understand the basic origin of these beliefs.

4. The resident will structure the therapy session to collaboratively set the agenda, review homework and assign appropriate new homework, work on key problems, summarize and close the session, and elicit and respond to feedback.
5. The resident will educate the patient how to use relaxation techniques, exposure and response prevention, and graded exposure to feared situations.
6. The resident will utilize the dysfunctional thought record and measure the impact it has on the patient's mood and behavior.
7. The resident will effectively plan termination with patients, employ booster sessions as needed, and teach relapse prevention techniques.
8. The resident will seek appropriate consultation and supervision for a patient treated with cognitive behavioral therapy, and understands the need for specialized treatment.

C. Attitudes

1. The resident will demonstrate empathy, respect, collaboration with, and an open and nonjudgmental approach toward the patient in cognitive behavioral therapy.
2. The resident will demonstrate the ability to tolerate ambiguity and display confidence in the efficacy of cognitive behavioral therapy.
3. The resident will demonstrate sensitivity to the sociocultural, socioeconomic, and educational issues that arise during the therapeutic relationship.
4. The resident will be open to constructive feedback from supervisors by permitting review of audio or videotapes, or direct observation of treatment sessions.

III. Psychodynamic Psychotherapy

A. Knowledge

1. The resident will demonstrate understanding of at least one model of psychodynamic psychotherapy.
2. The resident will demonstrate understanding of the clinical psychodynamic psychotherapy concepts of the unconscious, defense mechanisms, resistance, and transference and countertransference.
3. The resident will acknowledge that symptoms, behaviors, and motivations may often have multiple and complex meanings that may not be readily apparent.
4. The resident will demonstrate an understanding of the influence of psychosocial development through the life cycle on the patient's thoughts, feelings, and behavior.
5. The resident will know the indications and contraindications for the psychiatric disorders treated by psychodynamic psychotherapy.
6. The resident will demonstrate understanding that competence at psychodynamic psychotherapy requires continued education and skill development.

B. Skills

1. The resident will be able to evaluate the capacity of the patient to engage in and utilize psychodynamic psychotherapy.
2. The resident will use effective interpersonal skills to collaboratively build and maintain a therapeutic alliance to promote self-reflection and inquiry into the patient's inner life.
3. The resident will establish treatment goals with the patient.
4. In order to understand the presenting problems, the resident will engage the patient in exploring their history of experiences, sociocultural influences, relationships, coping mechanisms, fears, traumas, losses, and hopes and wishes.
5. The resident will be able to listen effectively to the patient to understand nuance, meanings, and indirect communications.

6. The resident will be able to recognize and manage transference and countertransference, defense mechanisms, and resistance during the course of therapy.
7. The resident will be able to use self-reflection to learn about their own responses to patients in order to further the goals of psychodynamic psychotherapy.
8. The resident will demonstrate the use of clarification and confrontation.
9. The resident will utilize interpretation to manage transference and countertransference that otherwise would disrupt the therapeutic process.
10. The resident will be able to understand and manage the termination process.
11. The resident will demonstrate the ability to write a psychodynamic formulation.
12. The resident will seek supervision, consultation, or referral for specialized treatment.

C. Attitudes

1. The resident will demonstrate empathy, respect, collaboration with, and an open and nonjudgmental approach toward the patient in psychodynamic psychotherapy.
2. The resident will demonstrate the ability to tolerate ambiguity and display confidence in the efficacy of psychodynamic psychotherapy.
3. The resident will demonstrate sensitivity to the sociocultural, socioeconomic, and educational issues that arise during the therapeutic relationship.
4. The resident will be open to constructive feedback from supervisors by permitting review of audio or videotapes, or direct observation of treatment sessions.

IV. Supportive Psychotherapy

A. Knowledge

1. The resident will acknowledge that the principal goals of supportive psychotherapy are to maintain or improve the patient's self-esteem, minimize or prevent recurrence of symptoms, and maximize adaptive capacities.
2. The resident will demonstrate knowledge that supportive psychotherapy is commonly utilized in many therapeutic encounters.
3. The resident will acknowledge that the patient-therapist relationship is critically important in supportive psychotherapy.
4. The resident will know the indications and contraindications of supportive psychotherapy.
5. The resident will understand that competence in supportive psychotherapy requires continued education and skill development.

B. Skills

1. The resident will demonstrate the ability to establish and maintain a therapeutic alliance, and establish treatment goals.
2. The resident will demonstrate their ability to interact in a direct and nonthreatening manner.
3. The resident will demonstrate responsiveness to the patient and appropriately give feedback and advice.
4. The resident will demonstrate the ability to understand the patient as a unique member of their family, sociocultural, and community structure.
5. The resident will demonstrate the ability to choose interventions that are therapeutic for the patient without introducing their own beliefs or values.
6. The resident will demonstrate the ability to collaboratively confront behaviors that may pose a danger to the patient.

7. The resident will demonstrate the ability to both recognize, and identify, affects in their patient and themselves.
8. The ability to provide reassurance to minimize symptoms, improve morale and adaptation, and prevent relapse will be demonstrated by the resident.
9. The resident will support, promote, and recognize the patient's ability to achieve goals that will foster the patient's well-being.
10. The resident will teach the patient strategies to manage problems with affect regulation, thought disorders, and impaired reality testing.
11. The resident will demonstrate the ability to provide education and advice about the patient's psychiatric condition, treatment, and adaptation while being cognizant of sociocultural issues and community systems of care.
12. In patients with chronic psychiatric disorders, the resident will focus their therapeutic efforts at enhancing adaptive skills, relationships, and sources of anxiety or worry.
13. The resident will assist the patient with developing self-assessment skills.
14. The resident will utilize consultation and supervision appropriately, and refer for specialized treatment if indicated.

C. Attitudes

1. The resident will demonstrate empathy, respect, collaboration with, and an open and nonjudgmental approach toward the patient in supportive psychotherapy.
2. The resident will demonstrate the ability to tolerate ambiguity and display confidence in the efficacy of supportive psychotherapy.
3. The resident will demonstrate sensitivity to the sociocultural, socioeconomic, and educational issues that occur in the supportive psychotherapy relationship.
4. The resident will be open to constructive feedback from supervisors by permitting review of audio or videotapes, or direct observation of treatment sessions.

V. Psychotherapy Combined With Psychopharmacology

A. Knowledge

1. The resident will demonstrate knowledge of the diagnoses and clinical conditions that warrant the combined use of psychopharmacology and psychotherapy.
2. The resident will demonstrate knowledge of different methods of combining psychotherapy and psychopharmacology.
3. The resident will demonstrate knowledge of the specific indications for a recommendation of psychotherapy and psychopharmacology, and the rationale for the type of psychotherapy and medication recommended.
4. The resident will demonstrate knowledge of potential synergies and/or antagonisms in combining psychotherapy and psychopharmacology.
5. The resident will demonstrate understanding that taking medications may have multiple psychological and sociocultural meanings to a patient.
6. The resident will know the background, education, and training of other mental health professionals who may provide psychotherapy in patients who are receiving psychopharmacologic treatments.
7. The resident will understand that competence in combined psychotherapy and psychopharmacology requires continued education and skill development.

B. Skills

1. The resident will be able to gather sufficient information from a clinical assessment to determine the need for, recommend, and implement combined psychotherapy and psychopharmacology.
2. The resident will forge an active therapeutic alliance with the patient to facilitate adherence to combined psychotherapy and psychopharmacology.
3. By monitoring the patient's condition, the resident will modify the psychotherapeutic or pharmacologic approach as indicated
4. The resident will be able to appreciate and assess the importance of timing of psychotherapeutic and psychopharmacologic interventions.
5. The resident will develop an appreciation of factors that influence the combined use of psychotherapy and psychopharmacology, such as conscious and unconscious aspects of the doctor-patient relationship, the placebo effect, and concurrent medical conditions.
6. The resident will be able to recognize and identify affects in the patient and himself.
7. By using psychotherapeutic techniques, the resident will diminish resistance to and facilitate the use of psychopharmacology when appropriate.
8. The resident will be able to articulate both the potential beneficial and detrimental effects of medication use in the context of a psychotherapeutic treatment.
9. The resident will explore and understand the psychological and sociocultural meaning to a patient who is taking a pharmacologic agent.
10. The resident will be able to collaborate effectively with nonpsychiatric psychotherapists, and respond to conflicts and problems that arise in the therapeutic triad.

C. Attitudes

1. The resident will demonstrate empathy, respect, collaboration with, and an open and nonjudgmental approach toward the patient in combined psychotherapy and psychopharmacology.
2. The resident will demonstrate the ability to tolerate ambiguity and display confidence in the efficacy of combined psychotherapy and psychopharmacology.
3. The resident will appreciate that combined psychotherapy and psychopharmacology is an integrated treatment and not divisible into independent parts.
4. The resident will be open to constructive feedback from supervisors by permitting review of audio or videotapes, or direct observation of treatment sessions.

CONFERENCES/LECTURES/DIDACTICS/SEMINARS

Lectures/Didactics: General Comments:

The psychiatry didactic curriculum is designed to provide an interactive forum to augment the resident's independent reading and clinical experience. Residents are required to attend a minimum of 70% of all didactics in accordance with ACGME guidelines for graduation. If a resident does not attend 70% of the lectures in a given seminar, they will be required to repeat the seminar or complete a remediation project approved by the seminar director and residency Program Director. It is expected that each resident will attend all didactics, unless excused by the seminar director and residency Program Director. Attendance is monitored by way of sign-in logs, available at each lecture site. These logs will be collected by the Graduate Education Committee resident representative for each year of training, and submitted to the Residency Office. Attendance will be tallied and tracked by the Residency Training Office.

The didactic curriculum consists of PGY-1 Tuesday lectures from 3-5pm and PGY 2,3,4 Wednesday lectures from 3-5pm. Friday didactics are for all residents at all levels and consist of Grand Rounds,

journal club, and case conferences. There is an annual PRITE/Board Review curriculum woven into the didactic sessions. Topics covered include but are not limited to psychopharmacology, psychotherapy, DSM, addictions, child/adolescent, forensics, and geriatrics.

SUGGESTED ACTIVITIES:

Research:

1. Original research—hypothesis-driven, experimental in nature
2. Case reports/series
3. Literature review(s)
4. Textbook chapter(s)

Original, investigator-initiated research is the cornerstone of innovation in Psychiatry. Residents are encouraged to identify mentors working in basic, clinical, and/or educational research and begin formulating a project that can be completed during residency training. Case reports generate the interest and provide impetus for further, more rigorous investigations in our field. Should a resident and/or faculty member identify an interesting or unusual case, s/he is encouraged to further research and write up the case. Literature reviews and textbook chapters provide a summary and synthesis of current knowledge on a relevant topic in Psychiatry and often provide the novice's first understanding of an often overwhelming topic. Interested residents and faculty are encouraged to work together to review topics of mutual interest and that will contribute to the field.

Teaching:

1. *Teaching Scholar Apprenticeship*: A good teacher is hard to find but absolutely necessary in academics. Breaking down a subject to its essence so that it can be understood by the audience is imperative to outstanding teaching. Rarely are professional students and residents taught how to teach. This apprenticeship is designed to do that and should be a rigorous teaching experience. The resident will identify a faculty mentor who does a significant amount of teaching (e.g. a whole series of lectures to the residents on psychopharmacology). It is also expected that the mentor has a significant literature-based knowledge of the field and possibly clinical/basic experimental research experience in the area and/or has been honored for teaching expertise/leadership. The resident will be mentored in learning the subject matter and reading appropriate literature. The resident will be given graded experience in teaching (e.g. 1-2 lectures at first with the goal of the resident giving an entire set of lectures).
2. *Evidence-Based Medicine (EBM) Scholar*: EBM is crucial to quality psychiatric care. The resident will work closely with a faculty mentor (with peer review experience) to keep abreast of the latest evidence related to Psychiatric practice. The resident will post relevant updates to the Department website accessible to faculty, residents, students, and staff.
3. *Continuing Medical Education (CME) Scholar*: Lifelong learning is crucial to psychiatrists in order to stay abreast of the latest advances in our field. The resident will work closely with a faculty member to organize CME activities (including Grand Rounds presentations and required courses for licensure) for faculty, staff, and residents.

Creative:

1. History of Psychiatry—The history of Psychiatry is rich and fascinating and can inform our present and future work. This is an opportunity to explore an area of Psychiatry, Medicine, and/or Science in depth. This would require the resident along with their mentor to thoroughly research a person or group of persons who has made significant contributions to Psychiatry, Medicine, or Science (e.g. famous women in Psychiatry; Nobel Prize winners from Neuroscience or Psychiatry), or to thoroughly review the history of a particular breakthrough (e.g. introduction of antipsychotics or ECT) that contributed to furthering our field.
2. Creative Writing in Psychiatry—Creativity and Psychiatry go hand-in-hand. This should be a rigorous creative writing (e.g. short story, essay, poetry, etc.) experience under the mentorship of a faculty member or other established/published writer (e.g. in the local community or elsewhere). Coursework in creative writing is strongly encouraged.

3. Art and Psychiatry--Art can be an expression of our daily work as Psychiatrists and can be healing. Residents may pursue scholarly activities in specific artistic domains such as photography, music, sculpture or painting/drawing or multi-media presentations. Residents are expected to develop a body of work grounded in the science and practice of Psychiatry, created with the support and direction of an appropriate mentor. Mentors must have demonstrated expertise in their artistic domains. It is expected that the development of the work will take place over a minimum of 1 to 2 years and will be worthy of presentation in recital, showings, concert and/or publication as appropriate for the art form.

These creative options are for those residents who have particular talents, interests, and passion in literature and art that can be harnessed to further advance or shape their career in Psychiatry. Strong emphasis on the Psychiatrist-Patient Relationship; the effects of mental illness on providers, patients and families; or other aspects of psychiatric practice is encouraged.

AREAS OF EMPHASIS:

The following areas of emphases in psychiatry may be pursued for research, teaching, and creative activities:

1. Addiction Medicine/Psychiatry
2. Administrative Psychiatry
3. Advocacy
4. Child/Adolescent Psychiatry
5. Community Psychiatry
6. Continuing Medical/Psychiatric Education (CME)
7. Diagnosis
8. Diversity/Cultural Awareness in Psychiatry
9. Evidence-Based Medicine (EBM)
10. Forensic Psychiatry
11. Geriatric Psychiatry
12. Medical/Psychiatric Ethics
13. Neuroscience
14. Psychopharmacology
15. Psychotherapy
16. Quality Care/Patient Safety (QC/PS); Quality Improvement (QI)
17. Telepsychiatry
18. Treatment modalities--other (e.g. ECT)
19. Other (with prior written approval from the mentor and RSA committee)

SUGGESTED OUTCOMES: Documentation of the resident's work and progress in the chosen area/activity must be submitted and will be required. This will help provide a "paper trail" that will assist the program in the accreditation process and in writing letters of recommendation as well as assignment of elective time and determinations of the need for protected time for the activity should this be requested. Once the project is initiated and underway, the resident, mentor, and RSA committee must agree on an expected outcome(s). The following are suggested outcomes:

Research:

1. Publication-quality manuscript for submission to a peer-reviewed journal. The resident should be the first author or provide evidence of significant contribution (e.g. experimental work and/or writing). For case reports and literature reviews, the resident should be the first author.
2. Poster and/or oral presentation at a clinical/scientific/educational meeting. A copy of the abstract and relevant meeting program details should be provided as evidence of participation. The resident should be the first author, the presenter, or provide evidence of significant contribution as above for manuscripts.
3. Submitted, pending, or funded grant application. The resident should be the principle investigator (PI) or demonstrate significant scholarly input as a Co-PI (i.e. the resident should write a significant portion of the application or generate preliminary data).

Teaching:

1. A portfolio of resident-produced teaching materials (e.g. PowerPoint presentations, handouts, etc.) AND teaching evaluations from “students” and the mentor AND self-evaluation of the teaching experience.
2. Publication-quality manuscript (e.g. teaching experience-based, literature review, meta-analysis) for submission to a peer-reviewed journal. The resident should be the first author or provide evidence of significant contribution (e.g. significant portion of the writing and editing).

Creative:

1. Publication-quality manuscript or thesis for submission to a peer-reviewed journal. The resident should be the first author or provide evidence of significant contribution (e.g. significant portion of the writing and editing).
 2. Portfolio of creative work with a written description of the work AND mentor’s written evaluation AND written self-evaluation of the experience.
 3. Evidence of public exhibition of the work (e.g. programs, flyers, announcements, videos).
 4. Publications in non-peer-reviewed journals, magazines (e.g. a foundation publication).
- Residents will also be encouraged to share their work with fellow residents and faculty as well as the broader community via Grand Rounds or other seminar presentations or via the department website.

MENTORS/SUPERVISORS: A list of potential mentors (updated yearly on the website) and available projects will be provided. Residents may (and are encouraged to) seek out other mentors, including those outside the department. Each mentor should be willing to meet regularly with the resident to make sure that there is timely progress on the project. It is suggested that a mentor be sought out as early as the first year of residency to start planning the project. The mentor may (and is encouraged to) be a co-author on the resident’s work provided that the mentor makes a significant contribution (guidelines for authorship will be provided on the website).

RECOGNITION/AWARD: All scholarly activity projects should be submitted for review for completeness and quality. Some may be sent out for external review. Each year at graduation, 1-3 projects (depending on number and quality) will be selected for recognition/award. Any resident, at any level of training, is eligible for award.

RESIDENCY TRAINING POLICIES AND PROCEDURES

Professionalism

All resident are expected to comply with the standards of professional conduct established by the hospital. (see Houstaff Manual, current version) All residents should maintain a professional appearance, conduct, and attitude, as well as exhibit behavior that is exemplary of the medical profession. A University of Florida identification badge should be worn at all times while engaged in clinical activities on hospital grounds.

Approved attire in patient care areas shall not include shorts, cut-offs, jeans, or similar casual clothing. No flip-flops or heavy boots shall be permitted. Hair shall be trimmed and groomed. A style should be chosen that avoids dangling of hair into the face or onto the body of a patient during physical examination or other patient care activities. Hospital-supplied scrub clothing shall be worn by those working in specified areas and shall not be worn routinely by any other staff. Scrub suits should never be worn outside of the hospital.

UF Health Shands Policy: <https://gme.sites.medinfo.ufl.edu/files/2011/12/Personal-Appearance-and-Dress.pdf>

Communication, Distribution of Mail, Email, Pagers, Cell Phones, I-Pads

All residents and fellows in the Department of Psychiatry are issued a pager at the beginning of their residency/fellowship. **The resident is responsible for** insuring that the pager is functional, has a charged battery and is on during duty hours (8 AM-5 PM) and while on call. It is **strongly recommended** that residents test their pagers just prior to a call night. All affected services/personnel must be promptly notified when a resident is carrying a different pager. In cases where a pager is not functioning properly, residents shall provide all affected services/personnel with an alternate means of contacting them for clinical duties (ex. cell phone).

The UF COM is transitioning to SPOK for confidential paging and communication of protected health information. (Revised 5/10/16)

Each resident is assigned a mailbox in the MOB Clinic. Residents must check their mailbox **weekly**. The Departmental website should be accessed routinely for the most up-to-date on-call schedule, rotation schedules and communications from the Residency Education Office. Most importantly, the RT office relies on email as a primary source of communication to residents. Residents are responsible for checking their email **at least on a daily basis** to stay abreast of any changes or pertinent Departmental information. It is the responsibility of all residents to update the Residency Office any time one of their contact numbers changes (i.e. cell phone, home phone, email, pager, etc.).

Confidentiality:

The program recognizes that the rights and individual dignity of each patient (including the parents and/or surrogates of minors or incapacitated patients) are to be respected during the delivery of health care services. Cases are not to be discussed with others except in the course of providing patient care, supervision, and teaching. No Private/Personal Health Information (PHI) may be released without written consent from the patient or legal guardian. New federal guidelines (HIPAA) mandate strict compliance with serious penalties for violations.

All residents are required to complete on-line training and certification in HIPAA as it relates to hospital policies and procedures on an annual basis.

Banned Abbreviations

One of the National Patient Safety Goals requires hospitals and caregivers to keep patients safe by not using certain abbreviations (listed below) that could result in medical errors. The use of banned abbreviations in orders, progress notes, nursing notes, medication administration records and other forms of documentation, particularly related to medications has resulted in medical errors.

Nurses, physicians, and others who document will not use banned abbreviations in their documentation.

Nurses and pharmacists will not accept a medication order that includes a banned abbreviation. Clerks will assist by reviewing medication orders before faxing to pharmacy and notifying the nurse of an order with a banned abbreviation. The nurse will contact the provider to request a rewrite of the orders. If the banned abbreviation reaches the pharmacy, the pharmacist will contact the provider.

Preprinted orders with banned abbreviations should not be accepted and brought to the attention of management to be removed from use by the medical service using the order.

List of Banned Abbreviations

QD (daily)

QOD (every other day)

MS (morphine sulfate)

M₄SO₄ (morphine sulfate)

MgSO₄ (magnesium sulfate)

u (units)

IU (international units)

2.0 (trailing zero)

.2 (failing to put leading zero)

Board Certification

All residents are encouraged and expected to take the board examination for certification in psychiatry and neurology, through the American Board of Psychiatry and Neurology, Inc. Preparation for this examination is provided throughout training with a special emphasis in the fourth year Board Review Seminar.

Call Responsibilities

Residents are required to remain up to date with the call schedule and list of contact numbers that are available on the internal website. Residents should make contact with the attending on call at sometime during that business day and prior to 4 pm. Any changes to the call schedule must be properly communicated and can only be made among residents within the same class. No changes may be made within 7 days of the call date without approval from the training director. Residents transferring into a PGY-1, 2, or 3 position from another Psychiatry Residency, will be given credit for up to 1 yr of prior psychiatric call. In the event of a resident transferring into a PGY-4 position from a Psychiatry Residency, the resident will be given credit for up to 2 yrs of psychiatric call if completed in the previous program. Residents transferring from a specialty other than Psychiatry into a PGY-1, 2, or 3 position will be required to complete the standard 2 years of psychiatry call required by this program. In general, those entering at the PGY-3 level will be required to do at least 6 months of call, and those entering at the PGY-4 level will be required to do at least 3 months of call. This is to ensure a complete understanding of our psychiatric care system and to ensure the skills of the transferring resident.

On Call Facilities:

An on-call room is available for residents who wish to remain in-house for their call nights, or for those who find themselves “stuck” in-house overnight. For more information, please contact the chief residents.

Faculty members of the Department of Anesthesiology staff the Emergency Department at Shands Hospital. When providing consultation to the Emergency Department, residents should relate to these faculty as they would to any other faculty in the Department of Psychiatry. Any difficulties encountered in the Emergency Department should be discussed promptly with the attending on site, on call or the chief resident. Residents who are on night float at Vista are provided with food in the sleep room.

Meal Tickets (Gatorbites):

DESCRIPTION (General Rules):

1. GatorBites (\$7.00) will be assigned to each housestaff's GatorOne ID Badge for each night he/she is on in-house overnight call.
2. Half GatorBites (\$3.50) will be assigned to each housestaff's GatorOne ID Badge for each night he/she is on home-call but returns to the hospital over 50% of the time.
3. Weekends: Anyone who is on-call for the weekend 16+ hours shift will receive:
(\$7.00) Full GatorBites credit for each weekend day “in-house” call.
(\$7.00) Full GatorBites credit for each weekend night “in-house” call.
(\$3.50) Half GatorBites credit for coming into the hospital over 50% of the time on “home call”.
4. GatorBite credits can be reassigned. The Program Coordinator must contact the Housestaff Affairs Office with the changed information. Credits will be removed and added electronically - donating GatorBites from one housestaff to another.

PROVISIONS:

2. GatorBites are food credits with the intent to feed housestaff when they are on-call for their service and away from their home and family.
3. GatorBites can be used at all UF Health Science Center and Shands food vendors.
4. Bulk food cannot be purchased with GatorBites from any food service provider.
5. A daily limit of \$30 is electronically imposed on all Gatorbites.
6. GatorBite credits will be input into the computer system by the Housestaff/GME Office.
7. Any problems involving the use or misuse of GatorBites will be referred to the Associate Dean of Graduate Medical Education.

ACCOUNTABILITY OF HOUSESTAFF:

In order to receive GatorBite credits the department must ensure compliance with the following:

1. Residents must have no unsigned medical records (EPIC).
2. Residents must have entered their duty hours in New Innovations.
3. Residents must have up-to-date case logs
4. Residents misrepresenting any of these terms will lose GatorBites privilege as well as be written up for character problems and will be documented as unsatisfactory in the area of Professionalism (one of the clinical competencies) for the previous 6-month evaluation period.

Chief Resident Duties:

Generally, the Chief Resident shall serve as the primary liaison between the resident body and the administration/ Residency Training Office. Chief Residents are expected to:

Administrative:

- Assist the Residency Training Office in assigning residents to monthly rotations
- Orchestrate coverage/assign residents to cover both inpatient and consult services when the primary resident is out unexpectedly for sickness or other emergency
- Ensure that proper coverage has been arranged for clinical duties (both inpatient and consult) before any resident takes leave.
- Demonstrate a presence and visibility among the residents as a leader and role model
- Be available by pager or cell phone on a 24-hour basis to assist residents with on-call questions and responsibilities when necessary (shared with co-chiefs on a rotating basis)
- Assist in the revision and implementation of Residency Policies and Procedures
- Play an integral role in the recruitment process including all recruitment dinners and applicant tours (may be shared with co-chiefs)
- Attend quarterly (or as otherwise scheduled) Chief Resident's Council meetings. Both chiefs are encouraged to attend the meetings, but may cover for each other as needed.
- Prepare and distribute the on-call schedule
- Hold regular office hours
- Assist in the monitoring of duty hours for all residents

Education:

- Hold a monthly all-resident meeting
- Attend monthly meeting with the Program Directors
- Assist with quality improvement conferences
- Provide remedial counseling, instruction, and assistance to residents who fail to achieve competence in defined areas of training
- Participate fully in the orientation of incoming residents, both in June/July, and again for any off-cycle residents
- Participate in the evaluation of residents
- Regularly attend all GEC meetings
- Participate in and encourage resident scholarly activities (research, teaching, creative endeavors)
- Participate in and encourage resident teaching of medical and PA students
- Attend monthly VA inpatient meetings and Vista CQI meeting (every 2 months)

Leadership/Quality:

- Attend institutional leadership training conference as well as other leadership conferences when possible
- Be available by pager or cell phone, and when necessary in person, to handle any emergencies, or crises in residency training

- Attend all education conferences such as Grand Rounds, M&M/QI conferences, teaching conferences, or as otherwise requested by the Program Director or Chair. Chief Residents are expected to set the example for other residents in terms of conference attendance and participation.
- Maintain an environment of confidentiality

Outpatient Chief Resident Duties:

Generally, the Outpatient Chief Resident shall serve as the primary liaison between the clinic residents at all sites and the outpatient faculty/staff administration as well as the Residency Training Office. The Outpatient Chief Resident is expected to:

Administrative:

- Assist the Clinic Director/Residency Training Office in assigning residents to clinics and individual/group supervisors
- Orchestrate coverage/assign residents to cover outpatient assignments when the primary resident is out unexpectedly for sickness or other emergency. If coverage is not available, the outpatient chief may ultimately have to cover for resident who calls out sick.
- Ensure that proper coverage has been arranged for clinical duties before any resident takes leave.
- Demonstrate a presence and visibility among the clinic residents as a leader and role model
- Be available by pager on a 24-hour basis to assist residents with on-call questions and responsibilities when necessary. When not available, will assign backup or define other means of communication.
- Assist in the revision and implementation of Residency and Clinic Policies and Procedures
- Play an integral role in the recruitment process including recruitment lunches and applicant tours
- Meet monthly or as otherwise determined with the clinic director(s) and/or the Program Directors
- Attend quarterly (or as otherwise scheduled) Chief Resident's Council meetings. All chiefs are encouraged to attend the meetings, but may cover for each other as needed.
- Hold regular office hours

Education:

- Facilitate Quality Improvement Conferences and activities in the clinic
- Provide remedial counseling, instruction, and assistance to clinic residents who fail to achieve competence in defined areas of training
- Participate fully in the orientation of incoming clinic residents, both in July, and again for any off-cycle residents
- Participate in the evaluation of residents
- Regularly attend all GEC meetings
- Attend Resident Scholarly Activity (RSA) meetings and participate in and encourage resident scholarly activities (research, teaching, creative endeavors)

Leadership:

- Be available by pager, and when necessary in person, to handle any emergencies, or crises in residency training pertaining to the clinic.
- Attend all education conferences such as Grand Rounds, M&M, teaching conferences, or as otherwise requested by the Clinic Director, Program Director, or Chair. Chief Residents are expected to set the example for other residents in terms of conference attendance and participation.

Selection of Chief Residents:

The Chief Residents are appointed by the Program Director in consultation with the General Psychiatry Residents and Teaching Faculty including the Chair of the Department. Each Spring the residents will be asked to vote for their choice of Chief Residents for the upcoming academic year. However, it is ultimately the responsibility and discretion of the Program Director to select Chief Residents who will most appropriately satisfy the criteria listed below:

1. Demonstrates leadership skills at or above level of training

2. Communicates effectively with peers, superiors, and other medical professionals
3. Demonstrates an interest in teaching and/or research
4. Possess administrative and organizational skills
5. Evidence of high achievement both academically and clinically
6. No significant deficiencies noted in evaluations
7. Demonstrates ideals of professionalism and moral integrity
8. Demonstrates a sound work ethic

Clinical Competency Committee (CCC)

The CCC is appointed by the Program Director and is made up of at least three members of the program clinical faculty who have demonstrated leadership, interest, and commitment to residency education. Faculty from key areas of the training experience will be members. Non-physician members are also eligible for appointment at the discretion of the Program Director. Residents are not eligible for appointment to the CCC. The Program Coordinator and Department Education Coordinator also attend but are non-voting members. Minutes will be recorded by the Program/Education Coordinator for all meetings and made available to members for their review. Minutes will be kept by the Program Coordinator in the Residency Education Office. Milestones will be directly reported in New Innovations and ACGME ADS.

Clinical Skills Assessments

Per ACGME Psychiatry RRC requirements, each resident will (a resident must pass 3 CSA to be eligible for the ABPN certification exam) participate in a minimum of three Clinical Skills Assessments (CSAs) during their residency. Residents who elect to fast track to child/adolescent fellowship training will be required to pass 3 CSAs prior to transfer or face delay in transfer and extension of adult training. The program encourages residents and board-certified faculty to arrange CSAs on each rotation to provide an added avenue of direct assessment of resident skills. CSAs are also performed annually by the program. CSA results are recorded on the AADPRT Psychiatry Clinical Skills Assessment Form CSV.4. Per the ABPN, CSAs are valid for 7 years from the time of completion of residency training. Those who do not pass their certification exam within 7 years will be required by the ABPN to repeat their CSAs as well as other MOC requirements in order to be eligible to sit for the board certification exam. Please refer to the ABPN website (www.abpn.com) for more information and updates.

(Revised 4/10/16)

Compliance

Upon entering the Department of Psychiatry Residency program and executing your contract, your signature affirms you are not currently excluded, debarred or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs and that you have not been convicted of a criminal offense related to the provision of health care items or services. Your eligibility to participate in Federal health care programs is a condition of your employment with the University. If you are at any time excluded, debarred or otherwise declared ineligible to participate in Federal health care programs (other than through a College of Medicine-approved ""private contracting"" arrangement) or in Federal procurement or non-procurement programs or are convicted of a criminal offense related to the provision of Health care items or services, your employment may be terminated immediately.

Coverage

It is the responsibility of the resident to obtain proper coverage for all clinical and administrative activities prior to taking any form of leave. Barring incapacitating physical illness, residents are also expected to assist in finding coverage when they are on sick leave. The chief residents should be involved in the process of approving coverage.

Duty/ Work Hours

Graduate education in psychiatry requires a commitment to patient care. Patients have a right to expect a healthy, alert, responsible, and responsive physician dedicated to delivering effective and appropriate care. Different rotations may require different work hours and patterns. There is a distinction between in hospital call time and at home call time with regard to actual work time.

Residency training in psychiatry is a full-time responsibility; activities outside the program must not interfere with the resident's opportunity to rest, relax and study. **SEE GME Policy** <https://gme.sites.medinfo.ufl.edu/files/2011/12/Duty-Hours.pdf>

Evaluation and Advancement

Patient Logs:

It is imperative that residents keep an ongoing record of the cases in which they have participated. This is a requirement for the ongoing educational portfolio and for graduation. Credentialing and other evaluation requests are increasingly asking for resident experience with certain patient populations. Each resident is required to update his or her Patient Logs in New Innovations, preferably daily. These will be reviewed at the semi-annual evaluation, or otherwise at the discretion of the Program Director.

Required in patient logs: Age, gender, diagnoses, and main type of encounter: new evaluation, transfer, psychotherapy, medical management.

Minimum total number of Logs at the end of each PGY level:

PGY-1: >400

PGY-2: >800

PGY-3: >1200

PGY-4: >1600 needed for graduation

Note: minimum total number of Logs are subject to change after annual review of overall log data by the Clinical Competency Committee (CCC) and the Program Director. Requirements may be changed for individual residents at the discretion of the Program Director under special circumstances (e.g. off-cycle resident). (Revised (5/10/16))

Resident Portfolios:

The resident portfolio should contain a minimum of the following:

- Patient Logs 1600
- List of 20 research articles utilized in patient care and a brief summary of each article
- List of 5 ethical dilemmas and how they were handled
- Description of your quality improvement plan and how this plan has improved your performance as a resident
- Summary of activities demonstrating patient advocacy
- 5 complete psychiatric evaluations including biopsychosocial formulations and treatment plans
- Summary of what has been learned during this academic year and perceived areas of strength and weakness
- Copy of one referral letter sent to another physician
- Updated CV
- PIP Module (revised 5/10/16)

Faculty Evaluations

Faculty complete electronic evaluations via New Innovations for each clinical rotation. All written evaluations are made available to residents for their review and signature, before being placed in the permanent file. Supervisors are responsible for providing feedback to their residents while they are on-service. Residents with significant deficiencies may be counseled by the Program Director.. A final evaluation of each resident that completes the program is submitted by the Program Director before graduation. This will include a review of the resident's performance during the final period of training and will verify that the resident can practice psychiatry independently.

Resident/Fellow Evaluation

Formative Evaluation

The faculty must evaluate resident performance in a timely manner (within 2 weeks) for each rotation or similar educational assignment, and document this evaluation (ideally in New Innovations) at the completion of the assignment.

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 based on the specialty-specific milestones;
- 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 or fellow with documented semiannual evaluation of performance with feedback. These must be a documented face-to-face meeting with the program director or designee (advisor).
The evaluations of resident performance must be accessible for review by the resident (i.e. via New Innovations).

Summative Evaluation

The specialty- specific Milestones must be used as one of the tools to ensure residents/fellows are able to practice core professional activities without supervision upon completion of the program. 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. This evaluation must:

- 1) Document the resident's performance during the final period of education, and
- 2) Verify that the resident has demonstrated sufficient competence to enter practice without supervision.

Graduate Education Committee

The Program Director chairs a monthly Graduate Education (Policy) Committee (GEC) composed of one resident representative from each PGY level, the chief residents, the PGY faculty coordinators, members of the teaching faculty from each ACGME-approved subspecialty residency (Child and Adolescent Psychiatry, Forensics), and other departmental teaching faculty at the discretion of the Program Director. The committee's responsibilities are as follows:

1. Participation in program development and evaluation, including clinical rotations/electives, didactics, conferences, quality improvement and research experiences.
2. Evaluation of instructors.
3. Review of residency policies and procedures.
4. Adjunct/resource to the Program Director in the evaluation of applicants to the program.
5. Development and periodic review of the program's goals and objectives.
6. Review and resolution of resident concerns.

Minutes are recorded for all meetings, completed by the Program Coordinator, and made available to the committee members for review. Minutes are maintained by the Program Coordinator in the Residency Training Office. Public minutes are distributed to all faculty and residents.

HIPAA Policy <http://privacy.ufl.edu/privacy-policies-and-procedures/information-privacy-statement/>

The University of Florida values individuals' privacy and actively seeks to preserve the privacy rights of those who share information with us. Your trust is important to us and we believe you have the right to know how information submitted to the University of Florida is generally handled.

We provide the following privacy notice to define UF's information policy and practices, and to assist you in protecting your privacy.

Privacy Notice

The University has adopted the following privacy policies and practices for any and all parts of the University of Florida where **Personal Identification Information (PII)** in any format is created, received, maintained, and transmitted. However, in legal terms, it shall not be construed as a contractual promise, and the University reserves the right to amend its policies at any time without notice. Privacy and public records obligations of the University are governed by applicable Florida statutes and U.S. federal laws.

This Privacy Statement speaks generally to the information created, received, maintained, and transmitted by and to official University of Florida components. However, the amounts and types of information will vary from site to site within the University. Therefore, in addition to this general explanation of policy and practice, the university has published more specific privacy notices pertaining to personal information associated exclusively with the internet, academics, finances, employment, and health care. Thus it is wise for you to read the specific notices to ensure you understand the privacy policies and practices applicable to a particular entity and the types of **PII** they maintain.

Official University Components

The University of Florida includes hundreds of departments, divisions, clinics, offices, and other units with varying levels of University involvement and commitment. Official University components are defined as UF's colleges, schools, departments, divisions or other units and any other areas specifically designated as official by the UF Board of Trustees, the President of UF, or a UF Provost or Vice President.

Personal Identification Information (PII)

Any name or number that may be used, alone or in conjunction with any other information, to identify a specific individual, including any:

1. Names and Numbers:
 - o Name,
 - o Postal or electronic mail address,
 - o Telephone number,
 - o Social security number,
 - o Date of birth,
 - o Mother's maiden name,
 - o Official state-issued or US-issued driver's license or identification number,
 - o Alien registration number,
 - o Government passport number,
 - o Employer or taxpayer identification number,
 - o Medicaid or food stamp account number,
 - o Bank account number,
 - o Credit or debit card number, or
 - o Personal identification number or code assigned to the holder of a debit card by the issuer to permit authorized electronic use of such card;

2. Unique biometric data, such as fingerprint, voiceprint, retina or iris image, or other unique physical representation;
3. Unique electronic identification number, address, or routing code; or
4. Medical records;
5. Telecommunication identifying information or access device; or
6. Other number or information that can be used to access a person's financial resources.

UF On-line Internet Policy: <http://privacy.ufl.edu/privacy-policies-and-procedures/onlineinternet-privacy-statement/>

Site Definitions

University Web space includes hundreds of sites with varying levels of University involvement and commitment as outlined below.

- **Official University Web Sites**

Except as noted, the information in this privacy notice applies to all official University of Florida Web sites, which are defined as the Web pages of university colleges, schools, departments, divisions or other units and any other sites specifically designated as official by a vice president, dean, department head or director. Official pages are generally recognizable by a standard page header and/or footer carrying the University logo, contact information and reference to this privacy statement.

- **Unofficial Web Sites**

Within the University of Florida domain – signified by the address “ufl.edu” or within the range of Internet protocol addresses assigned to the University of Florida – you may find Web sites over which the University has no editorial responsibility or control. Such sites are considered unofficial and include, but are not limited to, the Web pages of individual faculty members or students and the Web pages of student organizations and other entities not formally a part of the University. While UF encourages compliance with this Web Privacy Statement at such sites, in order to better understand the policies and practices under which they operate, please consult the privacy statements of individual sites or seek information directly from the persons responsible for those sites.

In-Training Examination

The Psychiatry Resident In-Training Examination (PRITE) provides an external criterion to scrutinize the program's curriculum content, goals, and effectiveness. Residents take this in-training examination in all stages of training. It may be used as one factor, among many, for assessing the competency of a resident. The primary objective is to provide educationally useful feedback to residents in the form of comparisons with peers in specific areas of knowledge. Residents are expected to take the PRITE during each year of training. In general, leave will not be granted during the time of the PRITE administration. Should a resident have to miss an annual examination for any reason, the Program Director must approve such an absence well in advance and remedial academic work will be required and defined at the discretion of the Program Director.

Medical Records and Documentation

The medical record is a critically important document. It is essential that the information in the record be accurate, timely and pertinent to the care of the patient. The record is also a legal document. The Joint Commission (JCAHO) sets specific requirements for Accreditation of Hospitals and Organizations These include a date and time on all entries, legible signature with degree indicated, and certain specific content requirements for the H&P and discharge summary among others. Medical staff bylaws at most training facilities require that discharge summaries be written before the patient actually leaves the floor, but no later than 48 hours post-discharge. All student entries and verbal orders must be countersigned within 24 hours.

In the outpatient setting, all notes must be completed by the end of the next business day (5pm).of the patient visit.

The Program Director, as well as the Chairman, is periodically provided with a list of residents with delinquent records. Failure to resolve these delinquencies promptly will result in suspension of clinical duties. Revised 5/10/16)

Milestones

The Milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME-accredited residency or fellowship programs. Milestones are designed for residency/fellowship programs to use in semi-annual review of resident performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident progresses from entry into residency through graduation.

Outside Employment Policy for Housestaff

I. Overview: University/ACGME/Department Regulations

- A. Housestaff must adhere to the State University System Guidelines regarding outside activities/outside employment, conflict of interest, and additional compensation. Such outside activity includes private practice, private consultation, teaching or research, or other employment outside State government which is not part of assigned University duties and for which the University provides no compensation.
- B. The Accreditation Council for Graduate Medical Education (ACGME) requires that the sponsoring institution have an outside professional employment policy and a monitoring mechanism. Per ACGME requirements, outside employment (“moonlighting”) must not interfere with the ability of the resident to achieve the goals and objectives of the educational mission of the residency program. All moonlighting activities must conform to the ACGME guidelines for duty hours. Thus, (1) moonlighting must be considered part of the 80-hour weekly limit on duty hours, (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) a 10-hour time period must be provided between all daily duty periods and after in-house call, and (4) continuous on-site duty, including in-house call, must not exceed 24 consecutive hours, plus up to an additional four hours to participate in didactic activities, transfer care of patients, or conduct outpatient clinics.
- C. The Department of Psychiatry has formulated guidelines for moonlighting effective July 1, 2008. The Program Director must approve all moonlighting activities. To be eligible for moonlighting, residents must be at the 50th percentile on the PRITE examination (a hardship clause allows a case by case exception by the Program Director after formal review). All moonlighting must be conducted within the rules of the contract without exception, and residents are expected to review all patients seen with the designated supervisor.
- D. Residents and Fellows who wish to moonlight must first seek approval to apply from their Training Directors. The Moonlighting Application Packet, including the application form, CV, copy of the Medical License and two statements of recommendation from faculty members must be submitted to the Vice Chair for Education. Once all materials are received and reviewed, applications will be presented to the GEC for final approval.

II. Description of Activities:

There are two categories of outside/extracurricular employment in University of Florida policy:

Programmatic: activities initiated by the Department to provide additional clinical experiences. A contractual agreement between the College of Medicine and the sponsoring health care facility governs these activities. These activities usually occur at non-campus health care affiliates. Supplemental salary income is provided **by the University** to residents who participate in **programmatic** activities.

Non-programmatic: activities initiated by the resident, which do not involve any agreement between the College of Medicine and an outside employer. The University of Florida Psychiatry Residency Training Program does **not** permit residents to participate in non-programmatic activities during their training. However, a hardship exemption may be granted by the Vice Chair for Education on a case by case basis after formal review, and approval by the Chair of the Department.

III. Outside Employment (Moonlighting) Rules

- A. Adherence to all University, ACGME, and Departmental regulations is required.
- B. Moonlighting requires prior written approval of the Program Director.
- C. PGY 1 residents are not allowed to moonlight. PGY-2 residents are allowed to moonlight only at the discretion of the Program Director. PGY-3 and above may apply to moonlight.
- D. Violation of any aspect of the above policies may be subject to disciplinary actions up to and including dismissal from the residency program.

Revised: 10/20/14

Policy on Security

The purpose of this policy is to identify Federal and State laws, industry regulations, and University of Florida (UF) policies that govern the management, protection and acceptable use of information assets, and to expressly include them in the UF Health Science Center information security program policy in our efforts to protect the privacy of individuals, and valued information assets of the UF Health Science Center. Faculty, staff and students shall visibly display their UF Gator1 or other approved identification badge at all times when at an HSC facility unless work requirements specify otherwise. <https://security.health.ufl.edu/policies/>

It is a violation of the accreditation of the hospital (JCAHO) to go without a name badge.

<http://intranet.shands.org/licacc/Intranet/Policies/CP1.25.pdf>

Promotion and Termination

Resident contracts will be issued and executed on a yearly basis. Therefore, upon joining the residency program you will sign a one-year contract. Upon completing your first year of training and provided you have met all the expected criteria for a PGY-1, you will be issued a new resident contract for the next level of training. This process will continue throughout the four years of general psychiatry training. Promotion to the next level of training is dependent, in part, on the faculty's assessment of the resident and their attainment of competency for that level of training. Residents must demonstrate achievement of the milestones listed in the goals and objectives for each rotation and each year. Promotion and retention are also dependent on continued appropriate moral, ethical and professional conduct by the resident. If it is determined that a resident's progress is not satisfactory, the Program Director, in consultation with the GEC and the Designated Institutional Official (DIO), may decide to terminate the resident, place the resident on probation, or require some form of remediation. The resident will be promptly notified by the Program Director of any such action and given the right to appeal as outlined in the due process policy.

Promotion to the next level of training is dependent, in part, on the faculty's and CCC's assessment of the resident and their attainment of competency for that level of training. Residents must demonstrate achievement of the milestones listed in the goals and objectives for each rotation, and for each year. Promotion and retention are also dependent on continued appropriate moral, ethical and professional conduct by the resident.

Quality Improvement Measures

Faculty:

Anonymous Individual faculty evaluation forms are provided to the resident annually via New Innovations. Results are tabulated and made available to the faculty member and Program Director.

Program:

Program Evaluation Forms are completed electronically via New Innovations by residents annually. The resident completes the form and the online results are received by the Residency Education Office. Evaluation statistics are summarized on a spreadsheet and summary report provided to the Program Director and Chairman. Results of program evaluation forms are utilized by the Program Director, GEC and Departmental Chairman to improve the overall training experience for residents.

Team Projects:

All residents are required to participate in annual Quality Improvement team projects.

Reporting of Adverse Events

Any adverse event or situation occurring or involving a patient under the care of a psychiatry resident must be reported immediately to the supervising attending. It will be at the discretion of the supervising physician to convene a Mortality and Morbidity (M&M) conference. The conference should not occur less than 3 working days from the event or exceed more than 10 working days after the event. The residency Program Director, Assistant residency Program Director, clinic director, supervising physician, chief residents, and resident involved in the case will all attend the M&M conference.

Resident Teaching

Incoming interns are required to participate in a Resident as Teacher One-Day Workshop. At all levels of training, residents are expected to teach those at more junior levels including medical students. Teaching effort and evaluations are used in the evaluation of residents. Teaching should not take the form of abusive pimping, but rather an honest effort to impart information, encourage a spirit of inquiry and foster an atmosphere where discovery is a valued attribute.

Residents should maintain professional boundaries with medical students while on service. Part of the resident's responsibility is to teach students in the course of caring for patients. Since the resident may participate in evaluating the student, social contact with the student outside of the hospital should be limited to group activities as long as the student is on the resident's service (e.g. no dating).

Supervision

Individual Supervision:

The rotation attending provides the interns with individual supervision and mentoring. PGY2 residents in the Outpatient Clinic are assigned 2 individual psychotherapy supervisors at specific times that will not interfere with their clinic schedules. Upper level residents are given more independence in arranging supervision. Each PGY3 and PGY4 resident selects two faculty members to serve as their individual supervisors. It is the resident's responsibility to contact their supervisors and set up weekly (1hr) meetings. Supervisors provide biannual reports to the Training office documenting supervision attendance.

At all levels of training, residents receive two hours of supervision, at least one of which is individual supervision, from designated faculty, per ACGME Psychiatry RRC requirements. Weekly supervision is not required during PGY1 off-service rotations such as Neurology and Medicine.

A supervision log will be required to be reviewed during semi-annual evaluations. Residents and supervisors must sign and date the supervision logs at each session (including group therapy supervision) to document regular attendance.

Individual supervision shall meet the following training objectives:

1. To provide a mentoring relationship that nurtures academic growth and development throughout training
2. To review clinical psychotherapy cases and augment didactics in this area
3. To provide individual counseling, monitoring, and evaluation of resident performance and achievement
4. To assist the Program Director in developing and implementing plans for remediation when necessary
5. To assist the Program Director in assessing the level of competency attained by a resident during training, with special emphasis on, but not limited to the six core competencies.

Supervision of Resident Clinical Activities:

On all clinical services attending faculty provide close supervision of all patient care. Residents should be supervised in a way that provides opportunity for the individual resident to assume increasing responsibility for patient care commensurate with their level of training, ability and experience.

USMLE Step 3 Policy

The program follows the Institutional Policy on Step 3 (see Institutional Policy). Additionally, if a resident fails Step 3 on the first attempt, that resident will be asked to take a preparatory course at the resident's own expense. Any required leave will be determined at the discretion of the Program Director. In general, any unused educational days may be used. If further leave is required, vacation days will be used. Step 3 and the resident's overall academic standing will be considered by the program's Academic Standards Committee in determining subsequent year contracts.

Residents who wish to transfer to the program from another accredited training program or who have otherwise had significant gaps in training will be required to provide a passing Step 3 score in order to be considered for any open positions in the training program.

Florida Medical License Reimbursement

Residents are strongly encouraged to obtain licensure in the state of Florida by the end of their PG-2 year of training. The department will provide reimbursement for the cost of the initial medical license application expense AFTER the license has been issued PROVIDED:

- For US Graduates, applications must be submitted before the end of December of the PGY-2 and processed by the end of March of PGY-2.
- For International Medical Graduates, applications must be submitted before the end of June in the PGY-2 and processed by the end of September of PGY-3.

NOTE – An appeal may be made for licenses not processed within the deadline due to extenuating circumstances out of the resident's control.

Resources

Counseling and Support Services:

<https://gme.sites.medinfo.ufl.edu/files/2011/12/Counseling-and-Support-Services-1.pdf>

Dental Care

GATOR DENTAL CARE

<http://adminaffairs.med.ufl.edu/fringe-benefits/housestaff-benefits/>

UF Resident's Priority Program

- Your first appointment includes a screening and a referral if
- necessary; we will try to schedule a cleaning at the same
- time if possible.

- Contact us via email: priority@dental.ufl.edu; send us your name and the best number for daytime contact.
- We'll respond within one business day; schedule first appointment within two weeks.
- Emergency appointments scheduled within 24 hours.
- Professional discount in our Faculty Practice and some graduate clinics.
- This program is also available for your spouse and your dependents.

Call 273-7846, For children, call our pediatric dental center at 273-7643

Housestaff Affairs Office

The Housestaff Affairs Office was developed to provide an ombudsman role for all housestaff physicians who are rotating through Shands Hospital at the University of Florida in Gainesville. Moving into a new city and a new part of the country in a new job can bring on many questions and concerns. This office was established to support the housestaff in a variety of these areas as well as provide support for residents within the hospital environment, overseeing such requirements as sleep room facilities, access to counseling services and facilitating problems that arise within the housestaff. The office is located on the 6th floor of Shands Hospital and the telephone number is 265-0787.

Housestaff Exercise Room

Shands Hospital and the University of Florida have developed an exercise room specifically for housestaff. It is located on the 6th floor (6238) and has a variety of options for working out. The equipment in this area was chosen to support the mental and physical well-being of residents. Aerobic stair steppers, wind and friction resistant bicycles and a universal gym encompass an array of opportunities for housestaff to release energy and stress as well as develop a personal fitness program.

Housestaff Lounge

A lounge, located on the 6th floor of Shands North Tower, was established by Shands Hospital and the University of Florida specifically for housestaff physicians. Location and the current door lock combination can be obtained from your chief resident or through the Housestaff Affairs Office personnel.

Housing

The Housestaff Affairs Office provides resources for housing for incoming residents and fellows by making available a listing of homes, condos, etc. which the completing residents and fellows are selling.

Library

The University of Florida maintains a full-service medical library located on the first floor of the Communicore Building.

Loan deferment

Housestaff Affairs Office handles all loan deferments and forbearance forms.

Loans

The University of Florida Alumni has an interest free loan for unplanned emergency situations available to residents and fellows. The forms for this loan are available in the Housestaff Affairs Office.

Medline/Computers/Information Resources

Shands Hospital has placed a computer in the Housestaff Lounge on the sixth floor of Shands Hospital. This computer has EPIC, Citrix, Aidsline, Medline, Foxline, AMA FREIDA, etc. available for residents and fellows in the College of Medicine to use. The Medical Center Library has an Informatics Lab available for residents and fellows in the College of Medicine. There are several computers available in the SpringHill Medical Office Building. Residents also have access to computers in all essential clinical sites

Resident Assistance Program

<http://gme.med.ufl.edu/contact-us/insurance-benefits-health-life-disability-etc/resident-assistance-program/>

Social Events

Graduation Reception

In honor of the graduating general psychiatry residents, this event is usually held in June. All residents, fellows and faculty members are invited to attend.

Incoming Resident Dinner

An annual dinner is held in honor of all the new residents in the Department of Psychiatry during Orientation at the Program Director's home. All residents are invited

Holiday Reception

A Departmental reception is held for all the Department faculty, residents and staff; this usually is held early in the month of December.

Psychiatry Movie Night

Occasionally, at various faculty member's homes.

Book Money, Travel

Book Allowance

Residents receive a \$200 book allowance each year, which can be used for the purchase of books or journals. All purchases are to be made by the resident and receipts are turned in to the Department Fiscal office for reimbursement.

Department Sponsored Membership APA

Annual Membership Dues are paid by the department

Travel

There are appropriate opportunities for residents to travel to meetings. These include attendance at educational seminars and presentation of original data in a peer review program. However, funds are limited and the residents' primary responsibility is to the educational and clinical requirements of the program. The following guidelines are the policy of the Department:

- The Program Director and Chairman, as well as the immediate service supervisor must approve resident travel to all meetings.
- Residents are allowed to travel to one meeting during their four (4) years that will be supported by the Department during their PGY-3 or higher. This includes a meeting where the resident presents data. The department will support the resident up to \$400 in trip expenses on a reimbursement basis in lieu of annual book allowance for that year. In general, total time away from Gainesville should not exceed five (5) days unless otherwise approved by the Program Director.

- Residents may travel to other meetings in addition to their one guaranteed meeting to present data in peer reviewed programs. Prior to submission of abstracts, the resident must obtain approval from the faculty member with whom they have worked and also the approval of the Program Director and Chairman. The resident should know the source of funding for travel prior to the submission of the abstract. In the absence of funding, the resident will be financially responsible. Every effort should be made to have travel funded by other than departmental sources. Travel time should be the minimal amount of time necessary to present the paper. Residents who travel to meetings must also have the approval of the service chief of the rotation to which they are assigned, and the Program Director.

USEFUL INFORMATION

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION/RESIDENT REVIEW COMMITTEE (ACGME/RRC)

Training programs in this country are accredited by the Accreditation Council for Graduate Medical Education and the Residency Review Committees of each specialty. The ACGME is a voluntary organization made up of representatives of the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, and the Council of Medical Specialty Societies. The ACGME establishes institutional requirements for those entities that sponsor training programs. In Gainesville the sponsoring institution is the University of Florida. Each specialty that offers certification also has an RRC made up of representatives of the major specialty societies of that specialty. For Psychiatry, they are the American Board of Psychiatry and Neurology, the American College of Psychiatrists, The American Association of Directors of Psychiatry Residency Training, The American Psychiatric Association and the AMA Council on Medical Education. The RRC establishes the program requirements for psychiatric education and periodically reviews programs. Our program was last reviewed in April, 2006, and received continued full accreditation. A copy of the full text of the institutional and specialty requirements can be found in the residency training office. Residents and faculty are encouraged to read these documents.

AMERICAN BOARD of PSYCHIATRY and NEUROLOGY -www.abpn.org

Mission and Goals

Mission and History

The mission of the American Board of Psychiatry and Neurology, Inc. is to develop and provide valid and reliable procedures for certifications and maintenance of certification in psychiatry and neurology by:

- Communicating and collaborating effectively with training programs, residents, candidates, diplomates, professional organizations, and the public;
- Applying the best technologies and information available to collect and analyze pertinent data;
- Developing the best testing methods to evaluate candidate and diplomate competencies; and
- Operating programs and services efficiently.
-

Methods for achieving that goal include (but are not limited to) efforts to:

1. Describe, in terms of knowledge and skills, a physician with special expertise in evaluation, diagnosis, and treatment of patients with psychiatric and/or neurologic disorders or who require psychiatric and/or neurologic assessment.
2. Set the standards for knowledge and skills required for certification.
3. Construct and administer examinations designed to evaluate required knowledge and skills.
4. Monitor, evaluate, and improve the standards and procedures of the certification process.
5. Participate in the appropriate Residency Review Committees of the Accreditation Council for Graduate Medical Education (ACGME) to set standards for the quality and scope of residency training programs to ensure that their graduates will obtain necessary training credit toward certification.
6. Issue certificates and other forms of recognition to successful candidates.
7. Make lists available of diplomates who have fulfilled the requirements for certification.

8. Inform the public, other professions, and other medical organizations of the purposes, activities, and responsibilities of the Corporation.
9. Participate in the activities of the American Board of Medical Specialties (ABMS) and its member Boards.

GME Policies and Procedures 2016

<http://gme.med.ufl.edu/policy-procedures/gme-policies-and-procedures/> (right-click to open hyperlink)

Graduate Medical Education Policies & Procedures:

- [Annual Letter to the OMS 2013](#)
 - [Housestaff and Faculty Accomplishments](#)
- [Annual Institutional Review – Calendar Year 2014](#)
 - [2014 ACGME Clinical Learning Environment Review Full Report to UF Health Shands Hospital](#)

HR Policies:

- [Accommodation for Disabilities](#)
- [Extra Duty Policy](#)
- [Extra Duty Form](#)
 - [Extra-Duty-Policy-Form-H1-B-and-J-1\(PDF\)](#)
- [Faculty and Resident Schedules](#)
- [Graduate Medical Education Administration](#)
- [Health-Requirements](#)
- [Housestaff Benefits](#)
- [Housestaff – Faculty Fatigue](#)
- [Housestaff Leave Policy](#)
- [Housestaff – Mistreatment-Policy](#)
- [Impaired Physician](#)
- [Program Policies](#)
- [Sexual Harassment](#)
 - [Sexual Harassment – Attachment](#)
- [Social Networking](#)
- [Procedure for Grievance Suspension Nonrenewal or Dismissal](#)

ACGME and Institutional Policies/Requirements:

- [Annual Review of Institutional Policies](#)
- [Appointment of Fellows and Other Learners](#)

- [Approval for Starting New GME Programs and Attachment](#)
- [Clinical Competency Committee](#)
- [Communication with Medical Staff](#)
- [Communication with Program Directors](#)
- [Correspondence between Programs and ACGME](#)
- [Duty Hours](#)
- [Eligibility and Selection of Residents](#)
- [Evaluations](#)
- [Institutional Program Review Committee](#)
- [Institutional Sponsorship](#)
 - [Institutional Statement of Commitment](#)
- [Medical Licensure-Registration](#)
- [Promotion of Residents](#)

UF Health Policies:

- [Ebola Patients and Housestaff Policy](#)
- [EBOLA RESPONSE PLAN](#)
- [TAB B\(UF Health Shands Hospital Notification Call Tree\)](#)
- [Personal Appearance and Dress](#)

Other:

- [Counseling and Support Services](#)
- [Critical Care Training Programs](#)
- [Disaster Policy](#)
- [National Resident Matching Program Participation](#)
- [Notification to Applicants Invited to Interview](#)
- [Pain Medicine Training Program-Educational Resources](#)
- [Program Documentation Policy – NI Requirement](#)
- [Quality Improvement Education and Activities](#)
- [Records Retention](#)
- [Request for New FTE-Changes in Resident Complement](#)
 - [Request for New FTE-Changes in Resident Complement Attachment](#)
- [Request Not to Participate in Care](#)

- [Residency Closure and Reduction](#)
- [Residency Training-Guidelines for Technical Standards](#)
- [Resident Contract](#)
- [Resident Curriculum add RAsT](#)
- [Resident Participation in Root Cause Analyses Policy \(RCA\)](#)
- [Resident Prescription Writing Policy](#)
- [Resident Responsibility](#)
- [Resident Transferring into Program](#)
- [Restrictive Covenant](#)
- [Supervision of Residents](#)
- [Transitions in Care Policy](#)
- [Vendor Interactions](#)
 - [Vendor Interactions Attachment 1](#)
 - [Vendor Relationships – 119-11 Business Relationships between Staff and Pharmaceutical Representatives](#)
- [Work Environment](#)

These policies are reviewed annually by the Graduate Medical Education Committee during the month of December.

**LETTER OF OFFER TO
RESIDENTS OF THE
UNIVERSITY OF FLORIDA
COLLEGE OF MEDICINE**

DATE

Dear **Dr. NAME**

The College of Medicine, University of Florida (hereinafter "the University") is pleased to offer you a position as a resident or fellow at the program level PGY-2 in the graduate medical education program, General Psychiatry, in the Department of Psychiatry.

This contract describes various aspects of the graduate medical education programs for residents and fellows at the University. Trainees in such programs (residents and fellows) are hereinafter referred to as "residents." The University reserves the right to make changes without notice in the future to any aspect of these programs.

During your residency you will be required to exhibit the qualifications and talents for the specialty to which you have been accepted for graduate medical education training. For each specialty, you must possess and demonstrate critical thinking skills, sound judgment, emotional stability and maturity, empathy for others, physical and mental stamina, and the ability to learn and function in a variety of settings. You must also be able to perform the essential functions of the specialty and meet the academic standards of the curriculum.

This contract is contingent upon the completeness and accuracy of the appointment documents prepared and submitted by you. Falsification of any of the appointment documents or failure to meet eligibility requirements constitute a basis for non-appointment or termination. This contract, in conjunction with University rules, policies and procedures, governs the relationship between the University and you. This contract constitutes the entire agreement between the parties and supersedes any and all prior and contemporaneous oral or written agreements or understandings between the parties.

Resident Responsibilities:

The position of resident involves a combination of supervised, progressively more complex and independent patient evaluation, management functions and formal educational activities. Among a resident's responsibilities in a training program of the University are the following:

- 1) To meet the qualifications for resident eligibility outlined in the Essentials of Accredited Residencies in Graduate Medical Education in the AMA Graduate Medical Education Directory or the Specialty Guidelines of the American Dental Association's Council on Dental Accreditation;
- 2) To develop a personal program of self-study and professional growth with guidance from the teaching staff;
- 3) To provide safe, effective, and compassionate patient care, commensurate with the resident's level of advancement, responsibility, and competence, under the general supervision of appropriately privileged attending teaching staff;
- 4) To participate fully in the educational and scholarly activities of their program and, as required, assume responsibility for teaching and supervising other residents and students;
- 5) To participate in institutional orientation and educational programs and other activities involving the clinical staff;
- 6) To submit to the program director confidential written evaluations of the faculty and the educational experiences;
- 7) To participate on institutional committees and councils to which the resident is appointed or invited, especially those that relate to their education and/or patient care;
- 8) To adhere to established practices, procedures, and policies of the University and of those applicable from affiliated institutions.
- 9) Licensure: All residents are required to comply with state licensure requirements for physicians in training. Residents must hold before the start date of training either a valid unrestricted Florida medical or dental license or be registered with the Florida Board of Medicine/Board of Dentistry for a Training License or Dental Residency Permit. All residents will be required to obtain a National Provider Identifier (NPI) number. Failure to meet applicable eligibility requirements without delay and obtain and maintain a training license/permit or a valid unrestricted Florida license may result in one or more of the following:
 - delay or revocation of appointment
 - preclude advancement to the next program level
 - preclude continuation in the program

- disciplinary action for non-academic deficiency
- An unrestricted Florida license is not required of residents; however, should a resident obtain an unrestricted medical license in Florida, it is solely his/her responsibility to maintain active status with the Medical / Dental Board, including timely renewal and payment of all associated renewal fees.
- 10) Confidentiality: all residents have an obligation to conduct themselves in accordance with the Confidentiality policies of the University and its primary teaching hospitals, including Veterans Affairs Medical Center. Failure to follow these policies may be cause for immediate dismissal.
 - 11) Background Checks: Your acceptance and continued participation as a resident in the graduate medical education program is contingent upon the results of a criminal background check.
 - 12) OIG/GSA Checks: Your acceptance and continued participation as a resident in the graduate medical education program is contingent upon your eligibility to participate in Medicare, Medicaid, Tricare or other Federal health care programs. A check will be performed of the U.S. Department of Health and Human Services Office of Inspector General (“OIG”) list of excluded individuals and the U.S. General Service Administration (“GSA”) excluded parties’ list system as part of your appointment process. If your name appears on the OIG or GSA excluded party lists or if you are at any time excluded from participation in Medicare, Medicaid, Tricare or other Federal health care programs or are convicted of a criminal offense related to the provision of health care items or services, your participation as a resident in the graduate medical education program may be terminated immediately.
 - 13) Case Documentation: documentation of clinical experiences, cases and/or procedures is mandated by the Residency Review Committees. Residents who do not maintain accurate case documentation may not advance to the next level of training or be allowed to complete their program until compliance is achieved.
 - 14) To develop competencies in:
 - Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
 - Medical knowledge about established and evolving biomedical, clinical, and cognate sciences and the application of this knowledge to patient care
 - Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
 - Interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals
 - Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
 - Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value
 - 15) To comply with duty hours assignments consistent with patient safety, educational requirements and personal development as outlined in departmental and institutional policies.

Duration of Appointment and Conditions for Reappointment: Your initial appointment will begin on 7/1/2016 and may continue for a period of 12 total month(s). Your appointment will be processed by the University after you have accepted this official letter of offer, have met the

conditions stated, and completed applicable registration, licensure, and proof of the right to work in the United States as required by law. We anticipate you will remain in the prescribed course of your residency until completion. However, it is understood that appointments are renewed annually and that continued retention in the training program depends on your satisfactory performance/training progress, including your adherence to acceptable professional behavior, as well as the continuation of requisite funding for the program and the best interests of the program as determined by the Associate Dean. A resident's reappointment and progression to more advanced levels will be based on the results of periodic reviews of the resident's educational and professional achievement, competence and progress as determined by the program director and teaching faculty. However, no appointment shall create any rights, interests, or expectancies of continuation beyond the term of the appointment itself. At the completion of each academic year, your performance will be reviewed and the recommendations for continuation communicated to you by the Program Director or designee. Unsatisfactory progress or performance may result in probation, non-advancement, dismissal or non-renewal. The program maintains a confidential record of the evaluations. Residents may review their evaluations with their advisor, the program director, or University representative.

The primary site of your graduate medical training will be the University of Florida Health Science Center-Gainesville with its major teaching hospital and affiliates, but the location of the training for any resident may occur at various additional sites. All assignments and call schedules are made at the discretion of the appropriate program director. In addition, should residency programs be closed or downsized, the University will inform the resident well in advance of such events. Every effort will be made to complete the resident's course of training or to find another site for the resident to complete training.

Residents are not automatically entitled to additional training beyond the prescribed number of years in order to achieve board eligibility in the designated specialty. Any such extension of the residency and the required funding must be approved by the Program Director and the University's College of Medicine Associate Dean for Graduate Medical Education/Designated Institutional Official (Director of Graduate Medical Education).

Residents in all core residency training programs sponsored by the University of Florida College of Medicine Gainesville must pass the USMLE/COMLEX Level 3 examination by the completion of the PGY-2 year. Failure to pass USMLE/COMLEX Level 3 by the conclusion of the PGY-2 year may result in suspension from training without pay until USMLE/COMLEX Level 3 is successfully passed. No resident may receive a salary increase to the PGY-3 level without prior passage of USMLE/COMLEX Level 3, but may, at the discretion of the program director, be promoted to the PGY-3 level clinically. Alternatively, programs may elect to non-renew residency training contracts for residents who have not successfully completed USMLE/COMLEX Level 3 by March 1 prior to the PGY-3 year. International Medical Graduates who first enter US GME training at the fellowship level (i.e. have not completed core residency training) are exempt from this policy. Other individual exceptions to this policy may be granted only by appeal to the Designated Institutional Official.

University of Florida College of Medicine Policies and Procedures for Grievances, Suspension, Non-renewal, or Dismissal of a Resident.

The position of the resident presents the dual aspect of a student in graduate training while participating in the delivery of patient care. For purposes of this policy, the term "resident" applies residents, fellows, and adjunct clinical post-doctoral associates in training programs recognized and approved by the Graduate Medical Education Committee at the University of Florida College of Medicine. These training programs may be either ACGME Accredited Programs or non-accredited programs formally approved by the GMEC.

The University of Florida College of Medicine is committed to the maintenance of a supportive educational environment in which residents are given the opportunity to learn and grow.

Inappropriate behavior in any form in this professional setting is not permissible. A resident's continuation in the training program is dependent upon satisfactory performance as a student, including the maintenance of satisfactory professional standards in the care of patients and interactions with others on the health care team. The resident's academic evaluation will include assessment of behavioral components, including conduct that reflects poorly on professional standards, ethics, and collegiality. Disqualification of a resident as a student or as a member of the health care team from patient care duties disqualifies the resident from further continuation in the program.

Grievances: A grievance is defined as dissatisfaction when a resident believes that any decision, act or condition affecting his or her program of study is arbitrary, illegal, unjust or creates unnecessary hardship. Such grievance may concern, but is not limited to, the following: academic progress, mistreatment by any University employee or student, wrongful assessment of fees, records and registration errors, discipline (other than nonrenewal or dismissal) and discrimination because of race, national origin, gender, marital status, religion, age or disability, subject to the exception that complaints of sexual harassment will be handled in accordance with the specific published policies of the University of Florida College of Medicine.

Prior to invoking the grievance procedures described herein, the resident is strongly encouraged to discuss his or her grievance with the person(s) alleged to have caused the grievance. The discussion should be held as soon as the resident becomes aware of the act or condition that is the basis for the grievance. In addition, or alternatively, the resident may wish to present his or her grievance in writing to the person(s) alleged to have caused the grievance. In either situation, the person(s) alleged to have caused the grievance may respond orally or in writing to the resident.

If a resident decides against discussing the grievance with the person(s) alleged to have caused such, or if the resident is not satisfied with the response, he or she may present the grievance to the Chair. If, after discussion, the grievances cannot be resolved, the resident may contact the Associate Dean of Graduate Medical Education (ADGME). The ADGME will meet with the resident and will review the grievance. The decision of the ADGME will be communicated in writing to the resident and constitute the final action of the University.

Suspension: The Chief of Staff of a participating and/or affiliated hospital where the resident is assigned, the Dean, the President of the Hospital, the Chair, the Division Chief or Program Director may at any time suspend a resident from patient care responsibilities. The resident will be informed of the reasons for the suspension and will be given an opportunity to provide information in response.

The resident suspended from patient care may be assigned to other duties as determined and approved by the Chair. The resident will either be reinstated (with or without the imposition of academic probation or other conditions) or dismissal proceedings will commence by the University against the resident within thirty (30) days of the date of suspension.

Any suspension and reassignment of the resident to other duties may continue until final conclusion of the decision-making or appeal process. The resident will be afforded due process and may appeal to the ADGME for resolution, as set forth below.

Nonrenewal: In the event that the Program Director decides not to renew a resident's appointment, the resident will be provided written notice which will include a statement specifying the reason(s) for nonrenewal. This should be done at least 4 months prior to the end of the resident's current agreement.

If requested in writing by the resident, the Chair will meet with the resident; this meeting should occur within 10 working days of the written request. The resident may present relevant information regarding the proposed nonrenewal decision. The resident may be accompanied by an advisor during any meeting held pursuant to these procedures, but the advisor may not speak on behalf of the resident. If the Chair determines that nonrenewal is appropriate, he or she will use their

best efforts to present the decision in writing to the resident within 10 working days of the meeting. The resident will be informed of the right to appeal to the ADGME as described below.

Dismissal: In the event the Program Director of a training program concludes a resident should be dismissed prior to completion of the program, the Program Director will inform the Chair in writing of this decision and the reason(s) for the decision. The resident will be notified and provided a copy of the letter of proposed dismissal; and, upon request, will be provided previous evaluations, complaints, counseling, letters and other documents that relate to the decision to dismiss the resident.

If requested in writing by the resident, the Chair will meet with the resident; this meeting should occur within 10 working days of the written request. The resident may present relevant information regarding the proposed dismissal. The resident may be accompanied by an advisor during any meeting held pursuant to these procedures, but the advisor may not speak on behalf of the resident. If the Chair determines that dismissal is appropriate, he or she will use their best efforts to present the decision in writing to the resident within 10 working days of the meeting. The resident will be informed of the right to appeal to the ADGME as described below.

Appeal: If the resident appeals a decision for suspension, nonrenewal or dismissal, this appeal must be made in writing to the ADGME within 10 working days from the resident's receipt of the decision of the person suspending the resident or the Chair. Failure to file such an appeal within 10 working days will render the decision of the person suspending the resident or the Chair the final agency action of the University.

The ADGME will conduct a review of the action and may review documents or any other information relevant to the decision. The resident will be notified of the date of the meeting with the ADGME; it should occur within 15 working days of the ADGME's receipt of the appeal. The ADGME may conduct an investigation and uphold, modify or reverse the recommendation for suspension, nonrenewal or dismissal. The ADGME will notify the resident in writing of the ADGME's decision. If the decision is to uphold a suspension, the decision of the ADGME is the final agency action of the University. If the decision is to uphold the nonrenewal or dismissal, the resident may file within 10 working days a written appeal to the Dean of the College of Medicine. Failure to file such an appeal within 10 working days will render the decision of the ADGME the final action of the University.

The Dean will inform the ADGME of the appeal. The ADGME will provide the Dean a copy of the decision and accompanying documents and any other material submitted by the resident or considered in the appeal process. The Dean will use his or her best efforts to render a decision within 15 working days, but failure to do so is not grounds for reversal of the decision under appeal. The Dean will notify in writing the Chair, the ADGME, the Program Director and resident of the decision. The decision of the Dean will be the final agency action of the University. The resident will be informed of the steps necessary for the resident to further challenge the action of the University.

Financial Support and Other Benefits Stipend:

Each resident is given a stipend to pursue the resident's graduate medical education in an amount appropriate to the resident's level in the program. Stipend levels are reviewed annually by the Graduate Medical Education Committee of the College of Medicine and recommendations for changes are subject to approval by University's Dean of the College of Medicine. Stipend levels begin on July 1 of each contract year and are paid biweekly. Additionally PGY-1 residents will receive a salary stipend for all attended mandatory orientation prior to July 1 of their start date. Residents are eligible to defer up to 20 percent of income in a 403(b) plan via payroll reduction.

Living quarters, meals, laundry, and other such expenses are the resident's responsibilities. In some cases and at the discretion of the University, a meal subsidy may be issued to the resident when the resident is assigned in-house call on nights and weekends; similarly, living quarters may be provided during some rotations outside of the primary location of the program.

Health, Life and Disability Insurance, Worker's Compensation Insurance: Health insurance is provided to the resident and his/her family; life and disability insurance are provided to the resident. If a resident suffers a work-related injury, the resident is generally covered under the workers' compensation program of the University provided the resident complies with the requirements of the worker's compensation program.

FICA Alternative Plan: As a resident, you automatically will be enrolled in the University of Florida's FICA Alternative Plan. Under the provisions of this retirement plan, instead of paying 6.2 % social security taxes post-tax, you will contribute 7.5% of your pre-tax wages into an investment account in your name. The Medicare contributions at 1.45% will continue to be withheld from your biweekly paychecks and will be matched by the University of Florida. Information regarding this program is available at: <http://www.hr.ufl.edu/retirement/other/FICA.asp>

Confidential Counseling: psychological support services are available through the Resident Assistance Program. The Resident Policy and Procedure Manual provide details of coverage.

Professional Liability Coverage: Professional Liability Coverage: As a participant in a clinical graduate medical education program of the University, a resident is an employee of the University of Florida, Board of Trustees (UFBOT), and the State of Florida agency that operates the University of Florida. Under Section 768.28, Florida Statutes, residents are personally immune from civil liability for any injury or damage suffered by a patient as a result of negligence occurring while residents are acting within the course and scope of their employment. The UFBOT is responsible for any civil claims or actions arising from the negligent acts of its employees and agents, including residents in University graduate medical programs.

The University of Florida J. Hillis Miller Health Center/Gainesville Self-Insurance Program (SIP), a self-insurance program established by the Florida Board of Governors pursuant to Florida Statutes Section 1004.24, provides professional liability protection to the UFBOT and Shands Gainesville Medical Center, Inc. (SGMC), for incidents in which patients suffer bodily injury, personal injury, or property damage caused by the negligence of UFBOT residents.

SIP also affords residents professional liability protection when residents act in the role of a "Good Samaritan", when involved in community service work that has been pre-approved by the University, and when serving on a University educational assignment outside of Florida. In light of the benefits of immunity provided by law, residents, while performing their duties must identify themselves at all times as UFBOT employees. Accordingly, residents must wear the University ID badge at all times while participating in the graduate medical education program.

Institutional Leave Policy: A comprehensive leave policy is outlined in the Resident Policy & Procedure Manual and includes uncompensated leave, compensated leave, temporary military duty, absences pertaining to education and training, and maternity/paternity leave. Subject to the approval of the program director and consistent with the guidelines of the appropriate specialty board, all residents accrue fifteen (15) days of annual leave. Residents may be permitted to carry over unused annual leave to a new year, as consistent with the academic departmental policy of the University; however, such carry-over must be approved by the program director and annual leave accrued may not exceed twenty-five

(25) workdays. Unused annual leave is considered non-reimbursable. Residents taking a non-medical leave of absence from the training program are not automatically guaranteed re-entry into the training program.

A resident will accrue ten (10) days of sick leave for each full year of completed participation in the program. The resident will be entitled to utilize sick leave for death, or in special cases, serious illness in the immediate family (spouse, parents, brothers, sisters, children, grandparents, and grandchildren of both resident and spouse). Sick leave may be advanced to housestaff proportionate to expected service. Housestaff may be permitted to carry over sick leave to a new

year, as consistent with department policy; however, carryover must be approved by the program director and cannot be more than of fifteen days (15) work days. All unused leave is considered non-payable leave, and there is no entitlement for lump-sum payment of unused leave upon separation of or completion of training.

The total time allowed away from a graduate medical education program in any given year or for the duration of the graduate medical education program will be determined by the requirements of the specialty board involved. If leave time is taken beyond what is allowed by the University or the applicable specialty board, the resident is required to extend his or her period of activity in the graduate medical training program accordingly in order to fulfill the appropriate specialty board requirements for the particular discipline. The resident will be paid for makeup or extended time if funds are available at that time.

Medical Requirements: Prior to your appointment as a resident, you are required to complete a University pre-employment health screening questionnaire. In addition, screening of the resident for infectious diseases, prophylaxis/treatment for exposure to communicable disease, and immunizations will be provided by the University or through arrangements with other health providers. The resident will have documentation of immunity to measles, mumps, hepatitis B, rubella and varicella (chicken pox); the resident will be required to have periodic tuberculosis skin tests. The resident must comply with the infection control policies and procedures of the institutions where the resident is assigned. A resident must meet the technical standards set by the College of Medicine and his/her respective program.

Americans With Disabilities Act: The University of Florida, under the guidelines of ADA and 504 federal legislations, is required to make reasonable accommodations to the known physical and mental limitations of otherwise qualified individuals with disabilities. For assistance contact the UF ADA Office at 392-7056 or 711 (Tdd/TTY).

Policies Regarding Sexual Harassment: Complaints of sexual harassment will be handled in accordance with the specific published policies of the University of Florida and the College of Medicine (as contained in the Resident Policy & Procedure Manual).

Physician Impairment and Substance Abuse: The University of Florida is a Drug Free Workplace. Violations can result in disciplinary action up to and including termination. Residents will be required to undergo and pass Drug Toxicology screening within their first year of training at University of Florida. In addition, random drug testing maybe required during training at the University of Florida. A violation may also be reason for evaluation and treatment of a drug and/or alcohol disorder or referral for prosecution. In addition to any disciplinary action, residents identified as such will be referred to the Professionals Resource Network (PRN). The Florida Medical Practice Act (F.S. 458) rule calls for all licensed practitioners to report to the appropriate authority any reasonable suspicion that a practitioner is impaired to practice. The legislation provides for therapeutic intervention through the Professionals Resource Network (PRN). This organization works closely with the State Board of Medicine and is recognized as the primary method of dealing with physician impairment in the state. Faculty, staff, peers, family or other individuals who suspect that a resident is suffering from a psychological or substance abuse problem are obliged to report such problems. Reporting can be directly to the PRN or to the program director, Chairman, or Associate Dean for Graduate Medical Education. Residents suspected of impairment will be relieved of all patient care responsibilities. Early involvement of the PRN is essential. All referrals are confidential. If the PRN feels intervention is necessary, they handle the situation and provide for treatment and follow-up. Residents can only return to clinical duties with the approval of the PRN. Re-entry into the Program is not automatic. The PRN maintains contact with the program directors about residents in the program of recovery.

The University makes available a Resident Assistance Program to its residents. The University also provides an educational program for residents regarding physician impairment, including substance abuse.

Disclaimer or Resident Assertions; Invention and Copyright Agreement: The resident agrees that unless approved by the University's Chair, all materials compiled or published by the resident relative to training and experiences received at the University and its affiliated hospitals, or arising from participation in training, patient care, or research pursuant to this agreement, will clearly state that the opinions or assertions contained therein are those of the resident and not those of the University. Pursuant to the University's rules, the resident must execute the University's Invention and Copyright Agreement.

Outside Professional Activities: All programs have established rules regarding outside and extracurricular activities that meet their RRC requirements and University policy. A prospective, written statement of permission from the program director and University's Associate Dean for Graduate Medical Education is required and is made part of a resident's file. Resident performance is monitored for the effect of these activities and adverse effects may lead to withdrawal of permission.

Programmatic activities are initiated by departments to provide clinical experiences which often are not afforded within the standard curriculum and which usually occur at non-campus health care affiliates. Supplemental compensation is provided by the University to residents who participate in programmatic activities.

Non-programmatic activities are initiated by the resident and do not involve any agreement between the University and the outside employer. Individual programs have total authority to decide whether non-programmatic activities are allowed in keeping with their Residency Review Committee guidelines and curriculum.

Residents are not required to engage in outside professional activities. The resident is referred to both the departmental policy for Outside Professional Activities and the complete policy on Outside Professional Activities set forth in the Resident Policy & Procedure Manual.

Certificate of Completion: A certificate of graduate medical training will be issued to a resident on the recommendation of the University's appropriate Chair and Program Director only after satisfactory completion of service and educational requirements and fulfillment of all other obligations and debts. Access to information about Board eligibility and examinations may be found at:<http://msquared.anest.ufl.edu/UFACGMEAccreditedPrograms-BoardCertificationInformation.html>

Medicaid Credit Balance: Your signature below affirms that you have diligently inquired and to your knowledge you have no outstanding Florida Medicaid credit balances that you incurred prior to your employment with the University of Florida that would in any way bar or delay Florida Medicaid reimbursement for your services rendered with the University of Florida. If any such credit balances are revealed at anytime and results in the University of Florida being unable to collect from Florida Medicaid reimbursement for services you render on behalf of the University of Florida, you will be considered to have failed to effectively maintain eligibility with that program, which is a condition of your employment. Should such an event occur and should you fail to promptly resolve the credit balance issue to the satisfaction of the University of Florida, you will be subject to immediate termination of your employment with the University of Florida. The Medicaid claim department is available to provide assistance to you (800-289-7799).

Federal Levy Program: The Taxpayer Relief Act of 1997, Section 1024, authorized the Centers for Medicare & Medicaid Services (CMS) to reduce certain federal payment, including Medicare and Medicaid payments, in order to allow collection of an employee's overdue federal debts. Please be aware that if any such overdue federal debts are revealed at any time during your employment with the University of Florida resulting in the university being unable to collect Medicare or Medicaid reimbursement for your services, you will be considered to have failed to effectively maintain

eligibility with that program, which is a condition of your employment. Should such an event occur and should you fail to promptly resolve the personal overdue debt issue to the satisfaction of the University of Florida, you will be subject to immediate termination of your employment with the University of Florida.

HIPAA Statement: All University of Florida Health Science Center employees are required to sign a statement agreeing to maintain the confidentiality of protected health information. Enclosed is a copy of the University of Florida's confidentiality statement. Please read, sign and return the confidentiality statement to me. All University of Florida Health Science center employees also are required to complete specialized training regarding privacy and security that involves HIPAA general awareness and Principal Investigator training, as applicable. Arrangements will be made to assist you with accessing this on-line training following your arrival at the university. Please be aware that all Health Science Center employees are required annually to re-sign the confidentiality statement and to complete on the on-line privacy and security training.

Employment Eligibility: This offer and your active employment status are contingent upon your eligibility to work under the provisions of all applicable immigration laws and regulations including the Immigration Reform and Control Act of 1986, as amended, and you're providing the necessary documents to establish identity and employment eligibility to satisfactorily complete U.S. Citizenship and Immigration Services' Form I-9. As a federal contractor, the University of Florida also participates in E-Verify, the federal on-line verification system. To comply with these requirements, on or before your first day of employment, you must complete Section 1 or Form I-9. Additionally, you must present documents that verify your identity and work authorization within the first three business days of your start date. Should you fail to provide the appropriate documentation by the end of the third business day as required by law; your appointment will be terminated until you can provide such documentation.

A list of acceptable documents to establish identity and employment eligibility can be found online at <http://adminaffairs.med.ufl.edu/files/2012/05/List-Accept-Doc.pdf>

Vero Rotations: Residents will participate in a one-month rotation at the Vero Beach facility in Vero Beach.

Sincerely,

Jacqueline A. Hobbs, MD, PhD, FAPA
Associate Professor & Program Director
Department of Psychiatry

Regina Bussing MD
Professor and Chair
Department of Psychiatry

Accepted:

TOP 10 Laws and Rules Every Physician Should Know

The following information is being provided as a resource to remind you of important laws and rules that affect your medical practice. It is still your responsibility to read and become familiar with the laws and rules of the State of Florida.

Law and/or Rule with cite	Description
<p>1. You must update your Practitioner Profile within <u>15</u> days</p> <p>s. 456.042, F.S.</p>	<p>This includes changes in –</p> <ul style="list-style-type: none"> • Address • Staff privileges • Medical malpractice history • Financial responsibility • Board certification • Education • Disciplinary/criminal history
<p>2. Before you move to a new practice, notify the Board</p> <p>s. 456.035, F.S.; s. 458.319(3), F.S.; s. 458.327(2)(e), F.S.</p>	<p>No current address on file? Here is what can happen:</p> <ul style="list-style-type: none"> • crisis at renewal time • late renewal may mean practicing on an inactive license • practice on inactive license = criminal offense
<p>3. Do not pre-sign prescriptions</p> <p>s. 458.331(1)(aa), F.S.</p>	<p>Board of Medicine Disciplinary Guidelines provide a maximum penalty of -</p> <ul style="list-style-type: none"> • Reprimand • \$5,000 fine • 2 years probation
<p>4. At license renewal, read the fine print before you renew</p> <p>s. 458.319, F.S.</p>	<ul style="list-style-type: none"> • It is your license on the line, not your office manager's! • CME and Financial Responsibility requirements are audited • Maintain copies of your CME certificates for at least 2 biennium • DIDN'T RECEIVE YOUR RENEWAL POSTCARD? Call (850) 488-0595 extension #3 • RENEW ONLINE at www.doh.state.fl.us/mqaservices • The Preventing of Medical Errors course has specific requirements including a study of root cause analysis, error reduction, prevention and patient safety, and the 5 most mis-diagnosed medical conditions in Florida during the previous biennium and those conditions are: <ul style="list-style-type: none"> • cancer • cardiac • acute abdomen • timely diagnosis of surgical complications • stroke and related cranial conditions • CME providers may be located on the Internet by typing

	<p>“continuing medical education” in the search field, or by contacting the American Medical Association at (312) 464-4952.</p>
<p>5. You must keep charts on the family, employees and friends that you treat</p> <p>s. 458.331(1)(r), F.S. and s. 458.331(1)(m), F.S.</p>	<ul style="list-style-type: none"> • A prescription creates the physician/patient relationship • Records are required even for family • Spouses/friends may become adverse parties • Cannot self-prescribe controlled substances
<p>6. Patient Boundaries</p> <p>S. 458.329, F.S. and s. 458.331(1)(j), F.S.</p>	<p>Board of Medicine has a zero tolerance policy on physician/patient sexual misconduct</p> <ul style="list-style-type: none"> • Typical penalty is suspension/revocation • Remember: A prescription creates a physician/patient relationship
<p>7. Pause before you make the incision on the correct site of the correct patient</p> <p>s. 458.331(1)(t), F.S.; s. 456.072, F.S.; and Rule 64B8-9.007, F.A.C.</p>	<ul style="list-style-type: none"> • The “pause” before the procedure must be in the patient chart • If you make the mistake, inform the patient and/or the patient’s representative and document it or the Board will increase the penalty. • Read the rule at 64B8-9.007 Standards of Practice.
<p>8. Internet Prescribing</p> <p>s. 458.331(1)(t), F.S. and Rule 64B8-9.014, FAC</p>	<ul style="list-style-type: none"> • Prescribing without a history and physical is both a standard of care violation and a violation of Board rule • Physician have been disciplined for this with penalties ranging from revocation to suspension, reprimands and fines • DO NOT JEOPARDIZE YOUR LICENSE – DON’T PRESCRIBE ON THE INTERNET!
<p>9. Relocating Practice?</p> <p>Rule 64B8-10.002, FAC</p>	<p>You are responsible to:</p> <ul style="list-style-type: none"> • hold patient records for 5 years • notify patients in letters or by sign as to where to pick up records • place a notice in newspapers and notify the Board of Medicine 30 days <u>before</u> you move • complete your hospital charts if leaving the area!
<p>10. Help for impaired practitioners</p> <p>s. 456.076, F.S.</p>	<p>Do you know a colleague with drug, alcohol, or psychiatric problems?</p> <ul style="list-style-type: none"> • You can get them help without subjecting them to disciplinary action • The Board has an excellent evaluation and rehabilitation program that is a phone call away: Professional Resource Network (PRN) – 1-800-888-8776 • For most practitioners, this is and remains a confidential process that offers help to those willing to change • This program was recently expanded to include medical students as well

Want the details on these Top 10? Accessing the laws and Rules

Laws: <http://www.leg.state.fl.us/statutes/index.cfm>

s. 458, Florida Statutes – Medical Practice Act

s. 456, Florida Statutes – General Provisions Applicable to All Health Care Practitioners

Rules: <https://www.flrules.org/Default.asp>

Chapter 64B8, Florida Administrative Code

Contact Information

Psychiatry Residency Training Office

The Psychiatry Residency Training Office is located in the Springhill Medical Office Building Adult Outpatient Clinic. The Education Program Coordinator and Program Coordinator provide support for all Psychiatry residents, including day to day activities such as pagers, call schedules, vacations, pay issues, lab coats, loan deferments, applications for licensure, etc., and are in general the point of first contact for Psychiatry Residents. The Program Office handles applications and coordinates interviews for fourth year medical students who are applying for general psychiatry at the University of Florida.

Psychiatry Office Contact Information:

Program Director:

Jacqueline A. Hobbs, MD, PhD, DFAPA Associate Professor

Vice Chair for Education

Director, Residency Training Program

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Associate Program Director:

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