Child Psychiatry Policy Manual

Program Policies Statement
These policies have been developed specifically for the Child Psychiatry program at
the University of Utah. Changes in these policies are reviewed, discussed, and
approved by the Residency Training Committee (RTC).

Any situations that arise, which are not covered by our program policies, are
covered in the University of Utah Graduate Medical Education Policies. The
University of Utah GME policies are the foundation we work from, with our program
policies providing more detail specific to our program, and individual program
requirements. All of our policies are in accord with the ACGME Competency
requirements for our residents.

Doug Gray, MD
Training Director

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Standards of Performance Policy

The Child Psychiatry Subspecialty Residency Program involves a comprehensive education in Child and Adolescent Psychiatry over a two-year program. Residents gradually take on more and more responsibility and autonomy throughout the program. For example, in the first year of the program, the training is heavily weighted towards experiences with teams on inpatient or residential psychiatry. In this way, the residents can be exposed to good role models, a teamwork approach, and can receive frequent and close supervision as they learn the practice of Child and Adolescent Psychiatry. By the second year of the program, the residents are working in a number of subspecialty areas where they have to assume more autonomy. These are, for the most part, outpatient rotations. The residents also have their own outpatient clinic where they see their own patients and create their own practice. The scope of outpatient training includes psychopharmacology, individual therapy, family therapy, and case management. Each case is presented by the resident to an attending, who signs the evaluation and treatment plan. It is the resident’s responsibility to present ongoing cases to the attending when there are questions or concerns, management issues, or when the patient is not making significant progress.

As residents enter the second year of training, there are opportunities for them to branch out into administrative roles, to spend time doing research, or to branch out clinically into an area of expertise. Each resident is asked to develop an area of expertise, and at minimum, be prepared to present their knowledge in a formal setting, such as Grand Rounds. In this way, not only do our residents finish the program with a very solid knowledge base of Child and Adolescent Psychiatry, but they also have the sense of how expertise can be developed in a very specialized area. Some of the clinical experiences in the second year, such as seeing emotionally disturbed preschoolers at The Children's Center, or working at the University Autism Program, will expose second-year residents to the life of child and adolescent sub-specialists, so they can explore career possibilities, separate from general Child and Adolescent Psychiatry.

The Child Psychiatry Program includes multiple evaluation methods. These are outlined in the Resident Evaluation Policy. Although there are many ways to measure the progress of our residents, the primary focus is on evaluations from each clinical rotation. The six competencies developed by the Accreditation Council for Graduate Medical Education (ACGME) have been integrated into the training program, and into the evaluations of our residents. Faculty supervision is documented at monthly meeting between the residents and Training Director. Starting in 2007, psychotherapy supervisors for each rotation will complete an Evaluation of General Psychotherapy Skills for each resident (see the Resident Evaluation Policy for a detailed look at all of the measures we use to evaluate our residents). While we have many ways to measure the competency of each resident, which gives us a comprehensive view, the evaluation of competency by the primary supervisor on each clinical rotation remains the gold standard.
As with any resident training program, residents are expected to carry their pagers while on duty, and to respond to pages promptly. Residents are expected to attend lectures, on time, and to come ready to participate. While the minimum attendance at lectures/seminars is 75%, residents should try to attend 100% of the time. (Wednesday afternoons, residents are excused from all clinical duties to allow full attendance.) Residents must be prepared to present when readings have been assigned. Each resident is expected to evaluate the training program, using rating forms for attendings and training sites, for each clinical rotation. Residents must take In Training exams and mock boards, as scheduled by the program, unless excused by the Training Director. Residents must give a Grand Rounds presentation prior to graduation, and this presentation must reflect substantial progress in developing expertise in an area of Child Psychiatry. Residents are expected to treat each patient and their family in a thoughtful and respectful manner. Residents must work within the practice style of their supervising attending, and any conflicts should be discussed with the supervisor and, when necessary, with the Training Director. During the two-year training program, residents are expected to make continuous progress and to gain the trust of the faculty so they can be given more autonomy and responsibility. Mock oral boards are given every six months. Residents are expected to demonstrate improvement in skills as they take these exams during the two years of training, and should be able to pass a mock board exam by the time of graduation. The Child PRITE exam is a measure of the resident’s fund of information. Residents are expected to be near the national median or above, and to maintain their status the second year as their comparison group becomes more competitive. Residents who have difficulty with written exams will be asked to develop a specific study plan. During their senior year at the outpatient clinic rotation, office staff will administer a patient satisfaction survey, typically filled out by the patient and their parents. These surveys are summarized by the clinic administrator in a letter placed in the resident’s file. Starting in July of 2006, residents are required to have a 360 degree evaluation for each year of training, completed at a core training site.

Residents meet with the Training Director to review their progress twice a year. The goal of the program is to make sure that every resident has a sufficient fund of knowledge and ability to practice general Child and Adolescent Psychiatry, but at the same time, expose them to subspecialty areas, administration, and research, so they can develop individual careers.

Last revised 5/14/09

Evaluation Policy

1) Clinical Evaluation of each resident on each rotation, using a format which addresses the Competencies as outlined by the ACGME (last revised 2002)
2) Psychotherapy Evaluation of General Psychotherapy Skills, to be completed by psychotherapy supervisors on each clinical rotation (Start date: January, 2007)

3) Resident Log (monthly) of Child and Adolescent Psychotherapy Experience (Start date: July 2006)

4) Resident Log (monthly) to document two hours of individual supervision per week (Start date: January, 2006)

5) Mock Oral Board Examinations, by Division Faculty. These are scheduled every six months for residents in child psychiatry, and for triple board residents during six month blocks where they are rotating on child psychiatry (Since 1999)

6) Child Psychiatry Resident In-Training Examination (Child-PRITE), yearly in December, for all child psychiatry residents. Triple board residents take the Child-PRITE during their second year and fifth year of training. (Since 1999)

7) Psychiatry Resident In Training Examination (PRITE), yearly for the residents of both programs, in October (Since 1999)

8) Documented Attendance at lectures and seminars. There is the expectation of residents attending all lectures, with 75% as the minimum, dependent upon circumstances. (Since 1999)

9) Individual Meeting with the Training Director every six months, which includes the development of "Expertise" in a specific area of interest, and a review of the Competency Measures (Since 1999)

10) 360 Degree Evaluation by staff and peers.
   - Behavioral Health Clinic (Since July, 2005)
   - UNI Inpatient rotation (Since July, 2006)

Measures of Competency for senior residents only

11) Survey of Clinical Experience. Training Director reviews the resident’s assessment of his/her clinical experience and develops a plan to enhance the clinical exposure for the resident, and to improve the program overall (Since 2004)

12) Patient Satisfaction Survey, Behavioral Health Clinic (Since 2005)
A patient satisfaction survey is given to the patients/parents seen by each resident at the Behavioral Health Clinic. These surveys are entered into a database. Results are given to the resident in the form of a letter from the Office Manager, and placed in the resident's file.

13) Senior Grand Rounds Presentation (Since 2002)
Assessment (Since 2007) of presentation by the Training Director, along with a copy of the presentation placed in the file.

Measures of Competency used for triple board residents only
14) Evaluations from Pediatrics and General Psychiatry, meetings with the Training Directors from those two disciplines, and the Pediatrics In Training Examination, yearly in July.

Documents Related to Core Competencies

Curriculum Document:

This document was revised years ago to include objectives relating to knowledge, skills, and attitudes. In 2007 it was revised again to reflect the relationship between the ACGME core competencies and each clinical rotation & seminar.

Core Competencies in Child and Adolescent Psychiatry:

This document was developed at resident retreats over the course of the 2005-2006 year. It was revised in July 2007. It covers the competencies in great detail, referencing each element to specific rotations, seminars, or experiences available during training.

Core Competence - Medical Knowledge:

This document is organized by broad topics in child psychiatry, such as "Development" and "Substance Abuse", and is formatted to describe the knowledge, skills, and attitudes needed to develop medical knowledge in each of these areas, as well as specific training experience providing the necessary knowledge.

Six Competencies:

- Patient Care
- Medical Knowledge
- Practice Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- System Based Practice

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Supervision Policy

1. Each training site has a full-time or adjunct faculty member who coordinates the training at that location. This training site supervisor directs the education of the residents who spend time at that training site.

2. The training site supervisor provides clinical supervision for residents or delegates this responsibility to other clinical supervisors at the training site. These
supervisors are either on the volunteer or full-time faculty, or are in the process of joining the volunteer faculty.

3. The clinical supervisor is responsible for the care of the patients who are seen by the resident. They are responsible for providing supervision for the residents so the resident can provide safe and responsible care for their patients.

4. The degree of supervision changes over time to reflect the professional development of our residents.
   • Year One: Rotations are on inpatient, day treatment, residential units, and inpatient consultation-liaison psychiatry. On these units, the residents work with an integrated team of professionals who review the residents’ cases on a daily basis. Each case seen by the resident is reviewed by the attending physician, who also documents his/her supervision in the chart. The training site for inpatient psychiatry is at the University Neuropsychiatric Institute (UNI). On the inpatient service, the name of the attending must be identified in the patient chart. The attending directs the evaluation of the patient by the resident and the treatment team. The attending physician must see the patient and document their involvement within 24 hours of admission. During the hospitalization, every time the resident provides treatment for the patient, he/she must document this in the progress notes. Residents and attendings must follow UNI’s guidelines for attending notification.
   • Year Two: Residents continue to have some rotations with residential or day treatment populations, where they still have the benefit of an integrated treatment team. They also spend 50% time for a full year on outpatient psychiatry. All of their outpatient evaluations and follow up notes are reviewed and signed by an attending. Both the resident and attending select patients to discuss during supervision. Residents must document each patient visit with a progress note, which is co-signed by the attending. Residents meet with their primary outpatient supervisors (full-time faculty) on a weekly basis, and in addition, are assigned secondary supervisors who meet with them regularly. However, in the outpatient setting, the attendings usually do not meet with the patients or their families, except in special circumstances. Thus, the residents develop some degree of autonomy. The goal is for senior residents to be viewed by the patients and families as the primary provider of outpatient psychiatric care, while the residents and patients have the benefit of having each case reviewed by a faculty member.

5. Any difficulties between the resident and the clinical supervisors should be reported to the training site supervisor, for review, as this person is responsible for the assignment of clinical work and supervision. If further review is needed, the Training Director should be included in the process.

6. Training sites, attendings, and residents are each evaluated every three months throughout the training program.
7. Individual supervision is defined by the Accreditation Council for Graduate Medical Education (ACGME) as one-to-one supervision in an office away from the medical ward, and other team members. The minimal requirement is two hours of individual supervision per week. Our residents spend four days per week on clinical duties. Thus, if the resident spends two days per week on a rotation, they must receive a minimum of one hour of individual supervision per week from the faculty at that training site. Typically, our residents receive additional supervision, above requirements. It is important to acknowledge that supervision occurs in many forms. For example, supervision can occur during rounds, in group supervision, as co-therapists for family therapy, and other opportunities. However, the resident must be given at least the minimal amount of individual supervision during each rotation, which is documented during monthly meetings with the Training Director.

8. Each training site must have its own plan in place for coverage of after-hours telephone calls and emergencies. In addition, when the primary clinical supervisor is out of town or unavailable, a back-up attending should be assigned, and the resident should be clear about lines of supervision in the absence of the primary supervisor. Any problems in this area should be reported to the training site supervisor, as well as the Training Director.

9. Program Values and Expectations
   - Supervisors should teach to the six core competencies as described in the child psychiatry resident clinical evaluation form.
   - The curriculum document for the child and adolescent psychiatry program outlines the goals, knowledge, skills, and attitudes the residents need to develop during each rotation and seminar. In addition, the relationship between the competencies and each rotation and seminar are outlined. Residents and faculty should use this document as a template to guide the training process.
   - Supervisors should teach the art and science of child and adolescent psychiatry, including the biological, psychological, and socio-cultural aspects of the field, according to his or her areas of expertise.

10. Training Director Responsibilities
    - Yearly review of specific supervision policy.
    - Adjustment of policy if needed.
    - Review of any changes and approval from the GME Office.
    - Implementation of policy.

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Promotion Policy
The Training Director meets with each resident twice a year to review their entire training program file. In addition, supervising attendings understand that they are
to notify the Training Director if any resident is struggling with meeting the competency requirements. When appropriate, more frequent clinical evaluations can be requested by the Training Director, to follow a resident's progress more closely. The Training Director uses the Residency Training Committee (RTC) as a sounding board for any difficulties the residents encounter. The Standards of Performance Policy outlines expectations for the residents, and the Resident Evaluation Policy outlines all of the measures of competency used by the program.

The RTC is required to meet quarterly, but every attempt is made to meet on a monthly basis, depending on holidays. Currently the RTC meets between nine to twelve times per year. Any difficulty experienced by our residents is reviewed in these meetings, especially disciplinary problems. Therefore, residents would expect to be promoted unless the RTC had been trying to remediate their problems.

At the end of each year, the Training Director presents a summary of each resident’s performance to the Residency Training Committee (RTC), and makes a recommendation regarding promotion. After discussion with the RTC, a majority vote is needed to promote or graduate the resident. If there are serious questions about promotion, every effort is made to make sure senior faculty members and administrators who serve on the RTC, are represented at the meeting.

The Chief Residents will participate in the promotion process, with the exception that they will be excused when their own file is reviewed by the RTC.

Starting in 2007, a form will be used to acknowledge their promotion by the Training Director and the RTC.

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**Resident Discipline Policy**

The goal of the Training Director and faculty is to support each of our residents so they can successfully complete the training program. Child Psychiatry residents will receive support from their peers, faculty members, program administration, and from the Training Director. The faculty will provide additional teaching, supervision, and support for any resident who is struggling. We all share the same goal of helping every resident to successfully finish their training and to develop a satisfying career.

University of Utah Graduate Medical Education Committee Resident Disciplinary Policy (dead link)

**Residency Training Committee**

The Residency Training Committee (RTC) requires representation by the following:
1. Residency Training Director
2. Department of Psychiatry
3. Department of Pediatrics
4. Division of Child and Adolescent Psychiatry
5. Chief resident from child psychiatry
6. Chief resident from triple board
7. A representative from the University Neuropsychiatric Institute
8. A representative from Primary Children’s Medical Center
9. A representative from Valley Mental Health
10. The training directors for psychiatry and pediatrics are committee members who are invited to attend meetings, but may elect to only attend when issues pertain to their program, or when requested by the committee.

The RTC is used to review the performance of our residents, our training sites, and our faculty. The Committee participates in development of the program. The RTC is responsible for program evaluation. The Committee is responsible for resident evaluation and/or advancement. The RTC is responsible for monitoring the entire teaching faculty and all of the courses. The goal is to problem-solve around any issues that are brought to the RTC, with hopes of continually improving the training available to our residents.

5/09

**Annual Program Review Policy**

Residents review their experience with Training Program Administration, including the Training Director, during monthly meetings. A more thorough discussion, as well as planning for the future of the Training Programs occurs at the Resident Retreats. Residents can also access the Chief Resident or any of the program administrators whenever an issue comes up.

The Residency Training Committee includes Chief Residents from both the Child Psychiatry Program, as well as the Triple Board Program. The RTC meets monthly, and over the course of the year, all of the important issues related to the program are discussed, and key decisions are made.

At least once a year, but typically twice a year, the Child and Adolescent Psychiatry Division Meeting is devoted to a review of the Training Programs. This gives the faculty a chance to catch up with changes in the programs, to address any problems that have developed, and for the Training Director to receive feedback. The results of the program review are brought back and discussed with the Residency Training Committee.
Resident Vacation/Conference & Family Medical Leave

Each resident receives three weeks of vacation and one week of conference leave.

It is preferred that residents take one week of vacation/conference leave once every three months. Exceptions to this could include a board review course, followed by a board examination. Exceptions require approval of faculty supervisors and the Training Director.

The Family Medical Leave policy was developed after consultation with the American Board of Psychiatry and Neurology, and the University of Utah GME Office. The policy was designed to answer the most frequent questions from residents:

There are 3 issues

• How much time can I take off?
• How much time do I have to make up?
• Who pays?

A. How much time can I take off?

1. You can take up to 12 weeks off via the Family Medical Leave Act.

B. How much time do I have to make up?

1. You can use vacation weeks and conference time---these weeks do not have to be made up.

   a. Conference time: The Child Psychiatry Program offers 1 week per year. The Triple Board Program offers 1 week per year for years 2-5. There is no conference time for Triple Board interns.

   b. May get permission to substitute CME or academic project for conference time, if approved by Training Director.

   c. Triple Board program: No conference time first year, one week years 2-5.

   d. Both programs get 3 weeks vacation time/year.

   e. With Training Director permission, could use some vacation time for the following academic year.
2. All other time needs to be made up in order to meet graduation requirements. See ACGME Requirements. Requirement for these programs do not allow any reduction in the actual number of weeks spent training in the program.

3. Where applicable, call needs to be made up, unless otherwise specifically negotiated with the Training Director for that specialty.

4. When making up a rotation, scheduling must not diminish the clinical experience of the currently scheduled residents.

C. Who pays?

1. The program will pay your salary for the first six weeks, and you can take an additional six weeks without pay.

2. Unfortunately, any rotation time which must be made up, will be unpaid. The resident will have to cover the expense of continuing their health insurance.

3. The University of Utah will cover the liability insurance for extended training.

If you can anticipate the absence, please look at your rotation schedule and call 1) The Triple Board Training Director, and 2) The Training Director(s) for the specialty you will be missing. For Pediatrics, start with the Chief Resident. Sometimes schedule can be moved to accommodate (i.e. A less physically taxing rotation after surgery, etc.)

Last revised 8-27-09

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**Work Hours Policy**

1. **Work Hours**

   - Child and Adolescent Psychiatry Rotations: General hours are from 7:30 to 8:00 a.m. to approximately 5:00 to 6:00 p.m., Monday through Friday. Saturday or Sunday rounds may be required infrequently, while on some rotations. Short term, there may be a once-per-week evening clinical experience (i.e., PCMC Child Residential Treatment Center).

2. **On-Call Schedule**

   - Child and Adolescent Psychiatry: Two to three weeks of telephone call is required during the last year of training. The rest of the child psychiatry program is call free.

   - Each hospital should have their own "on-call" system to cover the patients seen during the day. If there are any difficulties with getting appropriate supervision, notify the Residency Training Director or the Division Director as soon as possible.
We comply with the University of Utah GME Resident Work Hours Policy. The Child and Adolescent Psychiatry work week is 40-50 hours. The 80-hour per week resident work limit outlined by University policy should never come into play. Residents who moonlight must: 1) follow our departmental moonlighting policy, and 2) not exceed the 80-hour limit.

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Moonlighting Policy

The Child and Adolescent Psychiatry Training Program encourages residents not to moonlight, and to focus on academics. However, it is understood that some residents may have a financial need to moonlight, often because of educational debt.

Graduate medical education training is a rigorous full-time educational experience. It is important that residents have time for adequate rest and personal pursuits. Houseofficers should not be diverted from their primary responsibilities of patient care and learning by engaging in extra-curricular professional activities.

1. The Psychiatry Training Program permits moonlighting. Moonlighting, both internal and external, must be monitored and pre-approved by the program director to ensure that the moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

2. It is explicitly not permissible for a resident to moonlight while on-call (including home call) for his/her residency/fellowship program.

3. The resident must have an unrestricted license to practice medicine in the state in which the moonlighting activity is to take place.

4. If a resident chooses to moonlight, he or she is responsible for obtaining or verifying his/her own liability coverage. Even if this activity is being performed at the University, or an affiliated hospital, and/or additional compensation is being provided to the resident, it is outside the scope of a resident’s duties as a houseofficer.

5. Internal moonlighting (moonlighting that occurs within the residency program and/or sponsoring institution or the non-hospital sponsor’s primary clinical sites) hours must be counted toward the 80-hour weekly limit on work hours.

6. Each resident contemplating a moonlighting opportunity must present a proposal to the Residency Training Committee (RTC). The proposal must describe the clinical activity, the number of hours per week and projected schedule, the arrangement for supervision, and verification of licensure and liability coverage. The RTC will approve requests that are appropriate to the resident’s level of training, adequately supervised, and limited to reasonable amounts of time. Residents who are already engaged in a moonlighting activity that has been approved by the RTC must also present a request to increase their moonlighting workload.
7. Proposals for all moonlighting activities will be reviewed by the RTC and must be approved by the Program Director in writing on the "Moonlighting Authorization Form." Because internal moonlighting hours must be counted toward the 80-hour weekly limit on work hours, a copy of each internal "Moonlighting Authorization Form" must be filed with the Graduate Medical Education Office. A "Moonlighting Authorization Form" must be signed by the Program Director before a resident/fellow may participate in any moonlighting activity.

8. Moonlighting activities, whether internal or external, are prohibited if they interfere with the resident or fellow's educational experience or jeopardize patient safety. Moonlighting activities will be reviewed annually. Residents or Fellows on probation will not be permitted to moonlight. If the Program Director or RTC determines that moonlighting is interfering with a resident's performance, the resident may be required to develop a plan to improve deficits in performance, which may include decreasing or eliminating moonlighting activities.

9. Other extra-curricular professional activities that do not fall under the definition of "moonlighting should also be cleared with the program director so as not to interfere with the houseofficer's primary educational objectives.

6/09

Resident Selection & Replacement Policy
All applicants must fill out a standard application, including a one-two page letter describing their interest in child and adolescent psychiatry, and a current CV. In addition, applicants must provide the following documentation:

Internal Applicants, from the University of Utah General Psychiatry Program:

• Full residency training file, including Dean’s letter
• Letter from General Psychiatry Training Director covering: 1) A letter of reference reviewing the resident’s performance, and their professional behavior, 2) detailed information indicating the applicant will have met all training requirements by the end of the academic year (June 30), or outlining requirements that can be met during child psychiatry training.
• Letter of recommendation from a faculty member other than the Training Director (preferably a child psychiatrist)

External Applicants, from programs outside of Utah:

• Two letters of reference, preferably one from a child psychiatrist.
• Letter from Training Director covering: 1) A letter of reference reviewing the resident’s performance, and their professional behavior, 2) detailed information indicating the applicant will have met all training requirements by the end of the
academic year (June 30), or outlining requirements that can be met during child psychiatry training.

- Step Scores. PRITE scores are not required, but will be reviewed if the resident elects to send them to bolster their application.
- Dean's letter from Medical School

Typically, applicants interview with the following faculty:

- Child Psychiatry Training Director
- Assistant Training Director
- Chief Resident
- Several full-time child and adolescent faculty

Applicants are evaluated on the basis of their documentation, as well as their interview. A standardized evaluation form is used, with subscales (example "community service"), as well as an overall score for each applicant. This overall score will be the primary determinant of our match list.

Replacement residents must go through the same process as new residents. In addition, the child psychiatry Training Director requires a release of information form, signed by the applicant, allowing communication with the current training director.

All selected candidates are required to comply with the Health Sciences Center drug testing policy.

The University of Utah School Of Medicine does not discriminate on the basis of sex, race, age, religion, color, national origin, disability, or veteran's status.

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Technical Standards Policy (Applicants with Disabilities)

I. Introduction

The University of Utah School of Medicine Graduate Medical Education Program in Child and Adolescent Psychiatry complies with Section 504 of the 1973 Vocational Rehabilitation Act, as amended, and the Americans with Disabilities Act of 1990, in providing opportunities for qualified individuals with disabilities. At the same time, prospective candidates must be capable of meeting certain technical standards. The following technical standards specify those attributes the faculty considers to be essential in successfully completing residency training and in practicing medicine safely and responsibly. These standards describe the essential functions that residents must demonstrate in the requirements of post-graduate medical education, and thus, are pre-requisites to entrance, continuation, and completion of training in this program. Requests for reasonable accommodation are evaluated on an individual basis.
Applicants for the Triple Board Residency Program must meet the technical standards for Child and Adolescent Psychiatry, General Psychiatry, and Pediatrics.

II. Technical Standards
The resident must possess abilities and skills in five areas:

1. OBSERVATION. THE RESIDENT MUST BE ABLE TO:

   - Observe a patient accurately at a reasonable distance and close at hand, noting non-verbal as well as verbal signals.
   - Acquire information from written documents, films, slides, videos, or other media.
   - Observe and differentiate changes in body movement.
   - Efficiently read written and illustrated materials.
   - Observe and detect the various signs and symptoms of the disease processes that will be encountered during the training program.

2. COMMUNICATION. THE RESIDENT MUST BE ABLE TO:

   - Communicate effectively and sensitively with all patients.
   - Communicate effectively and efficiently with all members of the health care team in oral and written English.
   - Communicate clearly with and observe patients and families in order to elicit information including a thorough history from patients, families, and other sources.
   - Accurately describe changes in mood, activity, and posture.
   - Perceive verbal as well as non-verbal communications, and promptly respond to emotional communications (sadness, worry, agitation, confusion).
   - Communicate complex findings in appropriate terms to patients and their families.
   - Adjust form and content of communications to the patient's functional level or mental state.
   - Engage in a collaborative relationship with patients and families.
   - Record observations and plans legibly, efficiently, and accurately.
   - Complete forms according to direction in a complete and timely fashion.
   - Prepare and communicate precise but complete summaries of individual encounters.
   - Possess sufficient hearing for required diagnostic functions.
   - Gauge the emotional affect and content of speech.
   - In emergency situations, be able to take charge and understand and convey information for the safe and effective care of patients in a clear, unambiguous,
and rapid fashion, including appropriate communications with patients and their families.

• Generally communicate with patients and their families in an independent manner.

3. MOTOR. THE RESIDENT MUST BE ABLE TO:

• Perform palpation, percussion, auscultation, and other diagnostic maneuvers.
• Provide general care and emergency medical care such as airway management, placement of intravenous catheters, cardiopulmonary resuscitation, and application of pressure to control bleeding.
• Respond promptly to medical emergencies within the training facility.
• Not hinder the ability of co-workers to provide prompt care.

4. COGNITIVE. THE RESIDENT MUST BE ABLE TO:

• Demonstrate clinical reasoning and problem solving.
• Identify significant findings from history, physical exam, and laboratory data.
• Perceive subtle cognitive and behavioral findings and perform a mental status evaluation.
• Provide a reasoned explanation for likely diagnoses.
• Construct an appropriate diagnostic plan.
• Prescribe appropriate medications and therapy.
• Recall and retain information.
• Deal with several tasks or problems simultaneously.
• Identify and communicate the limits of their knowledge to others.
• Incorporate new information from peers, teachers, and the medical literature in formulating diagnoses and plans.
• Show good judgment in patient assessment, diagnostic, and therapeutic planning.

5. SOCIAL AND BEHAVIORAL. THE RESIDENT MUST BE ABLE TO:

• Maintain a professional demeanor.
• Maintain appropriate professional and ethical conduct.
• Be able to function at a high level in the face of long hours and a high stress environment.
• Develop empathic relationships with patients and families while establishing professional boundaries.
• Provide comfort and reassurance where appropriate.
• Protect patient confidentiality and the confidentiality of written and electronic records.
• Possess adequate endurance to tolerate physically taxing workloads.
• Flexibly adapt to changing environments.
• Function in the face of uncertainties inherent in the clinical problems of patients.
• Accept appropriate suggestions and criticisms and modify behavior.
• Give and accept criticism appropriately and without prejudice.

5/09

Library Designation Policy

After gathering information from faculty members and the residents, we have designated the library at Primary Children’s Medical Center to be our center for reference material. After negotiation with PCMC librarians and security staff, the following was organized:

1. Our residents from both programs will receive a parking pass for the duration of their training so they can use the parking garage for resident physicians at PCMC.

2. Each resident will receive a security badge, also good for the duration of their residency program, which will allow them to enter the hospital and to access the library after hours.

3. PCMC librarians have reviewed a list of the most prominent books used in child and adolescent psychiatry. This list was derived from the list of references used to develop the child psychiatry written examination. The librarians will acquire these books for the library, and new books as they become identified. They already have a very nice reference section. In addition, all of the child psychiatry books will be placed in one of two areas, and will have a special label put on them so they are easy to identify. The PCMC library continues to have a wonderful collection of journals for both pediatrics and child psychiatry, and they can obtain reference materials from other libraries, when necessary. In general, our residents have found the librarians at PCMC to be much more helpful than the staff at any other library they have ever used. Our faculty agree.

4. Individual training sites have some reference materials, and the outpatient clinic, which is the home base for the senior year of training, has a small but substantial library donated by the faculty. Books and journals are current.

5. The residents also have internet access on nearly every rotation, and most are well versed in using the internet. In the senior year, where the residents work more autonomously, each of the residents has access to high-speed internet in their own office.

Revised 5/09
PALS, ACLS and BLS Certification Policy

Residents come into the program at the PGY-4 or PGY-5 level. They have finished core training in medicine.

Neither ACLS or PALS training/certification are required.

Some training sites require BLS certification.

9/09