ORIENTING INTERNATIONAL MEDICAL GRADUATES TO PSYCHIATRY RESIDENCY TRAINING IN CANADA:

A CANADIAN PSYCHIATRIC ASSOCIATION MANUAL-2ND EDITION
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**Disclaimer: Please note that all websites listed in this manual were updated as of the Fall 2014. Over time it is expected that some if not all of the websites listed will become updated or obsolete. As such, we cannot confirm long term accuracy or functioning of any of the websites mentioned in this manual.**
1. Introduction
Dr. Sanjeev Sockalingam and Dr. Alpna Munshi

Welcome! If you are reading this introduction, it means you have cleared the many hurdles associated with applying for psychiatry residency and have received admission to a Canadian psychiatry residency program. Congratulations!

Before you begin your residency journey, we recommend reading this manual to help you during the early part of your residency and to serve as a resource during your training. We hope you find this manual useful and we look forward to working with you over the course of your training.

1.1 Rationale for This Manual

This manual was designed to be your quick reference guide based upon existing literature and feedback from international medical graduates (IMGs) in Canadian psychiatry residency programs. Past attempts to orient IMGs to Canadian postgraduate training programs have focused primarily on broad principles applicable to IMGs across all medical and surgical disciplines. However, specific tips and information to help psychiatry IMGs with their transition into psychiatry residency has not been readily accessible early in residency. In fact, a needs assessment from five Canadian psychiatry residency programs showed that nearly 90% of IMGs received little or no IMG-specific preparation for psychiatry residency\(^1\). The result of these training gaps are stories like Tariq’s, which highlight the struggles often facing IMGs early in their psychiatry residency.

Case 1:

_Tariq is scheduled to start his psychiatry residency at the University of Toronto after practising psychiatry for three years in Saudi Arabia. He is sponsored by his government and entered residency as a visa trainee. He has been living in Toronto for the last two months and recently completed his Pre-entry Assessment Program (PEAP). Tariq’s family will be arriving in Toronto in a few weeks and he is eager to see them._

_His first rotation is emergency psychiatry at a new and unfamiliar hospital. He has mixed feelings about starting residency including excitement, isolation and anxiety. He knows one resident in the psychiatry program who is three years ahead of him, and Tariq has used this individual as a resource a few times over the last month._
However, Tariq is struggling with issues of finding a home for his family. He is also wondering if and how he can get an Ontario driver’s licence for himself.

In addition to the practicalities of living in Canada, Tariq is concerned about some of the feedback he received during his PEAP. He recalled his last supervisor’s concerns about his language skills and knowledge deficits in psychiatry. Tariq felt confused about this feedback as he knew all the answers to his supervisor’s questions on rounds and often waited to be called upon to participate. He was unfamiliar with the structure of rounds in Canada as it was different from his past training and teaching experiences. Tariq recalled his anxiety and hesitation during presentations, as he was never given a clear guide on how to present or document new consults. He began feeling more anxious about the start of his emergency psychiatry rotation and had difficulty sleeping the night before. He wished that there was a way to prepare or to feel reassured about his psychiatry residency.

Unfortunately, Tariq’s challenges during his transition into psychiatry residency are not uncommon. In fact, several studies have highlighted several challenges facing IMGs early in their residency. For example, IMGs from non-Western countries may find the shift in the status of “the doctor” and reliance on large interdisciplinary teams a challenge due to Canadian shifts from a physician-focused team model to a more collaborative team approach. Moreover, IMGs may experience feelings of loss and disorientation, social isolation, language barriers and low self-esteem before adapting to their new professional environments.

Therefore, both IMG trainees and program directors have identified the need for orientation programs to facilitate IMG adjustment to the Canadian health care system. Transition into psychiatry residency may be further complicated by the emphasis on communication and the importance of the Mental Health Act in daily psychiatric care. Furthermore, psychiatrists are often called upon to act as a liaison and advocate for patients with mental illness, which may add to the burden on psychiatry IMG trainees early in their training.

A recent survey of IMGs in five Canadian psychiatry training programs explored the training needs specific to the transition into psychiatry residency. The survey results indicated that IMGs had the most difficulty with the Canadian mental health care system, medical documentation and understanding evidence-based mental health. Furthermore, nearly 70% of respondents indicated they would use a preparation-for-residency resource if made available, thus supporting...
the need for psychiatry-specific IMG resources including an IMG orientation manual.

1.2 Types of Psychiatry IMGs

Before we discuss common IMG issues, it is important to appreciate the range of trainees encompassed under the term IMG. An IMG, formerly called a foreign medical graduate, is defined as “a physician who obtained his or her medical degree in a medical school outside of Canada or the USA.” Using this definition, IMGs can be classified as three distinct categories:

a. **Canadian IMGs** — Canadians who completed their medical training outside of Canada
b. **Visa IMGs** — physicians who are recruited to Canada to meet the needs of Canadian postgraduate training programs, or who are sponsored to train in Canada and are expected to return to their sponsoring country at the conclusion of their training
c. **Immigrant IMGs** — individuals who have immigrated to Canada with medical degrees and enter Canadian residency training programs through IMG-specific programs or the second iteration of the Canadian Residency Matching Service (CaRMS). These residency training positions are provincially funded.

Moreover, IMGs entering psychiatry residency can be grouped as visa-funded trainees or Canadian-funded IMGs. Canadian-funded IMGs apply for designated IMG residency positions offered through the first iteration of CaRMS. Visa IMGs are doctors from abroad whose home countries finance their medical residency training within Canada, but are required to return home upon completion of their residency. Visa trainees do not participate in CaRMS. Therefore, this manual has been designed to cover a wide array of information and resources that will be pertinent to all IMGs training in Canada.
1.3 Goals of This Manual

In summary, we have developed this IMG orientation manual as a preparation resource for IMGs entering psychiatry residency in Canada. Given the varied training backgrounds of psychiatry IMGs in Canada, this manual will serve as a guide and provide an approach to managing a range of issues facing IMGs early in their residency.

We have organized the manual in specific sections correlating to key IMG concerns identified in the literature and by your peers.

It should be noted that not all IMGs will require this manual; however, the resources embedded in this manual reflect a multitude of IMG-specific dilemmas. Therefore, readers are encouraged to review the contents of this manual and encouraged to refer to relevant sections over the course of their psychiatry postgraduate training. We recognize that IMGs possess a plethora of talents and are an asset to psychiatry training programs. We hope this orientation manual provides a starting point for your success during your psychiatry residency.

References:
7. The Association of Faculties of Medicine of Canada. Available at: http://www.afmc.ca/img/OTI_3a_en.htm
2. Getting Started: Before Your Residency

Dr. Ahmed Alshareef, Dr. Daphne Voineskos, Dr. Araba Chintoh, and Dr. Darcy Waisman

2.1 Moving to Canada

Before moving to Canada, consider making a list of the necessary items you are bringing with you, so you can begin the academic year without having to worry about forgetting or returning things. With respect to legal documents, bring another document with your signature on it (if possible) in addition to your passport. Other documents will be beneficial as well, like a birth certificate and driver’s licence from your home country. You may also need extra official copies of your medical diploma and an updated curriculum vitae (C.V.).

Don’t forget to bring your credit cards from your home country and your bank account information. Pack your medical instruments with you including, but not limited to, your stethoscope, reflex hammer and tuning fork (you will need it for your first year rotations). Once you are settled into your psychiatry residency in your Postgraduate Year 2 (PGY2), proper recommended work clothing is business casual. However, in other rotations you might need to wear a lab coat on top of your work attire (note: lab coats and surgical scrubs are provided by your local hospital). Bring one or more formal attire for formal affairs. Although it is spring in the two months before July (the start of the academic year), you may need a light jacket for the weather. A very warm coat is essential for the winter season in most Canadian cities. Finally, don’t forget to bring your computer and an English dictionary.

2.2 Brief Introduction to Canada

Canada is a country of 10 provinces and three territories which are grouped into Western Canada, Central Canada, Northern Canada and Atlantic Canada, by region. You may also hear the term Eastern Canada, which includes both Central and Atlantic Canada. Canada’s population continues to grow, mostly from immigration. The last Canadian census in 2011 put our population at just under 33.5 million people. The majority of Canada’s population lives within 150 kilometres (93 miles) of the United States border. The highest proportion live in urban areas, mostly along the Quebec City to Windsor corridor, the Lower Mainland of British Columbia, which includes the region around Vancouver, and the Calgary-Edmonton area of Alberta.
According to the 2011 census, the most common ethnicities represented in the population included English, French, Scottish, Irish, German, Italian, Chinese, First Nations, Ukrainian, and East Indian. Approximately one-third of respondents identified their ethnicity as “Canadian.”

Of the people reporting an Aboriginal identity in 2011, 60%, identified as First Nations (North American Indian) only. Another 30%, identified as Métis only; and 4% identified as Inuit only. Other Aboriginal identities accounted for 2% of the Aboriginal population, and 0.8%, reported more than one Aboriginal identity.

Like many other developed countries, Canada is experiencing a demographic shift towards an older population, with more retirees and fewer people of working age. Canada’s population, however, is among the youngest in the G8 countries, with approximately 15% of the population aged 65 and over.

Canada’s two official languages are English and French. English and French have equal status in federal courts, Parliament, and in all federal institutions. Citizens have the right, where there is sufficient demand, to receive federal government services in either English or French, and official-language minorities are guaranteed their own schools in all provinces and territories.

2.2.1 Weather

The vastness and variety of Canada’s geography, ecology, vegetation and landforms have given rise to a wide variety of climates throughout the country. Average winter and summer high temperatures across Canada vary according to the location. Winters can be harsh in many regions of the country, particularly in the interior and Prairie provinces, which can experience daily average temperatures near −15 C, (5°F) but can drop below −40°C (−40°F) with severe wind chills. In noncoastal regions, snow can cover the ground almost six months of the year (more in the north). Coastal British Columbia enjoys a temperate climate, with a mild and rainy winter. On the east and west coasts, average high temperatures are generally in the low 20s°C (70s°F), while between the coasts, the average summer high temperature ranges from 25°C to 30°C (77°F to 86°F), with occasional extreme heat in some interior locations exceeding 40°C (104°F).

2.2.2 Arts and Culture
Historically, Canadian culture has been influenced by British, French and Aboriginal cultures and traditions. There are distinctive Aboriginal words, music, activities and traditions that are spread across Canada. Many North American indigenous words, inventions and games have become an everyday part of Canadian language and use. The canoe, snowshoes, the toboggan (sled), lacrosse, tug of war, maple syrup and tobacco are examples of products, inventions and games.\[http://en.wikipedia.org/wiki/Canada - cite\_note-193\]

Canadian culture has been greatly influenced by immigration from all over the world. Canadians value multiculturalism and see Canada as being inherently multicultural. However, the country’s culture has been heavily influenced by American culture because of its proximity and the high rate of migration between the two countries.

Canada’s national symbols are influenced by natural, historical and Aboriginal sources. The use of the maple leaf as a Canadian symbol dates to the early 18th century. The maple leaf is depicted on Canada’s flag, on the penny and the Coat of Arms. Other prominent symbols include the beaver, the Canada goose, the loon, the Crown, the Royal Canadian Mounted Police (RCMP), and more recently, the totem pole and the Inukshuk.

Canada nurtures its cultural arts. Urban centres foster the development of theatre, ballet, dance and opera companies and symphony orchestras. Canada’s cities contain many areas with boutiques, art galleries, restaurants and artist studios. The production of domestic and foreign film and television is a major Canadian industry, especially in Toronto, Calgary and Vancouver. Most Canadian cities celebrate diversity with a variety of multicultural and ethnic festivities that showcase ethnospecific foods, music, dance, and customs, and are often well attended and advertised, and are a source of pride for many Canadians.

### 2.2.3 Settling in Canada

Two essential things you need to settle in Canada are finances and accommodation. For most banks, all that is required to open an account are two pieces of identification (please see bank websites for list of acceptable identification). You can also apply for credit cards at the same bank.

With respect to accommodation, it is best to consider finding a place in the downtown area of your new city. Most hospitals are located in the
downtown core and travel would be kept to a minimum. If you are required to attend a hospital outside the city centre during your training, transportation via hospital shuttle services may be available. Public transit is also an option. Downtown living has easy access to such perks as sporting events, restaurants, museums, tourist attractions and a lively nightlife.

2.3 Getting Your Documents

2.3.1 Work Permit

Postgraduate medical trainees who are not Canadian citizens (or who do not have permanent resident status in Canada) require a work permit for the duration of their training program.

As soon as the Postgraduate Medical Education (PGME) office receives confirmation of your training appointment with supporting documents from the Department of Psychiatry, they will contact you at once regarding the work permit process. The PGME Office will provide you with documentation that will enable you to apply for the appropriate work permit from Citizenship and Immigration Canada.

Please note that, from the date the PGME office receives confirmation of your training appointment, it may take up to five months to obtain the work permit.

2.3.2 Driver’s Licence

Driver’s licences in North America are often used as a standard form of identification because it includes your signature (which will be helpful in most places). We strongly recommend you apply for one (even if you are not intending to buy a car).

All that you need for applying is an identification card with signature (immigration document, birth certificate, etc.) and your home country driver’s licence. If your home country’s driver’s licence is not in English, some cities have a specialized centre provided by the Ministry of Transportation to translate for you. You may need a proof of address which will usually be a home phone, cell phone or cable bill.

2.3.3 Social Insurance Number

The Social Insurance Number (SIN) is a nine-digit number that you need to work in Canada or to have access to government programs and
benefits. You can apply for a social insurance card at one of the Human Resources Centre of Canada. You will need the original copies of the following documents:

1. Identification document
2. Birth certificate for Canadian citizens
3. Work permit
4. Completed application form which can be obtained online or in person at the centre

Your original documents will be returned to you at the same time of the application, and your card will be mailed to your address within 10 working days. See: http://www.servicecanada.gc.ca/eng/sc/sin/

2.3.4 Provincial Health Plans

Canada has a national health insurance, also referred to as Medicare, consisting of 13 interlocking provincial and territorial health insurance plans. This national plan aims to provide all residents with reasonable access to medically necessary hospital and physician services on a prepaid basis. In some provinces, there may be a delay in obtaining your provincial health plan (e.g., 90 days) and you may be offered University Health Insurance Plan coverage through your postgraduate medical education office for a pre-determined fee.

Information on the application process for your province’s health plan can be found at: http://www.servicecanada.gc.ca/eng/subjects/cards/health_card.shtml

2.3.5 Provincial Colleges of Physicians and Surgeons

In general, each province has its own provincial College of Physicians and Surgeons. This body regulates the practice of medicine to protect and serve the public's interest. Each provincial college has its own application process and forms. You will need to review your provincial college’s website to find details on the application process.

2.3.6 Canadian Medical Protective Association (CMPA)

Provincial Colleges of Physicians and Surgeons require all applicants for
licensure to obtain adequate professional liability protection prior to commencing any medical practice. In addition, malpractice protection through CMPA membership is a requirement for registration with the PGME office. The CMPA provides its physician members with medico-legal advice, risk management education and legal assistance related to their clinical practice. The CMPA website includes downloadable application materials at: https://oplfrpd5.cmpa-acpm.ca/how-to-apply

2.3.7 Importance of Annual Renewal of Documentation in Residency

As a resident physician you will need to ensure that you obtain both a license to practice medicine, through your province’s college of physicians and surgeons, as well as adequate professional liability protection from the Canadian medical protective association (CMPA), prior to commencing your duties as a physician. This can be done online through the respective websites of the provincial college and CMPA. It is also extremely important to renew this documentation, on a once yearly basis, in order to ensure that you can continue to practice. It is recommended that you renew these at least one month prior to the start of each new residency year.
3. Understanding Canadian Psychiatry Residency Training

Dr. Ari Zaretsky, Dr. Sanjeev Sockalingam, Dr. Mohammad Alsuwaidan

3.1 Royal College Training Requirements

The residency program is laid out according to a very careful structure consistent with the Royal College of Physicians and Surgeons of Canada’s Specialty Training Requirements (STR) for Psychiatry. PGY-1 is the Basic Clinical Training year and each residency program has pre-determined rotation schedules for PGY-1 that adhere to Royal College guidelines. In general, the PGY-1 year consists of exposure to rotations in medicine (internal medicine, family medicine, pediatrics), psychiatry and electives or selective experiences.

During the PGY-2 and PGY-3 junior residency years, residents are required to complete 12 months of adult psychiatry training. This will usually involve a combination of inpatient and ambulatory settings. Six months of child psychiatry and six months of geriatric psychiatry training also occur during the junior residency years.

The PGY-4 and PGY-5 senior years of residency provide an opportunity for residents to consolidate their skills and to function as an independent consultant. During the PGY-4 and PGY-5 years, residents will complete three to six months of consultation-liaison psychiatry and approximately two months of shared care. Residents complete at least one month of addiction psychiatry during their PGY-2 to PGY-5 training years. In addition, residents will complete a three- to six-month rotation focused on Severe Persistent Mental Illness (SPMI) and its rehabilitation. During the PGY-5 year residents will have an opportunity to choose from a range of selects and electives as specified by the Royal College of Physicians and Surgeons of Canada. Residents are encouraged to review the Psychiatry STR located on the Royal College website.

3.2. Your Psychiatry Postgraduate Office

In keeping with Canadian Royal College Standards of Accreditation, each psychiatry residency program is overseen and directed by a psychiatry residency program committee, which is usually chaired by the Program Director. Residency program committees have resident representation such as the president of the local Psychiatry Resident Association, Chief Resident or another designated resident representative.
Your Psychiatry Postgraduate Education Office oversees administrative issues and is staffed by administrative staff that will be important resources to you during your residency training. The Postgraduate Education Office can help with issues pertaining to registration, rotations, vacation, medical or family leave and your evaluations.

3.3 Evaluation

Evaluation of competence occurs at a few points during your rotations. Generally speaking, there will be a midpoint evaluation in most programs, as well as an evaluation at the end of each rotation (clinical, research or psychotherapy). The primary supervisor for your rotation will complete this evaluation. Supervisors may gather input from all of the individuals who have worked closely with the resident during the rotation, including non-MD health care professionals. Rotation evaluations assess a resident’s functioning based on the specific goals and objectives of the rotation and are tailored for each individual rotation. All evaluations will address the seven Canadian Medical Education Directives for Specialists (CanMEDS) competencies expected of Canadian medical specialists: medical expert (knowledge and skills), communicator, collaborator, leader, health advocate, scholar and professional (see Appendix A). Residents are expected to receive mid-term written or verbal feedback at the middle of a rotation. If a resident is experiencing difficulty, it is important to identify specific areas for improvement at the mid-term in order to provide the resident with an opportunity to improve over the remainder of the rotation.

Residency programs may also use written and oral exams to evaluate residents during their residency training. Some programs administer written exams based upon residency curricula. Residents also have an opportunity to participate in the annual Canadian psychiatry in-training written examination (the COPE Exam).

In addition, oral exams may be scheduled at the end of each academic year and offer an opportunity for formative feedback. These exams consist of one or more examiners and a real patient. Sometime between the late spring of the PGY-4 year and the fall of the PGY-5 year, residents complete their STACER (Standardized Assessment of Clinical Encounter Report) examinations, which are the mandatory Royal College final exit exams. These exit examinations aim to evaluate if residents are performing at the level of a consultant psychiatrist. Passing these examinations is necessary before the resident is able to take the Royal College Certification Examinations in the spring of their PGY-5 year.
Receiving Feedback

Feedback is the communication of information about a past performance with the goal of improving trainee performance. The goal during residency is to receive frequent, specific, and constructive feedback to facilitate learning.

It is always a challenge when residents encounter a clinical or exam situation where they do not perform as well as they may have expected or have traditionally performed. While this may be upsetting to some, it is important to take the feedback in stride and to see residency as a optimal time to receive and incorporate detailed and helpful feedback as one hones one’s clinical and analytical skills. The process of giving and receiving feedback can be complicated by cultural differences in the manner and content of feedback from where you may have trained (even residents training at different medical schools within Canada experience this) and where you are currently training. Also, people may experience feedback or constructive criticism differently based on their cultural backgrounds or upbringing. These cultural and training differences can also influence how supervisors give feedback.

These complexities notwithstanding, please keep in mind that supervision and feedback on one’s performance becomes much more difficult to obtain once residency is done and you are out in the world of independent practice. As such, try your best to obtain as much direction and guidance as you can. If you have some issues with the feedback you’ve been provided, please consider speaking to your supervisor, a mentor, or postgraduate director about your concerns.

3.4 Resident Safety

Resident safety is of utmost importance for Canadian psychiatry training programs. Two key resident safety concerns are violence towards residents and the support for residents who experience a patient suicide. Psychiatry residents are at risk of violence and assaults due to the number of hours spent in acute treatment settings. In a survey of Canadian psychiatry residents, approximately 40% reported they had been assaulted by a patient at least once. Moreover, up to one-third of psychiatry residents experience patient suicide during their training (as above).

As a result, Canadian psychiatry residency programs are required to provide core training on violence and suicide risk assessment. Violence
risk assessment, prevention and management training are essential to minimizing resident assaults. Furthermore, it is important to be familiar with policies and safety procedures at your hospital site. Residents should be aware of the location of panic buttons or panic strips, and the availability of security and seclusion-restraint techniques in their training setting. In the event of a resident assault, it important for residents to notify their supervisor, psychiatry site postgraduate coordinator or program director in order to facilitate re-assessment of the site’s safety and to identify areas for improvement.

In the event of a patient suicide, residents should be aware of the resources and debriefing policies specific to their residency program. Programs aim to support residents experiencing a patient suicide, although the process and level of support will vary based upon each resident’s specific needs.

3.5 Culturally Competent Care in the Canadian Context

Dr. Alpna Munshi

One of the most rewarding aspects about working in Canada is the multicultural diversity of this country. According to CPA guidelines, these cultural variations have been shown to influence physicians’ ability to detect, diagnose and appropriately treat mental health problems. ¹

By not attending to issues around culture, it can also lead to perpetuating practices or reinforcing barriers to care that can unintentionally harm your patient.

Due to this important context, Canadian trained psychiatry residents must strive towards identifying and responding to institutional, societal, and political practices that are rooted in cultural biases and uneven power structures that can do harm to patients. Because of this diversity in Canada, and the impact that social and cultural determinants of health have on access to care and health care outcomes, the Canadian Psychiatric Association’s Section on Transcultural Psychiatry developed Guidelines for Training in Cultural Psychiatry.

The committee emphasises the importance of responding to this diversity in Canada by developing strategies for cultural safety, cultural competence, and culturally responsive care that can be adapted to
work with diverse groups. That means going beyond being aware of ethno-specific expressions or idioms of distress, and moving towards a firm grasp of attitudes, knowledge, and skills that make you a culturally competent psychiatrist, and give you the foundation to advocate for culturally safe practices in your institution and program.

Cultural competence means\(^1\):
- Having an awareness of the impact of the clinicians own ethnocultural identity on patients
- Knowledge of language and cultural background of groups seen in clinical practice and their interactions with mental health issues and treatment
- Skills for working with particular groups
- Development of a system that is capable of offering equitable care and outcomes

Some useful resources to learn more about cultural competency and cultural psychiatry and some tools to help you build these skills are listed below:


Fung et al. (2008). An integrative approach to cultural competence in the psychiatric curriculum. Academic Psychiatry, 32(4) 272-82

Outline for Cultural Formulation: DSM-V

Cultural Formulation Interview: DSM-V
3.6 Professionalism

Dr. Fernando Corbalan and Dr. Darcy Waisman

Professionalism means to behave according to the ethical principles guiding the practice of medicine. It represents an important part of a resident’s evaluation, because as a physician one is expected to perform and follow high ethical standards. Residents are constantly assessed based on their *excellence, humanism, and altruism*, which are evaluated through their demonstration of clinical competence, communication skills, ethical and legal understanding.

*Excellence* refers to the commitment to competence, the capacity to understand, to apply ethical principles and values, and to show respect for legal boundaries. A resident is expected to develop autonomy to demonstrate self-initiative, and to show interest with all of the commitments.

*Humanism* is the quality of being respectful, feeling compassion and empathy for patients, and others, under all circumstances.

*Altruism* consists on prioritizing patient’s interests over personal ones.

A summary of important behaviours to respect, a “do’s and don’t’s”

Do:
- Ask for help if you are experiencing distress
- Participate actively in the inter-professional health team
- Develop appropriate communication skills to interact with patients, family members, and other health related professionals
- Be respectful at all times with patients (and others)
- Be self-motivated in the search for scientific information

Don’t
- Miss orientation sessions or any scheduled activities
- Arrive late to clinical and academic appointments (like ground rounds, journal club, scientific meetings)
- Schedule vacations at the beginning of rotations
- Leave the hospital without notifying your supervisor (i.e., in the case of a personal emergency or if you finished your assigned tasks)
- Text during lectures or rounds
3.7 Children’s Aid Society

Dr. Laura M. Kennedy

It is important to become familiar with your mandatory reporting obligations, and one of those is when you suspect that harm may befall or has befallen a minor. The Children’s Aid Society is an independent organization with funding from the Canadian government to perform child protective services. Each province has their own CAS subsidiary. Their goal is to, "promote the best interests, protection and well being of children".[1]

Their principal goals are to:[2]

- Investigate reports or evidence of abuse or neglect of children under the age of 16 or in the society's care or supervision and, where necessary, take steps to protect the children
- Care for and supervise children who come under their care or supervision
- Counsel and support families for the protection of children or to prevent circumstances requiring the protection of children
- Place children for adoption.

Check with provincial reporting standards as some provinces may have other mandatory reporting obligations.

References:

4. How to Be an Avid Learner

Dr. Mohammad Alsuwaidan, Dr. Sanjeev Sockalingam

4.1 Seeking Out a Mentor

A mentor is more than a role model. A good mentor is engaged in the mentee’s interest and works with him or her towards a shared goal. The successful mentor fosters the mentee’s independence and does this while maintaining the ethics and values of the profession.

Mentors can be a useful resource to alleviate frustrations or distress, to help navigate the hospital or university system, and to guide your personal and professional growth. It is well known that trainees with mentors often experience higher levels of career satisfaction compared to trainees without mentors. (add reference)

Trainees can consider seeking mentors early in their residency. It should be noted that mentors may change with time and multiple mentors with expertise and knowledge in various areas may be needed.

Although you may encounter mentors by chance during your residency experiences, it is important to know where you can formally obtain a mentor. Some psychiatry residency programs have formal mechanisms for obtaining a mentor and your psychiatry postgraduate office will be able to provide you with guidance on obtaining a mentor. If you are seeking mentorship outside of your program, the Canadian Psychiatric Association (CPA) also has a formal national mentorship program and has created a national IMG mentorship program with access to mentors who are interested in assisting IMGs in Canadian psychiatry residency programs. See: http://www.cpa-apc.org/browse/documents/223

4.2 Learning Interviewing Skills

The psychiatric interview is the equivalent to the surgeon’s scalpel. This core skill is developed throughout your residency training, starting in your PGY-1 year through observed clinical interviews during psychiatry rotations. However, assessment and teaching of the psychiatric interview begins formally in your PGY-2 year. All PGY-2 to PGY-5 psychiatry residents are encouraged to practice these skills by scheduling mock oral examinations and through formal interviewing courses that may be offered in your program. In addition, you will receive formal feedback following your annual departmental oral examinations at the end of your PGY-2 and PGY-3 years. During your PGY-4 and PGY-5 years, you will need to pass two out of three final oral
examinations (called STACER exams) in order to proceed with your Royal College exam. When possible, you should take advantage of obtaining feedback on your psychiatric interviews with your primary supervisors during your residency.

Please see Appendix C for a list of common slang terms and resources to enhance your communication with patients during the psychiatric interview.

4.3 Asking Questions and Advocating for Yourself

Active participation is encouraged and appreciated by your teachers during your educational sessions. You can participate in sessions both by answering and asking questions. You may hear several of your teachers emphasize that “there is no such thing as a stupid question” and this is absolutely correct. Asking questions may also generate useful feedback which can be helpful in assessing your own performance.

If you think you require help with insufficient resources (e.g., no telephone in your office), supervisor issues or have rotation-specific concerns, we encourage you to advocate for your needs by contacting the appropriate individuals in your department. This may start with contacting the Chief residents at your site or your psychiatry resident association. If further assistance is required, you should consider contacting your psychiatry Postgraduate Site Coordinator at your base hospital, psychiatry PGY-1 Coordinator (if applicable), or the Psychiatry Residency Program Director. Remember, your needs are important and valued by the department and there are several resources in place for this specific purpose.

4.4 Research Training

Psychiatry research is evolving at a rapid pace and postgraduate training is an opportunity to take advantage of research opportunities and specific research supervisors in your psychiatry program. There are formal and informal research streams that you may participate in over the course of your residency training. It is important to keep in mind that you can participate in research at any time during residency, although designated research tracks have specific deadlines.

Formal research training tracks may be offered in your residency training program and can include the Clinician Scientist Program. The Clinician Scientist Stream (CSS) in PGY-1 through PGY-4 years will
allow residents who think that they may be interested in a research career, to become involved early on. The formal Clinician Scientist Program (CSP) will commence in the PGY-5 year under the new regulations of the Royal College of Physicians and Surgeons of Canada, when residents will be expected to be enrolled full time in graduate school.

In addition, your residency program may offer research half-days throughout your training. The criterion for research half-days is specific to your postgraduate training program and you should speak with your program director or the head of research in your psychiatry postgraduate office. Application for research half-days may include completion of specific forms and will likely require approval from your postgraduate office. It is important for you to identify a research supervisor and a clear research focus as part of this application process.

Informal research can be accomplished over the course of your rotations and may include case-reports, chart reviews and other small research projects. If you have an interest in research during the course of a particular rotation, you should discuss it with your supervisor as opportunities may be available to join active projects or to participate in small case series or case report projects. Finally, if you would like more research training after residency, research fellowships may be available. For more information, please contact your fellowship department or program heads if you are interested in research in a particular area of psychiatry (e.g., child psychiatry, geriatrics, forensics, psychosomatics, etc.).

4.5 Peer Study Groups

Peer study groups are a key to preparing for the Royal College examinations. They are arranged by the residents usually between PGY-2 and PGY-4 depending on the focus of the group. Although some residents will form study groups early in their residency, there is no designated time to begin your study group. It is encouraged that you join a study group by at least PGY-4 if not sooner in order to obtain the benefit from group learning, pacing yourself with your peers and sharing resources prior to your examinations. Some study groups will start early in residency and plan to meet less frequently to discuss interesting and valuable subjects. By PGY-3 or PGY-4, more regular study group meetings may be needed to work through standard content such as practice guidelines, chapters in Kaplan and Saddock Synopsis (the standard psychiatric textbook used in most Canadian
programs) and seminal research articles. During your PGY-5 years, you will likely use your study group to focus on preparing for the multiple choice questions and PDM (Phenomenology, Diagnosis, and Management exam) section of the Royal College exam. In addition, your psychiatry resident association or chief resident may have updated exam resources that can be useful for exam preparation. Staying connected during the stressful exam preparation phase is advised and study groups often serve this purpose as the exam approaches.

4.6 Staying Up-to-Date and Organized

Keeping up on new studies and emerging literature is one of the major challenges in medicine. For residents building a knowledge base for psychiatry and balancing their many clinical and educational demands, efficient mechanisms for staying up to date is essential. With recent technological advances, there are many ways to integrate continuing medical education into your day without sacrificing time or effort. The following are a list of some resources that may be useful for you to keep on top of emerging literature and journals:

PsychiatryOnline — http://www.psychiatryonline.com — From the American Psychiatric Association (APA), an excellent portal for APA books, journals and resources including the DSM-V.

UpToDate — http://www.uptodate.com — An excellent resource for up-to-date information in most medical areas. Does not place an emphasis on psychiatry but covers some topics. Great for first year rotations. Some medicine departments may provide free access.


Table of Contents — Another useful method of staying up to date is to visit the websites of the main psychiatric journals (e.g., American Journal of Psychiatry, Archives of General Psychiatry, Biological Psychiatry, Annals of General Psychiatry, British Journal of Psychiatry and Canadian Journal of Psychiatry) and subscribing to the table of contents. Usually this will be a link on the home page of each journal and is free. This way you will get a short email every month from the journals with article headlines and abstracts and you can open the ones you like through your university library or hospital library accounts.
**Podcasts** — Apple iTunes Store — Many medical/psychiatric journals have free podcasts (Internet broadcast radio-like programs) that summarize their contents monthly. This is a great way to keep up to date on-the-go using your iPod or other portable mp3 player. Accessible through the iTunes store podcast directory.

### 4.7 Professional Societies

As psychiatry residents, you will often receive lower membership rates for professional organizations and societies. The following is a list of key professional societies that may be useful to IMG trainees:

- **Canadian Psychiatric Association (CPA):** [http://www.cpa-apc.org](http://www.cpa-apc.org)
- **Canadian Academy of Child and Adolescent Psychiatry:** [http://www.cacap-acpea.org/](http://www.cacap-acpea.org/)
- **Canadian Academy of Geriatric Psychiatry (CAGP):** [http://www.cagp.ca](http://www.cagp.ca)
- **Canadian Academy of Psychiatry and the Law:** [http://www.capl-acpd.org/](http://www.capl-acpd.org/)
- **American Psychiatric Association (APA):** [http://www.psychiatry.org/residents/fellowships-awards](http://www.psychiatry.org/residents/fellowships-awards)
- **Association for Academic Psychiatry (AAP):** [http://www.academicpsychiatry.org](http://www.academicpsychiatry.org)

If you are involved in research or have an idea for a presentation, you may consider presenting at the annual conferences associated with the above listed associations.

### 4.8 Attending Conferences

All residents have academic days that can be used for conferences. It is important to consider location, costs, time for travel and the content of the conference program before committing to a conference. Both the Canadian Psychiatric Association and American Psychiatric Association have targeted content for members-in-training and can help you connect with fellow residents and students at conferences. Finally, you should plan well in advance for conferences outside of Canada if you require a visa to attend.

It should be noted that funding for travel to conferences is only offered at one hospital site if you are a presenter and for residents in the clinician scientist stream. Many conferences will have student travel awards that can be found on the conference or association websites.

Here are a few links highlighting some of the available travel bursaries:
APA: www.psych.org/MainMenu/EducationCareerDevelopment/ResidentsMembersinTraining/AwardsandFellowships.aspx (multiple awards)
AAP Fellowship Award (for residents):
http://www.academicpsychiatry.org/
Canadian Academy of Psychiatry and Law Fellowship Award:
http://www.capl-acpd.org/pages/capl-fellowship_award.html
Academy of Psychosomatic Medicine Trainee Travel Award:
http://www.apm.org/
American Academy of Child and Adolescent Psychiatry Travel Award (for general residents):
http://www.aacap.org/cs/residents/eop-generalresidents
American Psychosomatic Society:
http://www.psychosomatic.org/awards/
5. Tips on Documentation and Presentation
Dr. Sayed Abdulkader, Dr. Waleed Alghamdi,
Dr. Mohammad Alsuwaidan, Dr.Darcy Waisman, Dr. Laura M. Kennedy,
Dr. Alpna Munshi

5.1 Writing a Consult Note and Orders

In general, there are three different types of notes that you will be writing as a resident physician during your various rotations. These include the following:

1. Medical note
2. Psychiatric note
3. Follow-up or what is often referred to as a progress note.

Medical note

It will be important to familiarize yourself with the structure of this type of note for your off-service rotations (i.e. those attended outside of psychiatry, which you will complete during the first year of residency).

The items that should be covered when writing a medical note include:

- Personal (identifying) information
- Past medical history
- Reason for referral
- Chief complaint(s)
- History of presenting illness
- Medications
- Allergies
- Family and social history
- Physical examination findings
- Investigations
- Assessment/Impression
- Plan of management

Psychiatric note

We are going to change the format of this by putting it in table format. If that looks too cluttered we will put the table in the appendix and just put headings here.

The items that should be covered when writing a psychiatric note include:

- Personal (identifying) information
Reason for referral
Chief complaint
History of presenting illness (patient’s narrative of events)
Psychiatric functional inquiry (general screening for all relevant major psychiatric diagnoses, including a substance use history, and a careful safety screen for suicidality, homicidality and self harm).
Past psychiatric history (should include a general screening for any previous contact with mental health, diagnoses, admissions, therapy, safety concerns).
Past medical and surgical history
Medications (present and past medications, can also include a general screening for response, side effects, and compliance)
Allergies
Past family history (general screening for any family history of mental health, substance use, completed or attempted suicide, or relevant medical history)
Legal/forensic history
Psychosocial/personal history (This should include information on patient’s birth, mother’s pregnancy and delivery, development, childhood, adolescence, academic history, relationships, and any significant events, including trauma/abuse, or major life changes).
Mental status examination
DSM-5 diagnosis and differential
Formulation/impression (This should include comments on relevant biological, psychological, and social factors, which can be addressed in the following final section, your management plan).
Plan of management

Follow-up/Progress Note
The items which should be covered when writing a comprehensive and time efficient follow-up note can be remembered by use of the acronym S.O.A.P. As such, these notes are often commonly referred to in Canada as “S.O.A.P Notes”.

- **Subjective**: what the patient reports to you, in their own words, with respect to his or her symptoms and any new complaints.
- **Objective**: On a medical note, this refers to the findings on physical examination and any investigations. On a psychiatric
note, this usually refers to the mental status exam, and any relevant physical examination findings or investigations.

- **Assessment:** the up-to-date interpretation of both subjective and objective findings, often including the differential diagnoses.
- **Plan:** the next steps in the management plan.

As part of the plan section, you may wish to use the acronym D.A.V.I.D. (or fully D.D.A.V.I.I.D.D.) to help with writing your doctor’s orders.

- **Disposition:** e.g., admit, hold, discharge & **Diagnosis:** working/preferred diagnosis.
- **Activities:** e.g., activity as tolerated, bed rest, level of observation, passes or privileges, mental health forms.
- **Vitals:** e.g., daily, every 4hrs, postural vitals pre/post clozapine.
- **IV fluids (if needed) & Investigations:** e.g., blood work, urine, ECG, EEG, imaging.
- **Diet:** e.g., diet as tolerated, clear fluids, soft diet, diabetic diet, & **Drugs:** medications both standing and prn (as needed) orders.

### 5.2 Educational Hierarchy and Format

During most, if not all rotations, you will find yourself working as a member in a multidisciplinary team. This team might include the attending physician, a variable number of residents (seniors and juniors), medical students, the discharge planner, a nurse practitioner, a social worker and, of course, the nurses. Active communication between the different team members is essential in providing competent and efficient care for their patients. The role of the resident as a communicator is also an objective which residents will be evaluated on at the end of their rotations. To illustrate our point further, we give the following clinical examples:

**Case 2:**

*Tatiana is a first-year resident who was doing her internal medicine rotation. She used to come to the hospital early every day, check in with her senior resident, see her patients and write their notes and orders. She rarely spoke to the nurses or the team discharge planner to avoid bothering them. During her mid-rotation evaluation with her supervisor, she was informed that some of the nurses were not happy because they were not notified about the orders she wrote for patients which caused a delay in carrying out those orders. The discharge*
planner also noted that some of Tatiana’s patients were discharged without proper follow-up due to the lack of communication.

Case 3:
Raj is a first-year resident who started his emergency psychiatry rotation one week ago. He was present for morning rounds at the start of each day, which involved reviewing cases and teaching related to each case. The staff psychiatrist, resident on-call, medical student and social worker (clinician) were present for morning rounds each day. The staff psychiatrist routinely asked questions related to the cases as part of teaching during rounds. The staff directed these questions to the team in general and Raj was waiting to answer questions directed to him specifically. He was not sure when he was expected to answer questions and remained silent despite knowing the answers to the staff’s questions. At the end of the second week, his staff provided Raj with feedback specifically his “lack of knowledge” on topics discussed in morning report and his limited participation.”

These examples highlight the differences in the educational hierarchy and format that may be encountered in your rotation. Tatiana had difficulty communicating with other health care professionals, who may be valuable resources. Communication with the entire health care team is a requirement of residents and will be evaluated within the communicator role. Therefore, you should always involve allied health care staff in the treatment and discharge planning, as it is seen as a skill within the communicator and collaborator CanMEDs roles.

The example involving Raj illustrates potential challenges related to educational format. It is an expectation by staff that residents participate in rounds and if you are knowledgeable on a topic, it is encouraged that you contribute to the discussion when questions are directed at the group as a whole. If you do not speak, it may be taken as a sign that you do not know or do not care. In addition, asking and answering questions is a sign of interest to teachers. Some rounds formats may involve staff directing less difficult or general questions to medical students first, then junior residents and finally senior residents or fellows. In this case, you should allow more junior trainees to answer first and attend to questions appropriate to your training level. It is important to balance your participation in educational sessions with the educational opportunities of other learners in the session.

Here is a summary of learning tips:
1. When possible, share your ideas and experience about diagnosis and management.
2. If you disagree with fellow residents or staff, you should voice your opinion. This will not be interpreted as a sign of disrespect but will instead be a sign of interest.
3. Remember you will have some expertise in some areas of medicine that will be above that of your team members, so make sure you convey it during your training.

Common medical role terminology:

Dr. Laura M. Kennedy and Dr. Alpna Munshi

What is meant by “Staff”
A staff physician is the Canadian equivalent of what is often referred to as “consultant” in other countries. This is the senior physician who has completed all of their specialty training and is the physician who assumes responsibility for all patients referred under their care.

What is a “Consultant”
In Canada, a consultant is often a sub-specialist or specialist whose opinion is sought by another physician. For example, physicians may be asked to “consult” on a complex case for their colleague. This term is also used when referring a patient to a physician of another specialty. You may often hear physicians referring to “the consultant” in this case. Consultation Liaison psychiatry is a subspecialty within psychiatry where psychiatric consultants liaise with medicine colleagues about psychiatric issues that are co-morbid with medical ones. Psychiatric consultants may also work for third party organizations like insurance companies, or in collaborative care settings like family health teams.

In some non-Canadian medical settings, a “consultant” is a physician who has completed residency and any further subsequent specialty training in a designated medical specialty. The term consultant is often used in this way in the United Kingdom, Republic of Ireland and other parts of the commonwealth. The consultant physician assumes ultimate responsibility for the care of patients referred to them (and the Canadian equivalent to this term is “staff”).

What is meant by “Clinician”
The traditional meaning of the term is a medical doctor who largely assumes a clinical role as opposed to focussing primarily on research.
However, in many interdisciplinary settings, “clinician” may refer to any member who plays an active role in providing patient care, such as social workers, occupational therapists, and psychotherapists.

**CC3**- “Clinical clerk 3rd year”. This is a 3rd year medical student who is doing the first year of their clinical training.

**CC4**- “Clinical clerk 4th year”. This is a final year medical student completing core rotations as well as elective rotations.

### 5.3 Presenting Your Case: Do's and Don’ts

Presenting your case to the attending physician can sometimes be challenging. However, you will often find yourself in a position where you must present a patient’s case whether it is during rounds, calls or after seeing a consult on the ward. Here are a few tips to help make this experience as stress-free as possible:

1. Organization is a key to a successful presentation. Having the written note in front of you while presenting could be helpful to provide an organized and clear summary of the case.
2. Try always to present a plan of management for the patient. Do not wait for the attending to suggest the plan or even ask for one.
3. The best way to handle a situation where you are asked about something you do not know, is to say “I don’t know but I will check.” You may think it is embarrassing to say it, but it is even more embarrassing to give incorrect information.

*Tip:* Always document what you do for the patient no matter how little importance you think it has. This is simply because you cannot prove what is not documented in the patient’s chart.
6. **Boundaries in Psychiatry**
Dr. Alpna Munshi

According to the CMPA’s review of legal and College related cases involving psychiatrists between 2008-2013, “The most common criticisms related to issues of professionalism include inappropriate manner, boundary crossings, and confidentiality breaches.”

The clinical and therapeutic space lends itself to many types of interactions with patients, and it is important to learn the difference between boundary crossings and boundary violations.

**Boundary crossings:** Boundary crossings are minor deviations from the structures and procedures of traditional psychotherapy “that neither harm nor exploit the patient....examples include offering a tissue to a weeping patient or helping a patient who has fallen get up.” It is important for trainees to discuss these situations explicitly with supervisors to explore the conscious and unconscious meaning of these situations. An important goal is to learn the most empathic way of responding that uses this circumstance in a way that leads to the patient’s growth in therapy (as well as your own growth as a therapist), as opposed to using the boundary crossing in a way that exacerbates the power differential in the relationship.

**Boundary violations:** “Boundary violations harm the patient, usually by some form of exploitation, whether it be psychological, sexual, financial, emotional, or based on the patient’s dependency needs....the violation serves the therapist’s wishes, goals, and desires, not the welfare of the patient.”

According to the CMPA, one way to avoid engaging in boundary violations is to consult peer supervisors or resources available from provincial college or licensing bodies. The CMPA is also an important resource to guide you. We also strongly encourage you to use your psychotherapy supervision to clarify circumstances that may be ambiguous to you about the appropriate way to intervene in therapy when there may be the potential for boundary crossings or boundary violations.

References:
1CMPA Perspective.2014,6(2).
7. Psychotherapy Training During Residency

Dr. Sayed Abdulkader, Dr. Waleed Alghamdi

7.1 Getting Started

During your residency, the average amount of time required for psychotherapy is about seven hours a week. This includes seeing patients in sessions, psychotherapy supervision and weekly seminars during the second year. Psychotherapy usually starts in the second year of the program. As you know, there are different styles of such as psychodynamic psychotherapy, cognitive behavioural therapy, group therapy, interpersonal therapy and others. Residents usually start with the first two styles as early as possible during the second year. To find a suitable patient for psychotherapy, the following resources could be helpful:

1. Patients that you have seen in an in- or out-patient setting and think might be appropriate.
2. The psychotherapy coordinator at your site will usually have a list of possible candidates.
3. Your primary supervisor for the psychotherapy style.
4. Your fellow residents, as they might have patients who are suitable.

7.2 Pacing Yourself

It may take longer for some residents to find a patient than others. Do not get anxious; make sure that the site psychotherapy coordinator and
your psychotherapy supervisor are aware of the difficulty you are facing in finding a patient. When you start doing psychotherapy, it is usually helpful to spread patients’ sessions and supervision times over the week instead of condensing them into one or two days. Also, try to give yourself a few minutes before each session to clear your mind and maybe review the note of the previous session. The sessions can be audio- or video-taped for review with your supervisor, of course with the patient’s knowledge and consent.

7.3 Working Knowledge Versus Mastery

If you start feeling confused at the beginning, it is completely normal and everyone else feels the same. Learning psychotherapy, just like doing it, is a long and ongoing process. Listen carefully to your supervisor comments and advices and try to apply them during the following sessions. The following is a recommended list of books:

- McWilliams, Nancy. Psychoanalytic psychotherapy: A Practitioner’s Guide.
- Gabbard, Glen. Psychodynamic Psychiatry in Clinical Practice.
- Padesky, Christine, Greenberger, Dennis. Clinician’s Guide to Mind Over Mood (corresponding patient guide may be useful for both the therapist and patient).
- Write, Jesse H, Basco, Monica R, Thase, Michael E. Learning Cognitive-Behaviour Therapy: An Illustrated Guide. (includes a CD illustrating the use of CBT techniques within sessions).

7.4 Psychotherapy Documentation

It is often difficult to know what to include or exclude in your official medical chart for your psychotherapy sessions. Many residents will keep notes of their sessions for supervision but will write more concise notes for their psychotherapy patient’s medical chart. Please keep in mind that there may be times that your psychotherapy notes will be requested by insurance companies or for legal proceedings.
8. IMG Well Being

Dr. Abdullah Al-Ozairi, Dr. Mohammad Alsuwaidan, Dr. Darcy Waisman

8.1 Introduction

Residency is recognized as a stressful period for many individuals. This stress may be further magnified for IMGs due to the additional circumstances of being away from a familiar setting, support group, language and culture. Many residents strive to perform at the very highest levels in their residency; however, one important aspect of doing so is to take care of oneself in order to continue being productive in the future. The following section covers key areas in IMG well-being. The reader is also referred to the excellent book *Staying Human During Residency Training* by Allan Peterkin.

8.2 Staying in Touch with Your Culture

Although some IMGs aspire to be accepted and assimilate into the local culture, staying in touch with one’s cultural group may be an important source of support. This becomes especially important during culture-specific celebrations and holidays. Canada’s society is unique in being defined by its mosaic makeup, where multiple cultures constitute the Canadian identity. Most Canadian cities are culturally accepting and one is hard-pressed to find a language, culture, ethnic group or religion that is not represented in the city. IMGs may take advantage of this by connecting with their own unique cultural group.

As you settle in your new dwellings, some find it helpful to take the time to get to know people from your own culture or who may share similar backgrounds. This will make settling into your new city less scary, and a lot more homey. These same friends have likely gone through much of what you have, and can help in guiding you much as Tariq did in Case 1. In addition, other IMGs in the program can be valuable supports and resources. All IMGs are invited to attend their programs’ networking meetings or socials for psychiatry IMG’s, which are organized by the program to encourage peer support for IMG trainees in the department. Building alliances, seeking friendships and mentors can help you get the full experience of the city as quickly as possible.
8.3 Childcare and Family Services

Being away from one’s extended family can make childcare difficult, especially for IMG families in which the resident’s spouse is also working. This may lead to questions such as, “Should my child(ren) go to day care or not” or “What daycare/school should I choose?” Daycares may be difficult to access and can have a waiting list. It is best to think about daycare as early as possible.

*Tip: Check in with your local hospital as some have agreements with particular day cares. Your university may also have a list of childcare resources.*

8.4 Getting a Family Doctor

Taking care of your own health, as well as that of your family’s, is a vital aspect of well being. However, getting a family doctor is not easy. In fact, many people have difficulty with this, as family doctors’ rosters are full and are not accepting new patients. However, as residents, you may be able to find family doctors through your provincial residency association and these resources may also be available to residents’ partners/families.

8.5 Dealing with Stress

The transition into residency can be a stressful time for many residents. As IMGs, you are particularly prone to stress due to immigration, relocation and lack of a social network, in addition to starting a new residency. To help you along with supports, we have highlighted several organizations that can be of support to you.

8.5.1 Your Provincial Resident Association

Your provincial resident association is an excellent contact and may have help lines available to residents. These associations also have regularly scheduled activities during the year such as nights out, social events and resident half-days. Be sure to keep an eye out for these events as they can be a great way to meet new friends and connect with your resident body.

8.5.2 Psychiatry Resident Association

Many residency programs have affiliated psychiatry resident associations focused on advocating for psychiatry residents and planning social events. Your psychiatry resident association may be a
valuable source of information on rotations, hospital sites, electives and other training opportunities. Read your emails carefully or attend your psychiatry resident association meetings to obtain further information.

8.5.3 Taking Vacation

As a resident physician you will be allocated a certain number of vacation days each year. These are often divided into holiday days, and what are known as professional days. It is important to ensure you check with both your program and provincial residency regulations for specific details.

It is recommended that you schedule these vacation days, and obtain the appropriate approval from your program and the rotation in which you are seeking time off, as early as possible. This is not only professional, by giving advanced notice, but increases your chances of successfully getting the days off that you would like. In particular it is advised that you give lots of advanced notice if planning on taking time off around religious or civic holidays, as there tends to be higher demand for these days.

As in any work environment vacation time needs coordinated and approved at various levels within the department, e.g. chief resident, supervisor etc. The reason behind it is to ensure that coverage of units and departments are met. In addition there may be specific rules for IMGs, e.g. in Ontario IMGs may not take any vacation in the first three months during the Assessment Verification Period (AVP).

8.6 Where to Go if You Are Having Trouble: Understanding the Roles

8.6.1 Primary Supervisor

The primary supervisor is the person you will be working with, usually on a day-to-day basis. He or she will supervise your training and will assist in guiding you through the breadth of patient psychopathology and the vast amount of resources. He or she will also be evaluating you throughout the rotation, so please remember to ask for regular feedback on your performance to avoid surprises at the end.

In order to identify your training expectations and goals during your
residency rotations, it is advised that you organize a time early in your rotation to review your rotation-specific goals and objectives. This should include a discussion about your individual goals and objectives for the rotation. Further, it is important that you organize times to have mid-rotation evaluations and end-of-rotation evaluations, as these are mandatory requirements as part of your training. Finally, you will have an opportunity to provide anonymous evaluation of your rotation supervisors at the conclusion of your rotation or psychotherapy supervision. This is strongly encouraged as it will provide the supervisor with feedback over time and guide his or her development as a teacher.

8.6.2 Chief Resident

You may meet Chief Residents at resident lunches and they may serve as peers to discuss hospital site education, rotation or supervisor concerns. They may be able to offer you advice and can point you in the right direction. They are also responsible for the call schedules and can address any call related issues. As a fellow resident, they can help advocate for you.

8.6.3 Psychiatry Program Director

Finally, you should know that your program director takes intimidation and harassment issues between supervisors and residents seriously. The program director does everything within his or her power to support residents and help re-mediate staff that may have some supervisory skills deficits. He or she continues to seek feedback from residents about any incidents of intimidation or harassment experienced by residents, as his or her goal is to provide you with support and to ensure you have a positive educational experience during your residency rotations.
9. Appendices

Appendix A: CanMEDs Roles
Appendix B: Language and Newcomer Related Resources
Sandra Hummel and Dr. Araba Chintoh

Canadian English Language Resources
Welcome to Canada: Citizenship and Immigration Canada
http://www.cic.gc.ca/english/newcomers/map/services.asp

Language Instruction for Newcomers to Canada (LINC) (includes French) http://www.cic.gc.ca/english/newcomers/after-education-language.asp

Academic Association of Universities and Colleges of Canada
http://www.aucc.ca/media-room/publications/notes-for-international-students/

Canadian Universities Online lists courses for international students planning on studying in Canada, including English language learning courses http://www.cvu-uvc.ca/esl.html

Assessment Resources (Canadian Language Benchmarks)
Centre for Canadian Language Benchmarks
www.language.ca

Learn French
http://www.languagescanada.ca/en/study

French as a Second Language, Ontario

Alliance Française (Canada)
http://www.af.ca/af-in-canada/

Online English Language Learning
BBC Home
http://www.bbc.co.uk/learning/subjects/english.shtml

Bell English Online
http://www.bellenglish.com/

Check with your local university for additional language resources.
Dialling 3-1-1 from a touchtone phone provides you with easy access to non-emergency city services, programs and information 24 hours a day, seven days a week. Additional resources can be located through http://www.yellowpages.ca.

Appendix C: Examples of Slang

The following list is meant to provide some examples of North American slang that you may encounter during patient interviews or discussions with colleagues. This list is by no means exhaustive but should provide a starting point for understanding common slang terms.

**Acid** - Lysergic acid diethylamide (LSD)

**ASAP** — As soon as possible

**AWOL** — Taken from the military usage for “Absence Without Leave,” usually denotes someone who cannot be located.

I had a **bad Trip** last time I used speed- To be under the influence of a drug

**Bathsalts** - relatively new designer drug on the market that looks like bath salts. It's chemical composition is still under study however at present believed to contain methylenedioxypyrovalerone or mephedrone. It is known to induce an unusual set of symptoms including violence, paranoia, nudity and eating ones own feces

After 3 drinks I completely **blackout** - inability to remember for events following heavy intoxication by a drug, most commonly used in context of Alcohol use

I **blaze** twice a week- smoking marijuana

He **blew** all his money — spent

**Blow** - Cocaine

**Bong** - a water pipe or apparatus generally used to inhale Marijuana

I'm feeling really **blue** — depressed. Memory hint: this usage is based on the common associations of feelings to colors, i.e. blue-sadness, red-anger, green-nauseated/sick.

I am feeling real **bummed out** after the exam — depressed

My friend thinks I am a **bum** - a lazy person

**Chasing the Dragon** - a particular method used to inhale Heroin
*Common-law* — A common-law partner is a person of the opposite or same sex, who is living with another person in a conjugal (marriage-like) relationship and has done so for a period of at least one year. The partner may be allowed to make medical decisions.

He stopped smoking **cold turkey** — to stop using addictive substance abruptly and completely

**Cop**— police officer

**Couch potato** — lazy person

**Crack**— a form of cocaine that is smoked

**Crank or Ice** — methamphetamine

My parents **cut me off**— discontinuation of support/income, usually financial in nature

**Dolphins**— Ecstasy

**EtOH**— alcohol

I **flipped out** when I heard Tom say that — lost control

He is a **frequent flyer** at this hospital — person who presents or uses services frequently

**FYI** — For your interest, for your information

I have to **get it together** before my presentation — feel mentally all there

I want to give it **a shot** — a try

I have a **hangover** — unpleasant physical effects after alcohol use

I **heaved** all over the floor — vomited also puked, yakked

I had a **hit** of cocaine— a single dose of a drug

**Ice or Crank** — methamphetamine

I had one **toke** of the **joint** — one puff (or “drag”) of a marijuana cigarette

**Love Drug or X** — ecstasy (MDMA - 3,4 methylenedioxymethamphetamine)

**Mickey** — small bottle of liquor that fits into pocket

I usually get the **munchies** after a good hit— craving of food that follows Cannabis use
I got nailed by the police - arrested

*Pot* — marijuana

I felt anxious *out of the blue* — all of a sudden, with no clear trigger. Memory hint: this phrase is referring to the feeling as if it came from the sky, i.e. out of nowhere

I got **ripped off** - Having paid too much for a purchase

**ROCKS** - Crack Cocaine

**Roofies** — rohypnol

I **shoot up** Heroin on a daily basis - to inject intravenously

**Shrink** - psychiatrist

**Smack** - Heroin

**Speedball** — mixture of injected heroin and cocaine

**Special K** — ketamine

I **got Stoned** last night - to be under the influence of a drug, most commonly used for Cannabis

Give me a **straight** answer — be honest

**Uppers** - Amphetamines, Stimulants

I was **wasted** at the party last night — drunk

**Weed** - Marijuana

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**Additional slang websites:**

The Online Slang Dictionary — [http://onlineslangdictionary.com](http://onlineslangdictionary.com)

IPRC Street Drug Slang Dictionary (for street drug slang only) — [http://www.drugs.indiana.edu/drug-slang.aspx](http://www.drugs.indiana.edu/drug-slang.aspx)


[http://www.drugrehab.co.uk/street-drug-names.htm](http://www.drugrehab.co.uk/street-drug-names.htm)

**Erowid.org** – A psychoactive drug slang resource website
Appendix D: Psychopharmacology Textbooks

Below is a list of some commonly used and popular psychopharmacology resources:


4. For your non-psychiatric rotation the following may be used as a handy paperback that fits in your white coat: *Tarascon Pocket Pharmacopoeia 2014 Classic Shirt-Pocket* by Richard Hamilton which is currently in its 28th edition. It was published by Jones & Bartlett Learning (Nov. 5 2013). ISBN-10: 1284026701 / ISBN-13: 978-1284026702

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