The Psychiatry Milestone Project

A Joint Initiative of

The Accreditation Council for Graduate Medical Education

and

The American Board of Psychiatry and Neurology

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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. The Milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

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Milestone Reporting

This document presents milestones designed for 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. In the initial years of implementation, the Review Committee will examine aggregate milestone performance data for each program's residents as one element in the Next Accreditation System to determine whether residents overall are progressing. Thus, aggregate resident performance will be an additional measure of a program's ability to educate its residents.

Program directors have the responsibility of ensuring that residents' progress on all 22 psychiatry subcompetencies (as identified in the top row of each milestone table) is documented every six months through the Clinical Competency Committee (CCC) review process. The CCC's decisions should be guided by information gathered through formal and informal assessments of residents during the prior six-month period. The ACGME does not expect formal, written evaluations of all milestones (each numbered item within a subcompetency table) every six months. For example, formal evaluations, documented observed encounters in inpatient and outpatient settings, and multisource evaluation should focus on those subcompetencies and milestones that are central to the resident's development during that time period.

Progress through the Milestones will vary from resident to resident, depending on a variety of factors, including prior experience, education, and capacity to learn. Residents learn and demonstrate some skills in episodic or concentrated time periods (e.g., formal presentations, participation in quality improvement project, child/adolescent rotation scheduling, etc.). Milestones relevant to these activities can be evaluated at those times. The ACGME does not expect that resident progress will be linear in all areas or that programs organize their curricula to correspond year by year to the Psychiatry Milestones. All milestone threads (as indicated by the letter in each milestone reference number, the "A" in PC1, 1.1/A) should be formally evaluated and discussed by the CCC on at least two occasions during a resident's educational program.

Thread names, preceded by their indicator letters, are listed in the top row of each milestone table. Each thread describes a type of activity, behavior, skill, or knowledge, and typically consists of two-to-four milestones at different levels. For example, the "B" thread for PC1, named "collateral information gathering and use," consists of the set of progressively more advanced and comprehensive behaviors identified as 1.2/B, 2.3/B, 3.3/B, 4.2/B, 4.3/B and 5.2/A,B. The thread identifies the unit of observation and evaluation. For, PC1, thread "B," faculty members would observe a resident's evaluation of a patient to see whether he or she demonstrates the

collateral information gathering and use behaviors described in that milestone. Threads do not always have milestones at each level 1-5; some threads may consist of only one milestone (see the diagram on page vi).

For each six-month reporting period, review and reporting will involve selecting the level of milestones that best describes a resident's current performance level. Milestones are arranged into numbered levels. These levels do not correspond with post-graduate year of education.

Selection of a level for a subcompetency implies that the resident substantially demonstrates the milestones in that level, as well as those in lower levels (see the diagram on page vi). A general interpretation of levels for psychiatry is below:

Has not Achieved Level 1: The resident does not demonstrate the milestones expected of an incoming resident.

Level 1: The resident demonstrates milestones expected of an incoming resident.

Level 2: The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.

Level 3: The resident continues to advance and demonstrate additional milestones; the resident demonstrates the majority of milestones targeted for residency in this sub-competency.

Level 4: The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target.*

Level 5: The resident has advanced beyond performance targets set for residency and is demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.

*Level 4 is designed as the graduation *target* and *does not* represent a graduation *requirement*. Making decisions about readiness for graduation is the purview of the residency program (See the Milestones FAQ for further discussion of this issue: "Can a resident/fellow graduate if he or she does not reach every milestone?"). Study of Milestone performance data will be required before the ACGME and its partners will be able to determine whether Level 4 milestones and milestones in lower levels are in the appropriate level within the developmental framework, and whether Milestone data are of sufficient quality to be used for high stakes decisions.

Selecting the Appropriate Milestone Level for your Residents: The Role of Supervision

Faculty supervisors, especially those overseeing clinical care, will directly assess many milestones. The CCC assessment is based on evaluations completed by these clinical supervisors along with other assessments, including performance on tests and evaluations from other sources. The process of Milestone assignment assumes that all residents are supervised in their clinical work, as outlined in the ACGME's supervision levels and requirements. For the purposes of evaluating a resident's progress in achieving Patient Care and Medical Knowledge Milestones, though, it is important that the evaluator(s) determine what the resident knows and can do, separate from the skills and knowledge of his or her supervisor.

Implicit in milestone level evaluation of Patient Care (PC) and Medical Knowledge (MK) is the assumption that during the normal course of patient care activities and supervision, the evaluating faculty member and resident participate in a clinical discussion of the patient's care. During these reviews the resident should be prompted to present his or her clinical thinking and decisions regarding the patient. This may include evidence for a prioritized differential diagnosis, a diagnostic workup, or initiation, maintenance, or modification of the treatment plan, etc. In offering his or her independent ideas, the resident demonstrates his or her capacity for clinical reasoning and its application to patient care in real-time.

As residents progress, their knowledge and skills should grow, allowing them to assume more responsibility and handle cases of greater complexity. They are afforded greater autonomy - within the bounds of the ACGME supervisory guidelines - in caring for patients. At Levels 1 and 2 of the Milestones, a resident's knowledge and independent clinical reasoning will meet the needs of patients with lower acuity, complexity, and level of risk, whereas, at Level 4, residents are expected to independently demonstrate knowledge and reasoning skills in caring for patients of higher acuity, complexity, and risk. Thus, one would expect residents achieving Level 4 milestones to be senior residents at an oversight level of supervision. In general, one would not expect beginning or junior residents to achieve Level 4 milestones. At all levels, it is important that residents ask for, listen to, and process the advice they receive from supervisors, consult the literature, and incorporate this supervisory input and evidence into their thinking.

Additional Notes

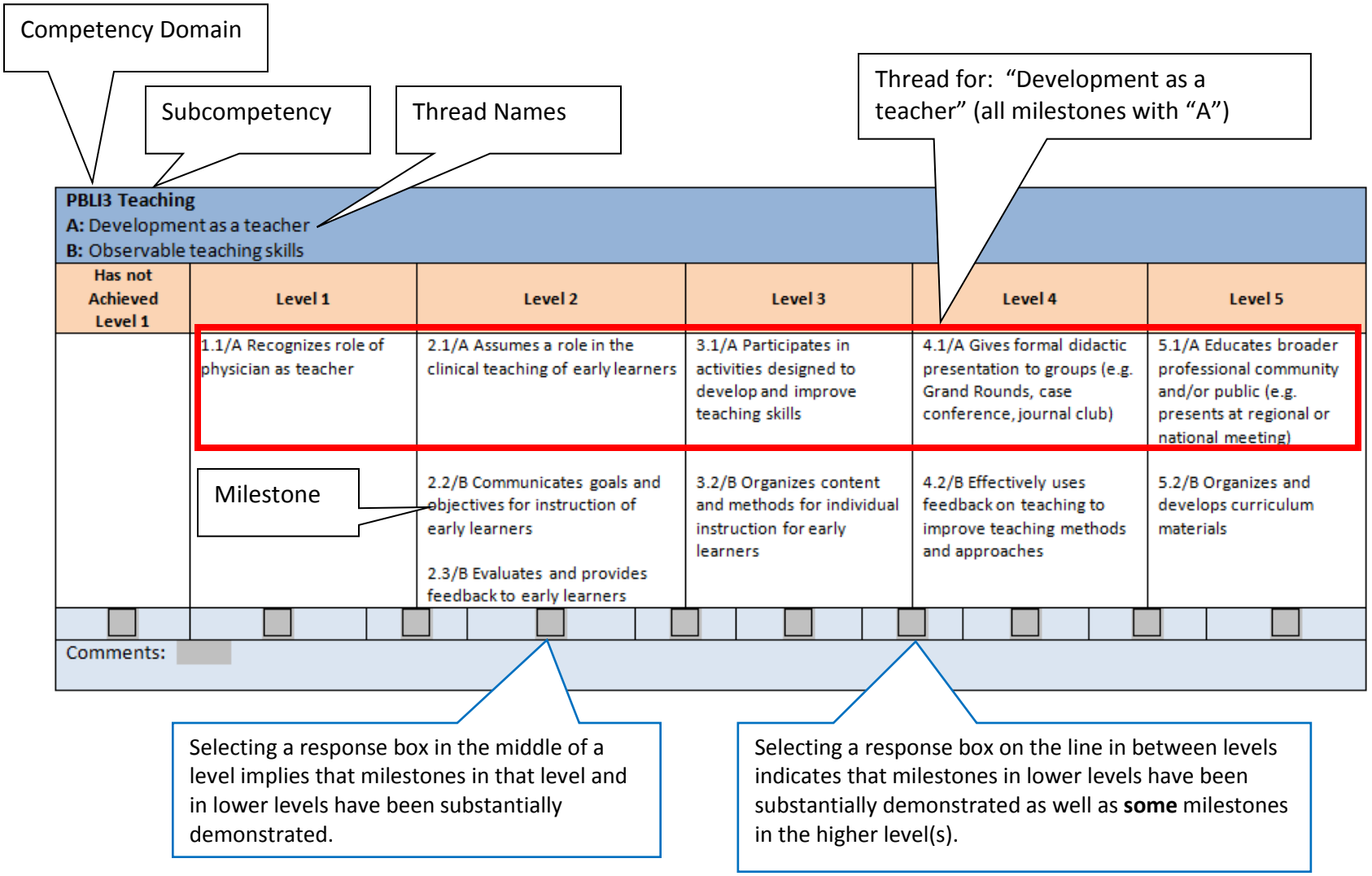
Please note that most milestone sets include explanatory footnotes for selected concepts. These appear at the bottom of each milestone table. The footnotes are essential tools in milestone evaluation.

The diagram below presents an example set of milestones for one sub-competency in the same format as the milestone report worksheet. For each reporting period, a resident's performance on the milestones for each sub-competency will be indicated by:

- selecting the level of milestones that best describes the resident's performance in relation to those milestones

or

- selecting the "Has not Achieved Level 1" response option



PSYCHIATRY MILESTONES
ACGME Report Worksheet

PC1. Psychiatric Evaluation
A: General interview skills
B: Collateral information gathering and use
C: Safety assessment
D: Use of clinician's emotional response

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Obtains general medical and psychiatric history and completes a mental status examination	2.1/A Acquires efficient, accurate, and relevant history customized to the patient's complaints 2.2/A Performs a targeted examination, including neurological examination, relevant to the patient's complaints	3.1/A Consistently obtains complete, accurate, and relevant history 3.2/A Performs efficient interview and examination with flexibility appropriate to the clinical setting and workload demands	4.1/A Routinely identifies subtle and unusual findings	5.1/A Serves as a role model for gathering subtle and reliable information from the patient 5.2/A, B Teaches and supervises other learners in clinical evaluation
	1.2/B Obtains relevant collateral information from secondary sources	2.3/B Obtains information that is sensitive and not readily offered by the patient	3.3/B Selects laboratory and diagnostic tests appropriate to the clinical presentation 3.4/B Uses hypothesis-driven information gathering techniques[2]	4.2/B Follows clues to identify relevant historical findings in complex clinical situations and unfamiliar circumstances	
	1.3/C Screens for patient safety, including suicidal and homicidal ideation	2.4/C Assesses patient safety, including suicidal and homicidal ideation 2.5/D Recognizes that the clinician's emotional responses have diagnostic value[1]		4.3/D Begins to use the clinician's emotional responses to the patient as a diagnostic tool	

Comments:
Footnotes: [1]This milestone refers to the use of the resident's own emotional response to the patient's presentation as a source of information to generate ideas about the patient's own inner emotional state, both conscious and unconsious. [2]This milestone focuses on the efficient and deductive conduct of the interview in accordance with diagnostic hypotheses to refine the differential diagnosis.

PC2. Psychiatric Formulation and Differential Diagnosis[1] **A**: Organizes and summarizes findings and generates differential diagnosis **B**: Identifies contributing factors and contextual features and creates a formulation					
Has not Achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	1.1/A Organizes and accurately summarizes, reports, and presents to colleagues information obtained from the patient evaluation 1.2/A Develops a working diagnosis based on the patient evaluation	2.1/A Identifies patterns and recognizes phenomenology from the patient's presentation to generate a diagnostic hypotheses 2.2/A Develops a basic differential diagnosis for common syndromes and patient presentations 2.3/B Describes patients' symptoms and problems, precipitating stressors or events, predisposing life events or stressors, perpetuating and protective factors, and prognosis	3.1/A Develops a full differential diagnosis while avoiding premature closure 3.2/B Organizes formulation around comprehensive models of phenomenology that take etiology into account [2]	4.1/A Incorporates subtle, unusual, or conflicting findings into hypotheses and formulations 4.2/B Efficiently synthesizes all information into a concise but comprehensive formulation	5.1/B Serves as a role model of efficient and accurate formulation 5.2/B Teaches formulation to advanced learners
☐	☐	☐	☐	☐	☐
Comments:					

Footnotes:

[1]A psychiatric formulation is a theoretically-based conceptualization of the patient's mental disorder(s). It provides an organized summary of those individual factors thought to contribute to the patient's unique psychopathology. This includes elements of possible etiology, as well as those that modify or influence presentation, such as risk and protective factors. It is therefore distinct from a differential diagnosis that lists the possible diagnoses for a patient, or an assessment that summarizes the patient's signs and symptoms, as it seeks to understand the underlying mechanisms of the patient's unique problems by proposing a hypothesis as to the causes of mental disorders.

[2]Models of formulation include those based on either major theoretical systems of the etiology of mental disorders, such as behavioral, biological, cognitive, cultural, psychological, psychoanalytic, sociological, or traumatic, or comprehensive frameworks of understanding, such as bio-psycho-social or predisposing, precipitating, perpetuating, and prognostic outlines. Models of formulation set forth a hypothesis about the unique features of a patient's illness that can serve to guide further evaluation or develop individualized treatment plans.

PC3. Treatment Planning and Management
A: Creates treatment plan
B: Manages patient crises, recognizing need for supervision when indicated
C: Monitors and revises treatment when indicated

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Identifies potential treatment options	2.1/A Sets treatment goals in collaboration with the patient	3.1/A Incorporates manual-based treatment[1] when appropriate	4.1/A Devises individualized treatment plan for complex presentations	5.1/A Supervises treatment planning of other learners and multidisciplinary providers
		2.2/A Incorporates a clinical practice guideline or treatment algorithm when available	3.2/A Applies an understanding of psychiatric, neurologic, and medical co-morbidities to treatment selection[2]	4.2/A Integrates multiple modalities and providers in comprehensive approach[3]	5.2/A Integrates emerging neurobiological and genetic knowledge into treatment plan[4]
		2.3/A Recognizes co-morbid conditions and side effects' impact on treatment	3.3/A Links treatment to formulation		
	1.2/B Recognizes patient in crisis or acute presentation	2.4/B Manages patient crises with supervision	3.4/B Recognizes need for consultation and supervision for complicated or refractory cases		
	1.3/C Recognizes patient readiness for treatment	2.5/C Monitors treatment adherence and response	3.5/C Re-evaluates and revises treatment approach based on new information and or response to treatment	4.3/C Appropriately modifies treatment techniques and flexibly applies practice guidelines to fit patient need	
☐	☐	☐	☐	☐	☐

Comments:

Footnotes:
[1]Manual-based treatment is any psychotherapy that relies on written instructions for the therapist on the steps and conduct of treatment, often including specific indications, techniques, goals, and objectives. Manual-based treatments are frequently theory-driven and evidence-based. Examples of manual-based treatments include Interpersonal Psychotherapy, Dialectical-Behavioral Therapy, and many Cognitive-Behavioral Therapies.
[2]Examples might include psychopharmacology in the presence of neurodegenerative disorders, traumatic brain injury, critical medical illness, and cancer treatment, as well as understanding the family, systems, and multidisciplinary team efforts for the best outcome for treatment.
[3]Understanding and use of an array of modalities and providers may include consideration of complementary and alternative medicine, occupational therapy, and

physical therapy.
[4]Examples may include cytochrome genetics, ethnic differences, and family counseling, etc.

PC4. Psychotherapy
Refers to 1) the practice and delivery of psychotherapies, including psychodynamic[1], cognitive-behavioral[2], and supportive therapies[3]; 2) exposure to couples, family, and group therapies; and 3) integrating psychotherapy with psychopharmacology
A: Empathy and process
B: Boundaries
C: The alliance and provision of psychotherapies
D: Seeking and providing psychotherapy supervision

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Accurately identifies patient emotions, particularly sadness, anger, and fear[4]	2.1/A Identifies and reflects the core feeling and key issue for the patient during a session	3.1/A Identifies and reflects the core feeling, key issue, and what the issue means to the patient	4.1/A Links feelings, behavior, recurrent/central themes/schemas, and their meaning to the patient as they shift within and across sessions	
	1.2/B Maintains appropriate professional boundaries	2.2/B Maintains appropriate professional boundaries in psychotherapeutic relationships while being responsive to the patient[5]	3.2/B Recognizes and avoids potential boundary violations	4.2/B Anticipates and appropriately manages potential boundary crossings and avoids boundary violations	
	1.3/C Demonstrates a professional interest and curiosity in a patient's story	2.3/C Establishes and maintains a therapeutic alliance with patients with uncomplicated problems[6] 2.4/C Utilizes elements of supportive therapy in treatment of patients	3.3/C Establishes and maintains a therapeutic alliance with, and provides psychotherapies (at least supportive, psychodynamic, and cognitive-behavioral) to, patients with uncomplicated problems 3.4/C Manages the emotional content of, and feelings aroused during, sessions 3.5/C Integrates the selected psychotherapy with other treatment modalities and other treatment providers [7]	4.3/C Provides different modalities of psychotherapy (including supportive therapy and at least one of psychodynamic or cognitive behavioral therapies) to patients with moderately complicated problems 4.4/C Selects a psychotherapeutic modality and tailors the selected psychotherapy to the patient on the basis of an appropriate case formulation 4.5/C Successfully guides	5.1/C Provides psychotherapies to patients with very complicated and/or refractory disorders/problems 5.2/C Personalizes treatment based on awareness of one's own skill sets, strengths, and limitations

			3.6/D Balances autonomy with needs for consultation and supervision	the patient through the different phases of psychotherapy, including termination 4.6/C, D Recognizes, seeks appropriate consultation about, and manages treatment impasses	5.3/D Provides psychotherapy supervision to others	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Footnotes:

[1]Psychodynamic therapy includes the capacity to generate a case formulation, to demonstrate techniques of intervention, and to understand the concepts of resistance/defenses, transference/countertransference.

[2]Cognitive-behavioral therapy includes the capacity to generate a case formulation, to demonstrate techniques of intervention, including behavior change, skills acquisition, and to address cognitive distortions.

[3]Supportive therapy includes the capacity to generate a case formulation, to demonstrate techniques of intervention, and to strengthen the patient's adaptive defenses, resilience, and social supports.

[4]This thread (A), consisting of the first items in Levels 1-4, regarding the development of empathy across residency, is adapted from the American Association of Directors of Psychiatric Residency Training (AADPRT) Psychotherapy Workgroup's document "Benchmarks for Psychotherapy Training."

[5]This refers to the ability to maintain professional boundaries in psychotherapy without being aloof or overly detached.

[6]Examples of uncomplicated problems are major depression or panic disorder without co-morbidity.

[7]At this level, the resident is expected to be able to integrate both psychotherapy and psychopharmacology in combined treatment of a patient, to deliver psychotherapy or psychopharmacology in collaboration with another provider who is doing the other treatment (shared treatment), and to be able to anticipate, discuss, and manage issues that result from a patient's receiving other treatments (e.g., family, couples, or group therapy; psychopharmacology) at the same time as individual psychotherapy.

PC5. Somatic Therapies **Somatic therapies including psychopharmacology, electroconvulsive therapy (ECT), and emerging neuromodulation therapies** **A:** Using psychopharmacologic agents in treatment **B:** Education of patient about medications **C:** Monitoring of patient response to treatment and adjusting accordingly **D:** Other somatic treatments					
Has not Achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	1.1/A Lists commonly used psychopharmacologic agents and their indications to target specific psychiatric symptoms (e.g., depression, psychosis)	2.1/A Appropriately prescribes[1] commonly used psychopharmacologic agents	3.1/A Manages pharmacokinetic and pharmacodynamic drug interactions when using multiple medications concurrently	4.1/A Titrates dosage and manages side effects of multiple medications	
	1.2/B Reviews with the patient/family general indications, dosing parameters, and common side effects for commonly prescribed psychopharmacologic agents	2.2/B Incorporates basic knowledge of proposed mechanisms of action and metabolism of commonly prescribed psychopharmacologic agents in treatment selection, and explains rationale to patients/families			5.1/B Explains less common somatic treatment choices to patients/families in terms of proposed mechanisms of action
		2.3/C Obtains basic physical exam and lab studies necessary to initiate treatment with commonly prescribed medications	3.2/C Monitors relevant lab studies throughout treatment, and incorporates emerging physical and laboratory findings into somatic treatment strategy 3.3/C Uses augmentation strategies, with supervision, when primary pharmacological interventions are only partially successful[1]	4.2/C Appropriately selects evidence-based somatic treatment options (including second and third line agents and other somatic treatments[2]) for patients whose symptoms are partially responsive or not responsive to treatment	5.2/C Integrates emerging studies of somatic treatments into clinical practice
		2.4/D Seeks consultation and			

		supervision regarding potential referral for ECT								
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Comments:										
Footnotes: [1]This includes: (a) selection of agent, dose, and titration, based on psychiatric diagnoses, target symptoms, and specifics of patient's history; (b) discussion of potential risks and benefits with patients (and family members, where appropriate); (c) decision regarding whether or not to prescribe a medication (or medication versus other type of treatment). [2]Examples of other somatic therapies include neuromodulation, biofeedback, and phototherapy.										

MK1. Development through the life cycle (including the impact of psychopathology on the trajectory of development and development on the expression of psychopathology)
A: Knowledge of human development
B: Knowledge of pathological and environmental influences on development
C: Incorporation of developmental concepts in understanding

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Describes the basic stages of normal physical, social, and cognitive development through the life cycle[1]	2.1/A Describes neural development across the life cycle[2] 2.2/A Recognizes deviation from normal development, including arrests and regressions at a basic level 2.3/B Describes the effects of emotional and sexual abuse on the development of personality and psychiatric disorders in infancy, childhood, adolescence, and adulthood at a basic level 2.4/C Utilizes developmental concepts in case formulation	3.1/A Explains developmental tasks and transitions throughout the life cycle, utilizing multiple conceptual models[3] 3.2/B Describes the influence of psychosocial factors (gender, ethnic, cultural, economic), general medical, and neurological illness on personality development 3.3/C Utilizes appropriate conceptual models of development in case formulation	4.1/B Describes the influence of acquisition and loss of specific capacities in the expression of psychopathology across the life cycle 4.2/B Gives examples of gene-environment interaction influences on development and psychopathology[4]	5.1/A Incorporates new neuroscientific knowledge into his or her understanding of development
☐	☐	☐	☐	☐	☐

Comments:

Footnotes:
[1]Includes knowledge of motoric, linguistic, and cognitive development at the level required to pass the United States Medical Licensing Examination (USMLE) Step 2, and also knowledge of developmental milestones in infancy through senescence, such as language acquisition, Piagetian cognitive development, and social and emotional development, such as the emergence of stranger wariness in infancy and the theme of independence versus dependence in adolescence.

[2]Knowledge of fetal, childhood, adolescent, and early adult brain development, including abnormal brain development caused by genetic disorders (Tay-Sachs), environmental toxins, malnutrition, social deprivation, and other factors.
[3]Using the theoretical models proposed by psychodynamic, cognitive, and behavioral theorists.
[4]An example is bipolar disorder with genetic diathesis + environmental stress leading to manic behavior.

MK2. Psychopathology[1]
Includes knowledge of diagnostic criteria, epidemiology, pathophysiology, course of illness, co-morbidities, and differential diagnosis of psychiatric disorders, including substance use disorders and presentation of psychiatric disorders across the life cycle and in diverse patient populations (e.g., different cultures, families, genders, sexual orientation, ethnicity, etc.)
A: Knowledge to identify and treat psychiatric conditions
B: Knowledge to assess risk and determine level of care
C: Knowledge at the interface of psychiatry and the rest of medicine

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Identifies the major psychiatric diagnostic system (DSM)	2.1/A Demonstrates sufficient knowledge to identify and treat common psychiatric conditions in adults in inpatient and emergency settings (e.g., depression, mania, acute psychosis)	3.1/A Demonstrates sufficient knowledge to identify and treat most psychiatric conditions throughout the life cycle and in a variety of settings[2]	4.1/A Demonstrates sufficient knowledge to identify and treat atypical and complex psychiatric conditions throughout the life cycle and in a range of settings (inpatient, outpatient, emergency, consultation liaison)[3]	
	1.2/B Lists major risk and protective factors for danger to self and others	2.2/B Demonstrates knowledge of, and ability to weigh risks and protective factors for, danger to self and/or others in emergency and inpatient settings	3.2/B Displays knowledge of, and the ability to weigh, risk and protective factors for, danger to self and/or others across the life cycle, as well as the ability to determine the need for acute psychiatric hospitalization	4.2/B Displays knowledge sufficient to determine the appropriate level of care for patients expressing, or who may represent, danger to self and/or others, across the life cycle and in a full range of treatment settings	5.1/B Displays knowledge sufficient to teach assessment of risks and the appropriate level of care for patients who may represent a danger to self and/or others
	1.3/C Gives examples of interactions between medical and psychiatric symptoms and disorders	2.3/C Shows sufficient knowledge to perform an initial medical and neurological evaluation in psychiatric inpatients 2.4/C Demonstrates sufficient knowledge to identify common medical conditions (e.g., hypothyroidism,	3.3/C Shows sufficient knowledge to identify and treat common psychiatric manifestations of medical illness (e.g., delirium, depression, steroid-induced syndromes) 3.4/C Demonstrates sufficient knowledge to include relevant medical	4.3/C Shows knowledge sufficient to identify and treat a wide range of psychiatric conditions in patients with medical disorders 4.4/C Demonstrates sufficient knowledge to systematically screen for, evaluate, and diagnose	5.2/C Shows sufficient knowledge to identify and treat uncommon psychiatric conditions in patients with medical disorders 5.3/C Demonstrates sufficient knowledge to detect and ensure appropriate treatment of

		hyperlipidemia, diabetes) in psychiatric patients	and neurological conditions in the differential diagnoses of psychiatric patients	common medical conditions in psychiatric patients, and to ensure appropriate further evaluation and treatment of these conditions in collaboration with other medical providers	uncommon medical conditions in patients with psychiatric disorders	
☐	☐	☐	☐	☐	☐	☐

Comments:

Footnotes:

[1]This milestone focuses on knowledge needed for patient care. Thus, knowledge of psychopathology can be assessed through multiple choice knowledge examinations (e.g., the Psychiatry Resident In-Training Examination (PRITE)), and/or through evaluations of the application of knowledge of psychopathology to patient care, such as standardized patients or case vignettes, clinical skills evaluations, and knowledge evidenced during clinical rotations and the routine, supervised care of patients during residency.

[2]This level includes identification and treatment of a wider array of conditions, across the life cycle (including childhood, adolescent, adult, and geriatric conditions), and in a variety of settings (e.g., outpatient, consultation liaison, subspecialty settings).

[3]"Atypical" and "complex" psychiatric conditions refer to unusual presentations of common disorders, co-occurring disorders in patients with multiple co-morbid conditions, and diagnostically challenging clinical presentations.

MK3. Clinical Neuroscience[1]
Includes knowledge of neurology, neuropsychiatry, neurodiagnostic testing, and relevant neuroscience and their application in clinical settings
A: Neurodiagnostic testing
B: Neuropsychological testing
C: Neuropsychiatric co-morbidity
D: Neurobiology
E: Applied neuroscience

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Knows commonly available neuroimaging and neurophysiologic diagnostic modalities and how to order them	2.1/A Knows indications for structural neuroimaging (cranial computed tomography [CT] and magnetic resonance imaging [MRI]) and neurophysiological testing (electroencephalography [EEG], evoked potentials, sleep studies)	3.1/A Recognizes the significance of abnormal findings in routine neurodiagnostic test[6] reports in psychiatric patients	4.1/A Explains the significance of routine neuroimaging, neurophysiological, and neuropsychological testing abnormalities to patients 4.2/A Knows clinical indications and limitations of functional neuroimaging[7]	5.1/A Integrates recent neurodiagnostic research into understanding of psychopathology
	1.2/B Knows how to order neuropsychological testing	2.2/B Describes common neuropsychological tests and their indications[2]	3.2/B Knows indications for specific neuropsychological tests and understands meaning of common abnormal findings		5.2/B Flexibly applies knowledge of neuropsychological findings to the differential diagnoses of complex patients
		2.3/C Describes psychiatric disorders co-morbid with common neurologic disorders[3] and neurological disorders frequently seen in psychiatric patients[4]		4.3/C Describes psychiatric co-morbidities of less common neurologic disorders[8] and less common neurologic co-morbidities of psychiatric disorders[9]	
			3.3/D Describes neurobiological and genetic hypotheses of common psychiatric disorders and their limitations	4.4/D Explains neurobiological hypotheses and genetic risks of common psychiatric disorders to patients	5.3/D Explains neurobiological hypotheses and genetic risks of less common psychiatric disorders[11] to patients

		2.4/E Identifies the brain areas thought to be important in social and emotional behavior[5]		4.5/E Demonstrates sufficient knowledge to incorporate leading neuroscientific hypotheses of emotions and social behaviors[10] into case formulation	5.4/D Integrates knowledge of neurobiology into advocacy for psychiatric patient care and stigma reduction[12]
☐	☐	☐	☐	☐	☐

Comments:

Footnotes:

[1]This milestone focuses on knowledge needed for patient care. Thus, knowledge of clinical neuroscience can be assessed through multiple choice knowledge examination (e.g., PRITE), and/or through evaluations of the application of knowledge of clinical neuroscience to patient care, such as standardized patients or case vignettes, clinical skills evaluations, and knowledge evidenced during clinical rotations and the routine, supervised care of patients during residency.

[2]Common neuropsychological tests include the Montreal Cognitive Assessment (or Mini Mental State Examination), Wechsler Adult Intelligence Scale (or Halstead-Reitan battery), Wechsler Memory Scale, Wide Range Achievement Test, Wisconsin Card Sorting Test, Clock Drawing Test.

[3]Examples include psychosis, mood disorders, personality changes, and cognitive impairments seen in common neurological disorders.

[4]These include drug-induced and idiopathic extrapyramidal syndromes, neuropathies, traumatic brain injury (TBI), vascular lesions, dementias, and encephalopathies.

[5]Areas might include dorsolateral prefrontal cortex, anterior cingulate, amygdala, hippocampus, etc.

[6]These include structural imaging and electrophysiologic testing.

[7]For example, positron emission tomography (PET)/single-photon emission computed tomography (SPECT) in the diagnosis of Alzheimer's disease (supportive but non-diagnostic); functional magnetic resonance imaging (fMRI) is not yet reimbursable for clinical use.

[8]Examples include: mood disorder due to neurological condition, manic type, in right hemisphere or orbitofrontal strokes/tumors; depression in peri-basal ganglionic infarcts; manic behavior in limbic encephalitis.

[9]Examples include: neuroleptic malignant syndrome; lethal catatonia; "Parkinson plus" syndromes (e.g., multisystem atrophy, dementia with Lewy bodies, etc).

[10]Social behaviors might include attachment, empathy, attraction, reward/addiction, aggression, appetites, etc.

[11]Examples include : Obsessive-Compulsive Disorder (OCD); eating disorders ; Gilles de la Tourette syndrome.

[12]Uses neurobiologic hypotheses of psychiatric disorders to advocate for health coverage, treatment availability, etc.

MK4. Psychotherapy
Refers to knowledge regarding: 1) individual psychotherapies, including but not limited to psychodynamic[1], cognitive-behavioral[2], and supportive therapies[3]; 2) couples, family, and group therapies; and, 3) integrating psychotherapy and psychopharmacology
A: Knowledge of psychotherapy: theories
B: Knowledge of psychotherapy: practice
C: Knowledge of psychotherapy: evidence base

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Identifies psycho-dynamic, cognitive-behavioral, and supportive therapies as major psychotherapeutic modalities	2.1/A Describes the basic principles of each of the three core individual psychotherapy modalities[4] 2.2/A Discusses common factors across psychotherapies[5] 2.3/B Lists the basic indications, contraindications, benefits, and risks of supportive, psychodynamic and cognitive behavioral psychotherapies	3.1/A Describes differences among the three core individual therapies 3.2/A Describes the historical and conceptual development of psychotherapeutic paradigms 3.3/B Describes the basic techniques of the three core individual therapies 3.4/B Describes the basic principles, indications, contraindications, benefits, and risks of couples, group, and family therapies 3.5/C Summarizes the evidence base for each of the three core individual therapies	4.1/A Describes proposed mechanisms of therapeutic change 4.2/C Discusses the evidence base for combining different psychotherapies and psychopharmacology 4.3/C Critically appraises the evidence for efficacy of psychotherapies	5.1/A Incorporates new theoretical developments into knowledge base 5.2/A, B Demonstrates sufficient knowledge of psychotherapy to teach others effectively
☐	☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐ ☐

Comments:
Footnotes: [1]This includes the capacity to generate a case formulation, to demonstrate techniques of intervention, and to understand the concepts of resistance/defenses, and transference/countertransference. [2]This includes the capacity to generate a case formulation, and to demonstrate techniques of intervention, including behavior change, skills acquisition, and addressing cognitive distortions. [3]This includes the capacity to generate a case formulation, to demonstrate techniques of intervention, and to strengthen the patient's adaptive defenses, resilience, and social supports. [4]Throughout this subcompetency, the three "core" or "major" individual psychotherapies refer to supportive, psychodynamic, and cognitive-behavioral therapy. [5]Common factors refer to elements that different psychotherapeutic modalities have in common, and that are considered central to the efficacy of psychotherapy. These include accurate empathy, therapeutic alliance, and appropriate professional boundaries.

MK5. Somatic Therapies
Medical Knowledge of somatic therapies, including psychopharmacology, ECT, and emerging somatic therapies, such as transcranial magnetic stimulation (TMS) and vagnus nerve stimulation (VNS)
A: Knowledge of indications, metabolism and mechanism of action for medications
B: Knowledge of ECT and other emerging somatic treatments
C: Knowledge of lab studies and measures in monitoring treatment

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Describes general indications and common side effects for commonly prescribed psychopharmacologic agents	2.1/A Describes hypothesized mechanisms of action and metabolism for commonly prescribed psychopharmacologic agents 2.2/A Describes indications for second- and third-line pharmacologic agents 2.3/A Describes less frequent but potentially serious/dangerous adverse effects for commonly prescribed psychopharmacological agents 2.4/A Describes expected time course of response for commonly prescribed classes of psychotropic agents	3.1/A Demonstrates an understanding of pharmacokinetic and pharmacodynamic drug interactions 3.2/A Demonstrates an understanding of psychotropic selection based on current practice guidelines or treatment algorithms for common psychiatric disorders	4.1/A Describes the evidence supporting the use of multiple medications in certain treatment situations (e.g., polypharmacy and augmentation)	5.1/A Integrates emerging studies of somatic treatments into knowledge base 5.2/A Effectively teaches at a post-graduate level evidence-based or best somatic treatment practices
	1.2/B Describes indications for ECT	2.5/B Describes length and frequency of ECT treatments, as well as relative contraindications	3.3/B Describes specific techniques in ECT 3.4/B Lists emerging neuro-modulation therapies[1]		
		2.6/C Describes the physical		4.2/ C Integrates knowledge	

		and lab studies necessary to initiate treatment with commonly prescribed medications		of the titration and side effect management of multiple medications, monitoring the appropriate lab studies, and how emerging physical and laboratory findings impact somatic treatments	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Comments:											
Footnotes: [1]Examples of neuromodulation techniques include TMS and variations, VNS, Deep Brain Stimulation, etc.											

MK6. Practice of Psychiatry **A:** Ethics **B:** Regulatory compliance **C:** Professional development and frameworks					
Has not Achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	1.1/A Lists common ethical issues in psychiatry	2.1/A Lists and discusses sources of professional standards of ethical practice 2.2/A Lists situations that mandate reporting or breach of confidentiality	3.1/A Discusses conflict of interest and management		
	1.2/B Recognizes and describes institutional policies and procedures[1]		3.2/B Describes applicable regulations for billing and reimbursement	4.1/B Describes the existence of state and regional variations regarding practice, involuntary treatment, health regulations, and psychiatric forensic evaluation	5.1/B Describes international variations regarding practice, involuntary treatment, and health regulations
	1.3/C Lists ACGME Competencies	2.3/C Describes how to keep current on regulatory and practice management issues		4.2/C Describes professional advocacy[2] 4.3/C Describes how to seek out and integrate new information on the practice of psychiatry	5.2/C Proposes advocacy activities, policy development, or scholarly contributions related to professional standards
☐	☐	☐	☐	☐	☐

Comments:

Footnotes:

[1] "Institutional policies and procedures" refers to those related to the practice of medicine and psychiatry at the specific institution where the resident is credentialed. These include a Code of Conduct (addressing gifts, etc.) and privacy policies (related to HIPAA, etc.), but not patient safety policies. These are usually covered during an orientation to the institution and program.

[2] Advocacy includes efforts to promote the wellbeing and interests of patients and their families, the mental health care system, and the profession of psychiatry. While advocacy can include work on behalf of specific individuals, it is usually focused on broader system issues, such as access to mental health care services or public

awareness of mental health issues. The focus on larger societal problems typically involves work with policy makers (state and federal legislators) and peer or professional organizations (American Psychiatry Association (APA), National Alliance on Mental Illness (NAMI), etc.).

SBP1. Patient Safety and the Health care Team
A: Medical errors and improvement activities
B: Communication and patient safety
C: Regulatory and educational activities related to patient safety

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Differentiates among medical errors, near misses, and sentinel events	2.1/A Describes the common system causes for errors	3.1/A Describes systems and procedures that promote patient safety	4.1/A Participates in formal analysis (e.g., root-cause analysis, failure mode effects analysis) of medical errors and sentinel events	5.1/A Leads multidisciplinary teams (e.g., human factors engineers[1], social scientists) to address patient safety issues
	1.2/B Recognizes failure in teamwork and communication as leading cause of preventable patient harm	2.2/B Consistently uses structured communication tools to prevent adverse events (e.g., checklists, safe hand-off procedures, briefings)			5.2/A, C Provides consultation to organizations to improve personal and patient safety
	1.3/C Follows institutional safety policies, including reporting of problematic behaviors and processes, errors, and near misses	2.3/C Actively participates in conferences focusing on systems-based errors in patient care		4.2/C Develops content for and facilitates a patient safety presentation or conference focusing on systems-based errors in patient care (i.e., a morbidity and mortality [M&M] conference)	
☐	☐	☐	☐	☐	☐

Comments:

Footnotes:
[1] Human Factors Engineering (HFE) is a framework for efficient and constructive thinking which includes methods and tools to help health care teams perform patient safety analyses (see: Gosbee J, Human factors engineering and patient safety, Quality and Safety in Health Care, 2002;11:352–354).

SBP2. Resource Management (may include diagnostics, medications, level of care, other treatment providers, access to community assistance) **A:** Costs of care and resource management					
Has not Achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	1.1/A Recognizes need for efficient and equitable use of resources	2.1/A Recognizes disparities in health care at individual and community levels 2.2/A Knows the relative cost of care (e.g., medication costs, diagnostic costs, level of care costs, procedure costs)	3.2/A Coordinates patient access to community and system resources	4.1/A Practices cost-effective, high-value clinical care[1], using evidence-based tools and information technologies to support decision making 4.2/A Balances the best interests of the patient with the availability of resources	5.1/A Designs measurement tools to monitor and provide feedback to providers/teams on resource consumption to facilitate improvement 5.2/A Advocates for improved access to and additional resources within systems of care
☐	☐	☐	☐	☐	☐
Comments:					
Footnotes: [1] Examples include: avoids higher-cost, newer antipsychotics when older formulations are adequate; recommends levels of care that are matched to clinical need and available in the community.					

SBP3. Community-Based Care
A: Community-based programs
B: Self-help groups
C: Prevention
D: Recovery and rehabilitation

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Gives examples of community mental health systems of care	2.1/A Coordinates care with community mental health agencies, including with case managers			5.1/A Participates in the administration of community-based treatment programs 5.2/A Participates in creating new community-based programs
	1.2/B Gives examples of self-help groups (Alcoholics Anonymous [AA], Narcotics Anonymous [NA]), other community resources (church, school) and social networks (e.g., family, friends, acquaintances)	2.2/B Recognizes role and explains importance of self-help groups and community resource groups (e.g., disorder-specific support and advocacy groups)	3.1/B Incorporates disorder-specific support and advocacy groups in clinical care	4.1/B Routinely uses self-help groups, community resources, and social networks in treatment[3]	
		2.3/C Describes individual and population risk factors for mental illness	3.2/C Describes prevention measures: universal, selective and indicated[1] 3.3/D Describes rehabilitation programs (vocational, brain injury, etc.) and the recovery model[2]	4.2/C Employs prevention and risk reduction strategies in clinical care 4.3/D Appropriately refers to rehabilitation and recovery programs 4.4/D Uses principles of evidence-based practice and patient centered care in management of chronically ill patients	5.3/D Practices effectively in a rehabilitation and/or recovery-based program

Comments:
Footnotes: [1]Universal prevention strategies are designed to reach the entire population; selective prevention are designed for a targeted subgroup of the general population; and indicated prevention intervention targets individuals. [2]The Substance Abuse and Mental Health Services Administration (SAMHSA) has a working definition for the recovery model applied to mental health and addictions. This definition acknowledges that recovery is a process of change for an individual consumer to improve health and wellness, live a self-directed life, and strive and reach his or her full potential. The guiding principles that inform a recovery model of care include hope, person-driven, holistic, peer supports, social networks, culturally-based, trauma-informed, strength-based, responsibility, and respect (see: http://www.samhsa.gov/newsroom/advisories/1112223420.aspx). [3]These community resources include supports and services from both the peer and professional workforces.

SBP4. Consultation to non-psychiatric medical providers and non-medical systems (e.g., military, schools, businesses, forensic)
A: Distinguishes care provider roles related to consultation
B: Provides care as a consultant and collaborator
C: Specific consultative activities

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Describes the difference between consultant and primary treatment provider	2.1/A Describes differences in providing consultation for the system or team versus the individual patient 2.2/B Provides consultation to other medical services 2.3/C Clarifies the consultation question 2.4/C Conducts and reports a basic decisional capacity evaluation	3.1/C Assists primary treatment care team in identifying unrecognized clinical care issues 3.2/C Identifies system issues in clinical care and provides recommendations 3.3/C Discusses methods for integrating mental health and medical care in treatment planning	4.1/B Provides integrated care for psychiatric patients through collaboration with other physicians[1] 4.2/C Manages complicated and challenging consultation requests	5.1/B Provides psychiatric consultations to larger systems 5.2/B Leads a consultation team
☐	☐	☐	☐	☐	☐

Comments:

Footnotes:
[1] Provides communication back to the primary care physicians in the outpatient setting, including collaborative and co-located settings such as a medical home.

PBLI1. Development and execution of lifelong learning through constant self-evaluation, including critical evaluation of research and clinical evidence **A:** Self-Assessment and self-Improvement B: Evidence in the clinical workflow					
Has not Achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	1.1/A Uses feedback from teachers, colleagues, and patients to assess own level of knowledge and expertise 1.2/A Recognizes limits of one's knowledge and skills and seeks supervision 1.3/B Describes and ranks levels of clinical evidence[1]	2.1/A Regularly seeks and incorporates feedback to improve performance 2.2/A Identifies self-directed learning goals and periodically reviews them with supervisory guidance 2.3/B Formulates a searchable question from a clinical question[2]	3.1/A Demonstrates a balanced and accurate self-assessment of competence, using clinical outcomes to identify areas for continued improvement 3.2/B Selects an appropriate, evidence-based information tool[1] to meet self-identified learning goals 3.3/B Critically appraises different types of research, including randomized controlled trials (RCTs), systematic reviews, meta-analyses, and practice guidelines	4.1/A Demonstrates improvement in clinical practice based on continual self-assessment and evidence-based information 4.2/A Identifies and meets self-directed learning goals with little external guidance 4.3/A, B Demonstrates use of a system or process for keeping up with relevant changes in medicine[2] 4.4/B Independently searches for and discriminates evidence relevant to clinical practice problems	5.1/A, B Sustains practice of self-assessment and keeping up with relevant changes in medicine, and makes informed, evidence-based clinical decisions 5.2/B Teaches others techniques to efficiently incorporate evidence gathering into clinical workflow 5.3/B Independently teaches appraisal of clinical evidence
☐	☐	☐	☐	☐	☐

Comments:

Footnotes:

[1]Examples include: practice guidelines; PubMed Clinical Queries; Cochrane, DARE, or other evidence-based reviews; Up-to-Date, etc.

[2]Examples include: a performance-in-practice (PIP) module as included in the American Board of Psychiatry and Neurology (ABPN) Maintenance of Certification (MOC) process; or regular and structured readings of specific evidence sources.

PBLI2. Formal practice-based quality improvement based on established and accepted methodologies[1]
A: Specific quality improvement project
B: Quality improvement didactic knowledge

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Recognizes potential gaps in quality of care and system-level inefficiencies[2]	2.1/A Narrows problems within own clinical service(s) to a specific and achievable aim for a quality improvement (QI) project	3.1/A Involves appropriate stakeholders in design of a QI project[4]	4.1/A Substantially contributes to a supervised project to address specific quality deficit within own clinical service(s), and measures relevant outcomes	5.1/A Independently proposes and leads projects to enhance patient care 5.2/A Uses advanced quality measurement and "dashboard" tools
	1.2/B Discusses with supervisors possible quality gaps and problems with psychiatric care delivery	2.2/B Outlines factors and causal chains contributing to quality gaps within own institution and practice[3]	3.2/B Lists common responses of teams and individuals to changes in clinical operations and describes strategies for managing same	4.2/B Describes basic methods for implementation and evaluation of clinical QI projects[5]	5.3/B Describes core concepts of advanced QI methodologies and business processes[6]
☐	☐	☐	☐	☐	☐

Comments:

Footnotes:
[1]Many of these requirements would be satisfied by active participation in an individual or group project within the residency program, department, or institution. Active participation, at a minimum, should include observation and participation through a full feedback cycle (e.g., one Plan-Do-Study-Act loop). Some didactic material or assigned readings may be helpful to supplement the case-based learning. Resources for didactics include the Institute for Health Care Improvement Open School (http://www.ihi.org/offerings/IHIOpenSchool/), World Health Organization Patient Safety Curriculum (http://www.who.int/patientsafety/education/curriculum/download/en/index.html), and Department of Veterans Affairs Patient Safety Curriculum (http://www.patientsafety.va.gov/curriculum/index.html).
[2] Examples include: problems with transfer of information during sign-out or patient movement between care areas; difficulty in moving needed resources to a patient's location; prescribing practices that markedly deviate from guidelines.
[3] Chooses an inefficient/ineffective practice or recent adverse outcome, identifies some factors contributing to the status quo, and displays some sense of which factors are amenable to intervention.
[4] Examples include, for a project involving a standard order protocol on an inpatient unit: meets with nurse managers and ancillary clinical staff members and learns about their needs/constraints before designing intervention; recognizes fear of change as a common characteristic in clinical environments and provides staff members space/time to adequately process and modify proposals. At this stage, requires supervision/guidance in such efforts.
[5] This might include variations on the Plan-Do-Study-Act theme (i.e., stating an understanding that an effective project should include a target population and intervention, an outcome measure, and some form of iterative refinement).
[6] Can state some core philosophical concepts of Lean Production, the Six-Sigma/Total Quality Management methods, or other emerging management philosophies, and gives examples of how these could apply in health care.

PBLI3. Teaching **A:** Development as a teacher **B:** Observable teaching skills					
Has not Achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	1.1/A Recognizes role of physician as teacher	2.1/A Assumes a role in the clinical teaching of early learners 2.2/B Communicates goals and objectives for instruction of early learners 2.3/B Evaluates and provides feedback to early learners	3.1/A Participates in activities designed to develop and improve teaching skills 3.2/B Organizes content and methods for individual instruction for early learners	4.1/A Gives formal didactic presentation to groups (e.g., grand rounds, case conference, journal club) 4.2/B Effectively uses feedback on teaching to improve teaching methods and approaches	5.1/A Educates broader professional community and/or public (e.g., presents at regional or national meeting) 5.2/B Organizes and develops curriculum materials
☐	☐	☐	☐	☐	☐
Comments:					

PROF1.[1] Compassion, integrity, respect for others, sensitivity to diverse patient populations[2, 3], adherence to ethical principles **A:** Compassion, reflection, sensitivity to diversity **B:** Ethics					
Has not Achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	1.1/A Demonstrates behaviors that convey caring, honesty, genuine interest, and respect for patients and their families 1.2/A Recognizes that patient diversity affects patient care 1.3/B Displays familiarity with some basic ethical principles (e.g., confidentiality, informed consent, professional boundaries)	2.1/A Demonstrates capacity for self-reflection, empathy, and curiosity about and openness to different beliefs and points of view, and respect for diversity 2.2/A Provides examples of the importance of attention to diversity in psychiatric evaluation and treatment 2.3/B Recognizes ethical conflicts in practice and seeks supervision to manage them	3.1/A Elicits beliefs, values, and diverse practices of patients and their families, and understands their potential impact on patient care 3.2/A Routinely displays sensitivity to diversity in psychiatric evaluation and treatment 3.3/B Recognizes ethical issues in practice and is able to discuss, analyze, and manage these in common clinical situations	4.1/A Develops a mutually agreeable care plan in the context of conflicting physician and patient and/or family values and beliefs 4.2/A Discusses own cultural background and beliefs and the ways in which these affect interactions with patients	5.1/A Serves as a role model and teacher of compassion, integrity, respect for others, and sensitivity to diverse patient populations 5.2/B Leads resident case discussions regarding ethical issues 5.3/B Adapts to evolving ethical standards (i.e. can manage conflicting ethical standards and values and can apply these to practice) 5.4/B Systematically analyzes and manages ethical issues in complicated and challenging clinical situations
☐	☐	☐	☐	☐	☐
Comments:					

Footnotes:
[1]The two Professionalism subcompetencies (PROF1 and PROF2) reflect the following overall values: Residents must demonstrate a commitment to carrying out professional responsibilities and adherence to ethical principles. Residents must develop and acquire a professional identity consistent with values of oneself, the specialty, and the practice of medicine. Residents are expected to demonstrate compassion, integrity, and respect for others; sensitivity to diverse populations; responsibility for patient care that supersedes self-interest; and accountability to patients, society, and the profession.
[2]Diversity refers to unique aspects of each individual patient, including gender, age, socioeconomic status, culture, race, religion, disabilities, and sexual orientation.
[3]For milestones regarding health disparities, please see SBP2.

PROF2. Accountability to self, patients, colleagues, and the profession **A:** Fatigue management and work balance **B:** Professional behavior and participation in professional community **C:** Ownership of patient care					
Has not Achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	1.1/A Understands the need for sleep, and the impact of fatigue on work 1.2/A Lists ways to manage fatigue, and seeks back-up as needed to ensure good patient care	2.1/A Notifies team and enlists back-up when fatigued or ill, so as to ensure good patient care	3.1/A Identifies and manages situations in which maintaining personal emotional, physical, and mental health is challenged, and seeks assistance when needed 3.2/A Recognizes the tension between the needs of personal/family life and professional responsibilities, and its effect on medical care	4.1/A Knows how to take steps to address impairment in self and in colleagues 4.2/A Prioritizes and balances conflicting interests of self, family, and others to optimize medical care and practice of profession[2]	5.1/A Develops physician wellness programs or interventions
	1.3/B Exhibits core professional behaviors[1] 1.4/B Displays openness to feedback	2.2/B Follows institutional policies for physician conduct	3.3/B Recognizes the importance of participating in one's professional community	4.3/B Prepares for obtaining and maintaining board certification	5.2/B Develops organizational policies, programs, or curricula for physician professionalism 5.3/B Participates in the professional community (e.g., professional societies, patient advocacy groups, community service organizations)
	1.5/C Introduces self as patient's physician	2.3/C Accepts the role of the patient's physician and takes responsibility (under supervision) for ensuring that the patient receives the best possible care	3.4/C Is recognized by self, patient, patient's family, and medical staff members as the patient's primary psychiatric provider	4.4/C Displays increasing autonomy and leadership in taking responsibility for ensuring that patients receive the best possible care	5.4/C Serves as a role model in demonstrating responsibility for ensuring that patients receive the best possible care
☐	☐	☐	☐	☐	☐

Comments:
Footnotes: [1]Professional behavior refers to the global comportment of the resident in carrying out clinical and professional responsibilities. This includes: a. timeliness (e.g., reports for duty, answers pages, and completes work assignments on time); b. maintaining professional appearance and attire; c. being reliable, responsible, and trustworthy (e.g., knows and fulfills assignments without needing reminders); d. being respectful and courteous (e.g., listens to the ideas of others, is not hostile or disruptive, maintains measured emotional responses and equanimity despite stressful circumstances); e. maintaining professional boundaries; and, f. understanding that the role of a physician involves professionalism and consistency of one's behaviors, both on and off duty. These descriptors and examples are not intended to represent all elements of professional behavior. [2]Residents are expected to demonstrate responsibility for patient care that supersedes self-interest. It is important that residents recognize the inherent conflicts and competing values involved in balancing dedication to patient care with attention to the interests of their own well-being and responsibilities to their families and others. Balancing these interests while maintaining an overriding commitment to patient care requires, for example, ensuring excellent transitions of care, sign-out, and continuity of care for each patient during times that the resident is not present to provide direct care for the patient.

ICS1. Relationship development and conflict management with patients, families, colleagues, and members of the health care team **A:** Relationship with patients **B:** Conflict management **C:** Team-based care					
Has not Achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	1.1/A Cultivates positive relationships with patients, families, and team members 1.2/B Recognizes communication conflicts in work relationships 1.3/C Identifies team-based care as preferred treatment approach, and collaborates as a member of the team	2.1/A Develops a therapeutic relationship with patients in uncomplicated situations 2.2/A Develops working relationships across specialties and systems of care in uncomplicated situations 2.3/B Negotiates and manages simple patient/family-related conflicts 2.4/C Actively participates in team-based care; supports activities of other team members, and communicates their value to the patient and family	3.1/A Develops therapeutic relationships in complicated situations 3.2/B Sustains working relationships in the face of conflict 3.3/C Facilitates team-based activities in clinical and/or non-clinical situations (including on committees)	4.1/A Sustains therapeutic and working relationships during complex and challenging situations, including transitions of care 4.2/C Leads a multidisciplinary care team	5.1/A Sustains relationships across systems of care and with patients during long-term follow-up 5.2/A, B Develops models/approaches to managing difficult communications 5.3/B, C Manages treatment team conflicts as team leader 5.4/C Leads and facilitates meetings within the organization/system
☐	☐	☐	☐	☐	☐
Comments:					

ICS2. Information sharing and record keeping
A: Accurate and effective communication with health care team
B: Effective communications with patients
C: Maintaining professional boundaries in communication
D: Knowledge of factors which compromise communication

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Ensures transitions of care are accurately documented, and optimizes communication across systems and continuums of care 1.2/A Ensures that the written record (electronic medical record [EMR], personal health records [PHR]/patient portal, hand-offs, discharge summaries, etc.) are accurate and timely, with attention to preventing confusion and error, consistent with institutional policies 1.3/B Engages in active listening, "teach back," and other strategies to ensure patient and family understanding 1.4/C Maintains appropriate boundaries in sharing information by electronic communication	2.1/A, B Organizes both written and oral information to be shared with patient, family, team, and others 2.2/B Consistently demonstrates communication strategies to ensure patient and family understanding 2.3/B Demonstrates appropriate face-to-face interaction while using EMR 2.4/C Understands issues raised by the use of social media by patients and providers	3.1/ A, B Uses easy-to-understand language in all phases of communication, including working with interpreters 3.2/B Consistently engages patients and families in shared decision making	4.1/A, B Demonstrates effective verbal communication with patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent 4.2/A, B Demonstrates written communication with patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent 4.3/C Uses discretion and judgment in the inclusion of sensitive patient material in the medical record	5.1/A Models continuous improvement in record keeping 5.2/C Participates in the development of changes in rules, policies, and procedures related to technology

		2.5/D Lists factors that affect information sharing (e.g., intended audience, purpose, need to know) 2.6/D Lists effects of computer use on accuracy of information gathering and recording and potential disruption of the physician/patient/family relationship	3.3/D Gives examples of situations in which communication can be compromised (e.g., perceptual impairment, cultural differences, transference, limitations of electronic media)	4.4/C Uses discretion and judgment in electronic communication with patients, families, and colleagues	
☐	☐	☐	☐	☐	☐
Comments:					