الهيئة السعودية للتخصصات الصحية
Saudi Commission for Health Specialties

Adult Psychosomatic Medicine Fellowship Program


بسم الله الرحمن الرحيم

PREFACE

- The primary goal of this document is to enrich the training experience of postgraduate trainees by outlining the learning objectives for them to become independent and competent future practitioners.
- This curriculum may contain sections outlining some regulations of training; however, such regulations need to be sought from the General Bylaws and Executive Policies on training published by the Saudi Commission for Health Specialties (SCFHS), which can be accessed online through the official SCFHS website. In the event of a discrepancy in regulation statements, the one stated in the most updated bylaws and executive policies will apply.
- As this curriculum is subjected to periodic refinements, please refer to the electronic version posted online for the most up-to-date edition at www.scfhs.org.sa.

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II. COPYRIGHT STATEMENTS

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III. FOREWORD

The Psychosomatic Medicine Fellowship curriculum development team appreciates the Scientific Committee members' valuable input and suggestions in developing this program. We want to express our heartfelt gratitude to all the members who contributed to preparing this curriculum, particularly the Curriculum Group, Curriculum Specialists, and Scientific Council. We would also want to note that the Royal College of Physicians and Surgeons of Canada owns the CanMEDS framework, and many of the descriptions' competencies were adapted from their resources.

IV. TABLE OF CONTENTS

V. INTRODUCTION

Context of Practice

Psychosomatic Medicine (PSM), also known as Consultation Liaison Psychiatry (CLP), is a medical specialty that focuses on the study and treatment of psychiatric disorders in patients with medical, surgical, obstetrical, and neurological conditions, especially those who have complex and chronic illnesses.

Psychiatric diseases are widespread, serious, and treatable in general. The predicted lifetime prevalence of any DSMIV/(CIDI) disorder in Saudi Arabia is 34.2 %. [1]

Furthermore, metabolic syndrome was found to be prevalent in 41.2% patients with psychiatric disorders in Saudi Arabia, as well as high triglycerides 32.8%, a large waist circumference 42.2%, high blood pressure 42.5%, high fasting blood sugar 47.8%, and low HDL cholesterol 52.5%. [2]

The most common psychiatric syndrome seen in hospitalized patients is delirium.[3] In Saudi Arabia, delirium was found to be prevalent in 32 % of intensive care unit patients and 20 % of general ward patients. [4]

Delirium is linked to a number of negative outcomes, including longer hospital stays, longer ventilation times, a higher chance of institutionalization, a lower quality of life, and a higher mortality risk. [5,6]

The role of psychosomatic medicine psychiatrists is to assist medical staff in the early detection and prevention of delirium and by managing the neuropsychiatric manifestations that co-occur with delirium.

Patients with other medical conditions such as coronary artery disease, stroke, diabetes mellitus, and epilepsy, on the other hand, are more likely to experience depression.[7] For example, research in Saudi Arabia have found that 20.6 % of people with diabetes mellitus suffer from depression. [8] Among

patients with myocardial infarction, approximately 23.17% had depression,[9] and 17% of stroke patients met the criteria for post-stroke depression.[10]

Comorbidity with depression negatively affects the course of medical conditions by increasing morbidity and mortality, increasing the use of medical resources and costs, amplifying physical symptoms, and causing additive functional impairment and poor quality of life.[11,12]

Modern psychosomatic medicine has a clear role to play in enhancing the care of general hospital inpatients by shifting clinical care from a biomedical to a biopsychosocial approach and treating concomitant psychiatric disease.[13] It has the potential to not only alleviate patients' distress, but also help enhance their medical results, shorten their hospital stays, and make better use of medical resources. [14]

Psychosomatic Medicine psychiatrists may have the greatest potential role in caring patients with a combination of medical and psychiatric disorders, known as multimorbidity.[15] These patients often have one or more psychiatric disorders, such as delirium, dementia, depression, anxiety, and substance abuse, in addition to many medical conditions, and often in the setting of psychological and social challenges.[16]

The proportion of patients with multimorbidity admitted to general hospitals is rising, owing to many variables, including an aging population.[17] Clinical and financial challenges for services with a high prevalence of multimorbidity such as acute medicine and trauma services and its management are significantly high. [18]

Therefore, the psychosomatic medicine psychiatrist assists the treating teams by offering diagnostic, treatment, and referral recommendations for patients with mental illnesses or psychological distress.

Psychosomatic medicine psychiatrists also provide integrative, collaborative mental health care as outpatient services for medical and surgical populations, including neuropsychiatry, perinatal psychiatry, psycho-oncology, transplant, bariatric surgery, and cardiac psychiatry psycho-nephrology, and shared care family medicine.

The area of psychosomatic medicine has made quick and spectacular growth in recent decades (and is projected to continue to do so in the future), necessitating the practice of the specialty in an environment where teaching and research are actively done.

The Psychosomatic Medicine Fellowship Program started initially in 2015 as the King Saud University Psychosomatic Medicine Fellowship Program, and then expanded the next year in 2016 to be a joint supervision agreement program between King Saud University and the Saudi Commission for Health Specialties. In April 2020, the Psychosomatic Medicine Fellowship Program was expanded to fall under the full supervision of the Saudi Commission for Health Specialties. This transition will improve the training standards and outcomes of the Psychosomatic Medicine Fellowship Program in training psychiatrists to become highly qualified psychosomatic medicine psychiatrists.

This fellowship is for a period of two (2) years. This program expects trainees to have outstanding clinical skills, a thorough understanding of the discipline, and a high level of professional ethics.

Goals and Responsibilities of Curriculum Implementation

This curriculum ultimately seeks to guide trainees to become *competent* in their respective specialties. Accordingly, this goal requires a significant amount of effort and coordination from all stakeholders involved in postgraduate training. As "adult-learners," trainees must be proactive, fully engaged, and exhibit the following: a careful understanding of learning objectives, self-directed learning, problem solving, an eagerness to apply learning by means of reflective practice from feedback and formative assessment, and self-awareness and willingness to ask for support when needed. The program director plays a critical role in ensuring that this curriculum is implemented successfully. Moreover, training committee members, particularly the program administrator and chief fellow, have a significant impact on program implementation. Trainees should be called to share responsibility in curriculum implementation. The Saudi Commission for

Health Specialties (SCFHS) applies the best models of training governance to achieve the highest quality of training. Additionally, academic affairs in training centers and the regional supervisory training committee play a major role in training supervision and implementation. The Specialty Scientific Committee will guarantee that the content of this curriculum is constantly updated to match the highest standards in postgraduate education of each trainee's specialty.

VI. ABBREVIATIONS USED IN THIS DOCUMENT

Abbreviation	Description
SCFHS	Saudi Commission for Health Specialties
CIDI	Composite International Diagnostic Interview
DSM–IV	The Diagnostic and Statistical Manual of Mental Disorders–IV
DSM–V	The Diagnostic and Statistical Manual of Mental Disorders–V
PSM	Psychosomatic Medicine
F(1)	(First) Year of Fellowship
F2	(Second) Year of Fellowship
(TBI)	Traumatic brain injury
(SOE)	Structured Oral Exam
OSCE	Objective Structured Clinical Examination
Mini-CEX	Mini-Clinical Experience report
IRB	Institutional Review Board
ITER	In-Training Evaluation Report
TC	Training Committee
FITER	Final In-Training Evaluation Report

VII. PROGRAM ENTRY REQUIREMENTS

- To be admitted to the program, an applicant should comply with the executive policy of the SCFHS on admission and registration (available online). To be admitted to the program, the candidate must have

1. Successfully completed an accredited training program in general psychiatry.
2. Successfully passed the final general psychiatry written exam.
3. Passed an interview conducted by the scientific committee.
4. Obtained three letters of recommendation from consultants with whom the candidate has recently worked.
5. Provided written permission from a sponsor, allowing the candidate to work on a full-time basis for the duration of the training program.

Program Durations

The training will last two (2) years in total.

Program Rotations

Structure of Rotations

<table>
<tr><th>Year</th><th colspan="13">Number of Blocks</th></tr>
<tr><td rowspan="2">1st year</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>Annual Vacation</td></tr>
<tr><td colspan="12"><u>11 Blocks:</u>
Psychosomatic Medicine Inpatient Service
(3 sessions per week)

<u>1 Block as Follows:</u>
2 weeks Palliative Care Services
2 weeks Neurocritical Care</td><td>1 block</td></tr>
</table>

<table>
<tr><td rowspan="3"></td><td colspan="12"></td><td rowspan="3"></td></tr>
<tr><td colspan="12">Psychosomatic Medicine specialized Clinic
2 sessions per week</td></tr>
<tr><td colspan="12">Research (Horizontal Rotation)</td></tr>
<tr><td rowspan="5">2nd Year</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>Annual Vacation</td></tr>
<tr><td colspan="12">Psychosomatic Medicine Inpatient Service
(2–3 sessions per week)</td><td rowspan="3">1 block</td></tr>
<tr><td colspan="12">Psychosomatic Medicine Specialized Clinics
2 sessions per week</td></tr>
<tr><td colspan="12">Research (Horizontal Rotation)</td></tr>
<tr><td colspan="6">Psychosomatic Medicine Subspecialized Clinics
(Mandatory)
6 blocks
3 sessions per week</td><td colspan="7">Psychosomatic Medicine Subspecialized Clinics
(Electives)
6 blocks
3 sessions per week</td></tr>
</table>

Terms and Conditions:

- Each training block is equal to 4 weeks rotation.
- Rotations will be decided according to the training center's resources, and will be at the discretion of the Training Committee at the training center.
- The Psychosomatic Medicine Inpatient Service session is a clinical round of the psychosomatic medicine inpatient multi-disciplinary team. The clinical round session lasts for at least 3 hours.
- The Psychosomatic Medicine Specialized Clinic is a half-day clinic (3-hour session)
- The Psychosomatic Medicine Subspecialized Clinic is a half-day clinic (3-hour session)
- The fellow is supposed to attend 7–8 clinical sessions (inpatient round/PSM clinic) per week.
- In the first year of the fellowship program, the fellow will attend the Psychosomatic Medicine Specialized Clinic only 1–2 clinics per week, as the

fellow will mainly be devoted to Psychosomatic Medicine Inpatient Services.

- In addition to the inpatient psychosomatic medicine rotation in the first year, the fellow should spend one block as follows:
  - Two weeks of palliative care at the same training center or other centers if palliative care is not available in the primary training center.
  - Two weeks with the neurocritical care team in the same training center or other centers if the neurocritical care team is not available in the primary training center.
- During the 2nd year of the program, the fellow is expected to have five clinics per week (two Psychosomatic Medicine Specialized Clinics and three Psychosomatic Medicine Subspecialized Clinics in different areas such as psycho-oncology, neuropsychiatry, bariatric surgery, and transplant psychiatry.
- It is mandatory for the fellow during the psychosomatic medicine outpatient experience during the 2nd year of the program to have exposure to at least three different subspecialties in psychosomatic medicine.
- The fellow should document in the logbook that he/she is involved in the assessment and management of a variety of cases during his/her attendance at a subspecialized psychosomatic medicine clinic as follows:
  - At least 10 cases of psychiatric care for oncology patients.
  - At least 10 cases of psychiatric care for patients undergoing bariatric surgery. This included preoperative psychiatric assessment and postoperative psychiatric care.
  - At least 10 cases of psychiatric care for patients undergoing transplant surgery This included preoperative psychiatric assessment and postoperative psychiatric care.
  - At least 10 cases of psychiatric care for patients with neuropsychiatric disorders, such as multiple sclerosis, traumatic brain injury, and epilepsy.

- At least 10 sessions of one of the psychotherapeutic interventions for medically ill patients, for example, interpersonal psychotherapy and cognitive-behavioral therapy.

- Examples of Subspecialty Psychosomatic Medicine Clinics and other elective rotations:
  - Psycho-Oncology Clinic
  - Neuropsychiatry Clinic
  - Bariatric Psychiatry Clinic
  - Transplant psychiatry
  - Traumatic Brain Injury (TBI) Clinic
  - Psycho-Nephrology Clinic
  - Diabetes Psychiatry Clinic
  - Psycho-Cardiology Clinic
  - Rheumatology-Psychiatry Clinic
  - Neuro-Critical Care Service
  - Palliative Care Consultation Service
  - Collaborative care primary mental health

Mapping of Learning Objectives and Competency Roles to Program Rotations:

The following are the competencies for the program rotations, which include the Psychosomatic Medicine Inpatient Service and Psychosomatic Medicine Specialized and Subspecialized Clinics. The following competencies are based on CanMEDS roles which are adopted from the Royal College of Physicians and Surgeons of Canada:

Medical Expert

Definition

As Medical Experts, physicians integrate all of the CanMEDS roles, applying medical knowledge, clinical skills, and professional values in their provision of high-quality and safe patient-centered care. Medical Expert is the central

physician role in the CanMEDS framework and defines the physician's clinical scope of practice.

Description

As Medical Experts who provide high-quality, safe, patient-centered care, physicians draw upon an evolving body of knowledge, clinical skills, and professional values. They collect and interpret information, make clinical decisions, and carry out diagnostic and therapeutic interventions. They do so within their scope of practice and with an understanding of the limits of their expertise. Their decision-making is informed by best practices and research evidence, and takes into account the patient's circumstances and preferences as well as the availability of resources. Their clinical practice is up-to-date, ethical, and resource efficient, and is conducted in collaboration with patients and their families, other healthcare professionals, and the community. The Medical Expert role is central to the function of physicians and draws on the competencies included in the CanMEDS Intrinsic Roles (Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional).

KEY CONCEPTS

- Agreed-upon goals of care: 2.1, 2.3, 2.4, 3.2, 4.1
- Application of core clinical and biomedical sciences: 1.3
- Clinical decision-making: 1.4, 1.6, 2.2
- Clinical reasoning: 1.3, 1.4, 2.1, 3.1
- Compassion: 1.1
- Complexity, uncertainty, and ambiguity in clinical decision-making: 1.6, 2.2, 2.4, 3.2, 3.3, 3.4.
- Consent: 3.2
- Continuity of care: 2.4, 4.1
- Duty of care: 1.1, 1.5, 2.4
- Integration of CanMEDS Intrinsic Roles: 1.2
- Interpreting diagnostic tests: 2.2
- Medical expertise: all enabling competencies

- Patient-centered clinical assessment and management: 1.4, 2.2, 2.4, 3.1, 3.3, 3.4, 4.1, 5.2
- Patient safety: 1.5, 3.4, 5.1, 5.2
- Prioritization of professional responsibilities: 1.4, 1.5, 2.1, 3.3, 5.1
- Procedural skill proficiency: 3.1, 3.3, 3.4
- Quality improvement: 5.1, 5.2
- Self-awareness of limits of expertise: 1.4, 3.4
- Timely follow-up: 1.4, 2.2, 4.1
- Working within the health care team: 1.3, 1.4, 2.1, 2.4, 3.3, 4.1, 5.1

Key competencies	Enabling competencies
Physicians are able to:	
• 1. Practice medicine within their defined scope of practice and expertise	• 1.1 Demonstrate a commitment to high-quality care of their patients • 1.2 Integrate the CanMEDS Intrinsic Roles into their practice of medicine • 1.3 Apply knowledge of the clinical and biomedical sciences relevant to their discipline • 1.4 Perform appropriately timed clinical assessments with recommendations that are presented in an organized manner • 1.5 Carry out professional duties in the face of multiple, competing demands • 1.6 Recognize and respond to the complexity, uncertainty, and ambiguity inherent in medical practice
• 2. Perform a patient-centered clinical assessment and establish a management plan	• 2.1 Prioritize issues to be addressed in a patient encounter • 2.2 Elicit a history, perform a physical exam, select appropriate investigations, and interpret their results for the purpose of diagnosis and management, disease prevention, and health promotion

	• 2.3 Establish goals of care in collaboration with patients and their families, which may include slowing disease progression, treating symptoms, achieving cure, improving function, and palliation • 2.4 Establish a patient-centered management plan
• 3. Plan and perform procedures and therapies for the purpose of assessment and/or management	• 3.1 Determine the most appropriate procedures or therapies • 3.2 Obtain and document informed consent, explaining the risks and benefits of, and the rationale for, a proposed procedure or therapy • 3.3 Prioritize a procedure or therapy, taking into account clinical urgency and available resources • 3.4 Perform a procedure in a skillful and safe manner, adapting to unanticipated findings or changing clinical circumstances
• 4. Establish plans for ongoing care and, when appropriate, timely consultation	• 4.1 Implement a patient-centered care plan that supports ongoing care, follow-up on investigations, response to treatment, and further consultation
• 5. Actively contribute, as an individual and as a member of a team providing care, to the continuous improvement of health care quality and patient safety	• 5.1 Recognize and respond to harm from health care delivery, including patient safety incidents • 5.2 Adopt strategies that promote patient safety and address human and system factors

Communicator

Definition

As Communicators, physicians form relationships with patients and their families that facilitate the gathering and sharing of essential information for effective health care.

Description

Physicians enable patient-centered therapeutic communication by exploring the patient's symptoms, which may be suggestive of disease, and by actively listening to the patient's experience of his or her illness. Physicians explore patients' perspectives, including their fears, ideas about the illness, feelings about the impact of the illness, and expectations of health care and health care professionals. The physician integrates this knowledge with an understanding of the patient's context, including socio-economic status, medical history, family history, stage of life, living situation, work or school setting, and other relevant psychological and social issues. Central to a patient-centered approach is shared decision-making: finding common ground with the patient in developing a plan to address his or her medical problems and health goals in a manner that reflects the patient's needs, values, and preferences. This plan should be informed by evidence and guidelines.

Because illness affects not only patients but also their families, physicians must be able to communicate effectively with everyone involved in the patient's care.

KEY CONCEPTS

- Accuracy: 2.1, 3.1, 4.2, 5.1
- Active listening: 1.1, 1.3, 1.4, 1.5, 2.1, 2.2, 2.3, 4.1, 4.3
- Appropriate documentation: 2.1, 5.1, 5.2, 5.3
- Attention to the psychosocial aspects of illness: 1.6, 2.1, 2.2, 4.1
- Breaking bad news: 1.5, 3.1
- Concordance of goals and expectations: 1.6, 2.2, 3.1, 4.3
- Disclosure of harmful patient safety incidents: 3.2
- Effective oral and written information for patient care across different media: 5.1, 5.2, 5.3.
- Efficiency: 2.3, 4.2, 5.2
- Eliciting and synthesizing information for patient care: 2.1, 2.2, 2.3
- Empathy: 1.1, 1.2, 1.3
- Ethics in the physician–patient encounter: 3.2, 5.1

- Expert verbal and non-verbal communication: 1.1, 1.4
- Informed consent: 2.2
- Mutual understanding: 1.6, 3.1, 4.1
- Patient-centered approach to communication: 1.1, 1.6, 2.1, 3.1
- Privacy and confidentiality: 1.2, 5.1
- Rapport: 1.4
- Relational competence in interactions: 1.5
- Respect for diversity: 1.1, 1.6, 2.2, 4.1
- Shared decision-making: 1.6, 4.1, 4.3
- Therapeutic relationships with patients and their families: 1.2, 1.3, 1.4, 1.5, 1.6
- Transition in care: 5.1, 5.2, 5.3
- Trust in the physician–patient relationship: 1.1, 5.2, 5.3

Key competencies	Enabling competencies
Physicians are able to:	
• 1. Establish professional therapeutic relationships with patients and their families	• 1.1 Communicate using a patient-centered approach that encourages patient trust and autonomy and is characterized by empathy, respect, and compassion • 1.2 Optimize the physical environment for patient comfort, dignity, privacy, engagement, and safety • 1.3 Recognize when the values, biases, or perspectives of patients, physicians, or other health care professionals may have an impact on the quality of care, and modify the approach to the patient accordingly • 1.4 Respond to a patient's non-verbal behaviors to enhance communication • 1.5 Manage disagreements and emotionally charged conversations • 1.6 Adapt to the unique needs and preferences of each patient and to his or her clinical condition and circumstances

• 2. Elicit and synthesize accurate and relevant information, incorporating the perspectives of patients and their families	• 2.1 Use patient-centered interviewing skills to effectively gather relevant biomedical and psychosocial information • 2.2 Provide a clear structure for and manage the flow of an entire patient encounter • 2.3 Seek and synthesize relevant information from other sources, including the patient's family, with the patient's consent
• 3. Share health care information and plans with patients and their families	• 3.1 Share information and explanations that are clear, accurate, and timely, while checking for patient and family understanding • 3.2 Disclose harmful patient safety incidents to patients and their families accurately and appropriately
• 4. Engage patients and their families in developing plans that reflect the patient's health care needs and goals	• 4.1 Facilitate discussions with patients and their families in a way that is respectful, non-judgmental, and culturally safe • 4.2 Assist patients and their families to identify, access, and make use of information and communication technologies to support their care and manage their health • 4.3 Use communication skills and strategies that help patients and their families make informed decisions regarding their health
• 5. Document and share written and electronic information about the medical encounter to optimize clinical decision-making, patient safety, confidentiality, and privacy	• 5.1 Document clinical encounters in an accurate, complete, timely, and accessible manner, in compliance with regulatory and legal requirements • 5.2 Communicate effectively using a written health record, electronic medical record, or other digital technology • 5.3 Share information with patients and others in a manner that respects patient privacy and confidentiality and enhances understanding

Collaborator

Definition

As Collaborators, physicians work effectively with other healthcare professionals to provide safe, high-quality, patient-centered care.

Description

Collaboration is essential for safe, high-quality, patient-centered care, and involves patients and their families, physicians, and other colleagues in the healthcare professions, community partners, and health system stakeholders.

Collaboration requires relationships based on trust, respect, and shared decision-making among a variety of individuals with complementary skills in multiple settings across the continuum of care. It involves sharing knowledge, perspectives, responsibilities, and a willingness to learn together. This requires understanding the roles of others, pursuing common goals and outcomes, and managing differences.

Collaboration skills are broadly applicable to activities beyond clinical care, such as administration, education, advocacy, and scholarship.

KEY CONCEPTS

- Collaboration with community providers: 1.1, 1.2, 1.3
- Communities of practice: 1.3, 3.2
- Conflict resolution, management, and prevention: 2.2
- Constructive negotiation: 2.2
- Effective consultation and referral: 1.2, 1.3, 3.1, 3.2
- Effective health care teams: all enabling competencies
- Handover: 3.1, 3.2
- Interprofessional (i.e., among health care professionals) health care: all enabling competencies
- Intraprofessional (i.e., among physician colleagues) health care: all enabling competencies
- Recognizing one's own roles and limits: 1.2, 3.1
- Relationship-centered care: all enabling competencies
- Respect for other physicians and members of the health care team: 2.1, 2.2
- Respecting and valuing diversity: 1.2, 2.1, 2.2
- Shared decision-making: 1.3
- Sharing of knowledge and information: 1.3, 3.1, 3.2

- Situational awareness: 1.1, 1.2, 2.2, 3.1, 3.2
- Team dynamics: 1.1, 2.2, 3.1
- Transitions of care: 3.1, 3.2

Key competencies	Enabling competencies
Physicians are able to:	
• 1. Work effectively with physicians and other colleagues in the health care professions	• 1.1 Establish and maintain positive relationships with physicians and other colleagues in the health care professions to support relationship-centered collaborative care • 1.2 Negotiate overlapping and shared responsibilities with physicians and other colleagues in the health care professions in episodic and ongoing care • 1.3 Engage in respectful shared decision-making with physicians and other colleagues in the health care professions
• 2. Work with physicians and other colleagues in the health care professions to promote understanding, manage differences, and resolve conflicts	• 2.1 Show respect toward collaborators • 2.2 Implement strategies to promote understanding, manage differences, and resolve conflicts in a manner that supports a collaborative culture
• 3. Hand over the care of a patient to another health care professional to facilitate continuity of safe patient care	• 3.1 Determine when care should be transferred to another physician or health care professional • 3.2 Demonstrate safe handover of care, using both verbal and written communication, during a patient transition to a different health care professional, setting, or stage of care

Leader

Definition

As Leaders, physicians engage with others to contribute to the vision of a high-quality healthcare system and take responsibility for the delivery of excellent patient care through their activities as clinicians, administrators, scholars, or teachers.

Description

The CanMEDS Leader role describes the engagement of all physicians in shared decision-making for the operation and ongoing evolution of the health care system. As a societal expectation, physicians demonstrate collaborative leadership and management within healthcare systems. At the system level, physicians contribute to the development and delivery of continuously improving healthcare and engaging with others in working toward this goal. Physicians integrate their personal lives with their clinical, administrative, scholarly, and teaching responsibilities. They function as individual care providers, as members of teams, and as participants and leaders in the health care system locally, regionally, nationally, and globally.

KEY CONCEPTS

- Administration: 4.1, 4.2
- Career development: 4.2
- Complexity of systems: 1.1
- Consideration of justice, efficiency, and effectiveness in the allocation of healthcare resources: 1.1, 1.2, 1.3, 1.4, 2.1, 2.2.
- Effective committee participation: 3.2
- Health human resources: 2.1, 4.2
- Information technology for health care: 1.4
- Leading change: 1.1, 1.2, 1.3, 1.4, 2.2, 3.2
- Management of personnel: 4.2
- Negotiation: 3.1
- Organizing, structuring, budgeting, and financing: 2.1, 2.2, 4.1, 4.2, 4.3.

- Personal leadership skills: 3.1, 4.1
- Physician remuneration: 4.2
- Physician roles and responsibilities in the healthcare system: 1.1, 1.2, 1.3, 1.4, 2.2, 3.2
- Physicians as active participant-architects within the healthcare system: 1.1, 1.2, 1.3, 1.4, 3.2
- Practice management to maintain sustainable practice and physician health: 4.1, 4.2, 4.3
- Priority-setting: 2.1, 3.2, 4.1
- Quality improvement: 1.1, 1.2, 1.3, 1.4, 2.2, 3.2, 4.3
- Stewardship: 2.1, 2.2
- Supervising others: 4.2
- Systems thinking: 1.1, 1.2, 1.3, 1.4, 2.1, 2.2
- Time management: 4.1, 4.2

Key competencies	Enabling competencies
Physicians are able to:	
• 1. Contribute to the improvement of health care delivery in teams, organizations, and systems	• 1.1 Apply the science of quality improvement to contribute to improving systems of patient care • 1.2 Contribute to a culture that promotes patient safety • 1.3 Analyze patient safety incidents to enhance systems of care • 1.4 Use health informatics to improve the quality of patient care and optimize patient safety
• 2. Engage in the stewardship of health care resources	• 2.1 Allocate health care resources for optimal patient care • 2.2 Apply evidence and management processes to achieve cost-appropriate care

• 3. Demonstrate leadership in professional practice	• 3.1 Demonstrate leadership skills to enhance health care • 3.2 Facilitate change in health care to enhance services and outcomes
• 4. Manage career planning, finances, and health human resources in a practice	• 4.1 Set priorities and manage time to integrate practice and personal life • 4.2 Manage a career and a practice • 4.3 Implement processes to ensure personal practice improvement

Health Advocate

Definition

As Health Advocates, physicians contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change.

Description

Physicians are accountable to society and recognize their duty to contribute to efforts to improve the health and well-being of their patients, their communities, and the broader populations they serve. Physicians possess medical knowledge and abilities that provide unique perspectives on health. Physicians also have privileged access to patients' accounts of their experiences with illness and the health care system.

Improving health is not limited to mitigating illness or trauma, but also involves disease prevention, health promotion, and health protection. Improving health also includes promoting health equity, whereby individuals and populations reach their full health potential without being disadvantaged by, for example, race, ethnicity, religion, gender, sexual orientation, age, social class, economic status, or level of education.

Physicians leverage their position to support patients in navigating the healthcare system and advocating with them to access appropriate resources in a timely manner. Physicians seek to improve the quality of both their clinical practice and associated organizations by addressing the health needs of the patients, communities, or populations they serve. Physicians promote healthy communities and populations by influencing the system (or by supporting others who influence the system), both within and outside their work environments.

Advocacy requires action. Physicians contribute their knowledge of the determinants of health to positively influence the health of the patients, communities, or populations they serve. Physicians gather information and perceptions about issues, working with patients and their families to develop an understanding of their needs and potential mechanisms to address these needs. Physicians support patients, communities, or populations to call for change, and they speak on behalf of others when needed. Physicians increase awareness about important health issues at the patient, community, or population level. They support or lead the mobilization of resources (e.g., financial, material, or human resources) on small or large scales.

Physician advocacy occurs within complex systems and thus requires the development of partnerships with patients, their families, and support networks, or community agencies and organizations to influence health determinants. Advocacy often requires engaging with other healthcare professionals, community agencies, administrators, and policymakers.

KEY CONCEPTS

- Adapting practice to respond to the needs of patients, communities, or populations served: 2.1, 2.2
- Advocacy in partnership with patients, communities, and populations served: 1.1, 1.2, 2.1, 2.2, 2.3
- Continuous quality improvement: 2.2, 2.3
- Determinants of health, including psychological, biological, social, cultural, environmental, educational, and economic determinants, as well as health care system factors: 1.1, 1.3, 2.2

- Disease prevention: 1.3, 2.1
- Fiduciary duty: 1.1, 2.2, 2.3
- Health equity: 2.2
- Health promotion: 1.1, 1.2, 1.3, 2.1
- Health protection: 1.3
- Health system literacy: 1.1, 2.1
- Mobilizing resources as needed: 1.1, 1.2, 1.3
- Principles of health policy and its implications: 2.2
- Potential for competing health interests of the individuals, communities, or populations served: 2.3
- Responsible use of position and influence: 2.1, 2.3
- Social accountability of physicians: 2.1, 2.3

Key competencies	Enabling competencies
Physicians are able to:	
• 1. Respond to an individual patient's health needs by advocating with the patient within and beyond the clinical environment	• 1.1 Work with patients to address determinants of health that affect them and their access to needed health services or resources • 1.2 Work with patients and their families to increase opportunities to adopt healthy behaviors • 1.3 Incorporate disease prevention, health promotion, and health surveillance into interactions with individual patients
• 2. Respond to the needs of the communities or populations they serve by advocating with them for system-level change in a socially accountable manner	• 2.1 Work with a community or population to identify the determinants of health that affect them • 2.2 Improve clinical practice by applying a process of continuous quality improvement to

	disease prevention, health promotion, and health surveillance activities • 2.3 Contribute to a process to improve health in the community or population they serve

Scholar

Definition

As Scholars, physicians demonstrate a lifelong commitment to excellence in practice through continuous learning and by teaching others, evaluating evidence, and contributing to scholarship.

Description

Physicians acquire scholarly abilities to enhance their practice and advance health care. Physicians pursue excellence by continually evaluating the processes and outcomes of their daily work, sharing and comparing their work with that of others, and actively seeking feedback in the interest of quality and patient safety. Using multiple ways of learning, they strive to meet the needs of individual patients and their families and of the health care system.

Physicians strive to master their domains of expertise and share their knowledge. As lifelong learners, they implement a planned approach to learning to improve each CanMEDS role. They recognize the need to continually learn and model the practice of lifelong learning for others. As teachers they facilitate, individually and through teams, the education of students and physicians in training, colleagues, co-workers, the public, and others.

Physicians are able to identify pertinent evidence, evaluate it using specific criteria, and apply it in their practice and scholarly activities. Through their engagement in evidence-informed and shared decision-making, they recognize uncertainty in practice and formulate questions to address knowledge gaps. Using skills in navigating information resources, they identify evidence syntheses that are relevant to these questions and arrive at clinical decisions that are informed by evidence while taking patient values and preferences into account.

Finally, physicians' scholarly abilities allow them to contribute to the application, dissemination, translation, and creation of knowledge and practices applicable to health and health care.

KEY CONCEPTS

Lifelong learning

- Collaborative learning: 1.3
- Communities of practice: 1.3
- Patient safety: 1.3
- Performance assessment: 1.2
- Personal learning plan: 1.1
- Quality improvement: 1.1, 1.2, 1.3
- Reflection on practice: 1.2
- Seeking feedback: 1.2
- Self-improvement: 1.1, 1.2, 1.3

Teacher

- Faculty, rotation, and program evaluation: 2.5, 2.6
- Formal and informal curricula: 2.1
- Hidden curriculum: 2.1
- Learner assessment: 2.5, 2.6
- Learning outcomes: 2.4, 2.5, 2.6
- Mentoring: 2.2, 2.5
- Needs assessment: 2.4
- Optimization of the learning environment: 2.2
- Principles of assessment: 2.6
- Providing feedback: 2.5, 2.6
- Role-modelling: 2.1, 2.5
- Supervision and graded responsibility: 2.3
- Teaching and learning: 2.2, 2.4, 2.5

Evidence-informed decision-making

- Effect size: 3.3, 3.4
- Evidence-based medicine: 3.1, 3.2, 3.3, 3.4
- Evidence synthesis: 3.2, 3.3
- External validity: 3.3
- Generalizability: 3.3
- Information literacy: 3.2
- Internal validity: 3.3
- Knowledge gaps: 3.1
- Knowledge translation: 3.3, 3.4
- Quality-appraised evidence-alerting services: 3.2, 3.4
- Recognizing bias in research: 3.3
- Structured critical appraisal: 3.3
- Uncertainty in practice: 3.1

Research

- Conflict of interest: 4.2, 4.5
- Confidentiality: 4.1, 4.2
- Informed consent: 4.1
- Research: 4.1, 4.2, 4.3, 4.5
- Research ethics: 4.2
- Research methods: 4.4
- Scholarly inquiry: 4.1, 4.2, 4.4, 4.5
- Scholarship: 4.1, 4.2
- Scientific principles: 4.1

Key competencies	Enabling competencies
Physicians are able to:	
• 1. Engage in the continuous enhancement of their professional activities through ongoing learning	• 1.1 Develop, implement, monitor, and revise a personal learning plan to enhance professional practice • 1.2 Identify opportunities for learning and improvement by regularly reflecting on and assessing their performance using various internal and external data sources • 1.3 Engage in collaborative learning to continuously improve personal practice and contribute to collective improvements in practice
• 2. Teach students, residents, the public, and other health care professionals	• 2.1 Recognize the influence of role-modelling and the impact of the formal, informal, and hidden curriculum on learners • 2.2 Promote a safe learning environment • 2.3 Ensure that patient safety is maintained when learners are involved • 2.4 Plan and deliver a learning activity • 2.5 Provide feedback to enhance learning and performance • 2.6 Assess and evaluate learners, teachers, and programs in an educationally appropriate manner
• 3. Integrate best available evidence into practice	• 3.1 Recognize practice uncertainty and knowledge gaps in clinical and other professional encounters and generate focused questions that address them • 3.2 Identify, select, and navigate pre-appraised resources • 3.3 Critically evaluate the integrity, reliability, and applicability of health-related research and literature • 3.4 Integrate evidence into decision-making in their practice

• 4. Contribute to the creation and dissemination of knowledge and practices applicable to health	• 4.1 Demonstrate an understanding of the scientific principles of research and scholarly inquiry and the role of research evidence in health care • 4.2 Identify ethical principles for research and incorporate them into obtaining informed consent, considering potential harms and benefits, and considering vulnerable populations • 4.3 Contribute to the work of a research program • 4.4 Pose questions amenable to scholarly inquiry and select appropriate methods to address them • 4.5 Summarize and communicate to professional and lay audiences, including patients and their families, the findings of relevant research and scholarly inquiry

Professional

Definition

As Professionals, physicians are committed to the health and well-being of individual patients and society through ethical practice, high personal standards of behavior, accountability to the profession and society, physician-led regulation, and maintenance of personal health.

Description

Physicians serve an essential societal role as professionals dedicated to the health and care of others. Their work requires mastery of the art, science, and practice of medicine. A physician's professional identity is central to this role. The Professional role reflects contemporary society's expectations of physicians, which include clinical competence, a commitment to ongoing professional development, promotion of the public good, adherence to ethical standards, and values such as integrity, honesty, altruism, humility, respect for diversity, and transparency with respect to potential conflicts of interest. It is also recognized that, to provide optimal patient care, physicians must take responsibility for their own health and well-being and that of their colleagues. Professionalism is the basis of the implicit contract between society and the medical profession, granting the privilege of physician-led regulation with the

understanding that physicians are accountable to those served, to society, to their profession, and to themselves.

KEY CONCEPTS

- Professional identity: 1.1, 4.1, 4.2

Commitment to patients

- Altruism: 1.1
- Bioethical principles and theories: 1.3
- Commitment to excellence in clinical practice and mastery of the discipline: 1.2
- Compassion and caring: 1.1
- Confidentiality and its limits: 1.1, 1.5
- Disclosure of physician limitations that affect care: 1.1
- Insight: 1.1, 1.3, 1.4, 2.1
- Integrity and honesty: 1.1
- Moral and ethical behavior: 1.1, 1.3
- Professional boundaries: 1.1
- Respect for diversity: 1.1

Commitment to society

- Commitment to the promotion of the public good in health care: 2.1, 2.2
- Social accountability: 2.1, 2.2
- Social contract in health care: 2.1, 2.2
- Societal expectations of physicians and the profession: 2.1, 2.2

Commitment to the profession

- Accountability to professional regulatory authorities: 3.1
- Codes of ethics: 3.1
- Commitment to patient safety and quality improvement: 2.1, 4.1
- Commitment to professional standards: 3.1
- Conflicts of interest (personal, financial, administrative, etc.): 1.4

- Medico-legal frameworks governing practice: 3.1, 3.3
- Responsibility to the profession, including obligations of peer assessment, mentorship, collegiality, and support: 3.2, 3.3, 4.3

Commitment to self

- Applied capacity for self-regulation, including the assessment and monitoring of one's thoughts, behaviors, emotions, and attention for optimal performance and well-being: 4.1
- Career development and career transitions: 4.1, 4.2
- Commitment to disclosure of harmful patient safety incidents, including those resulting from medical errors, and their impact: 4.2, 4.3
- Mindful and reflective approach to practice: 4.2
- Resilience for sustainable practice: 4.2
- Responsibility to self, including personal care, in order to serve others: 4.1

Key competencies	Enabling competencies
Physicians are able to:	
• 1. Demonstrate a commitment to patients by applying best practices and adhering to high ethical standards	• 1.1 Exhibit appropriate professional behaviors and relationships in all aspects of practice, demonstrating honesty, integrity, humility, commitment, compassion, respect, altruism, respect for diversity, and maintenance of confidentiality • 1.2 Demonstrate a commitment to excellence in all aspects of practice • 1.3 Recognize and respond to ethical issues encountered in practice • 1.4 Recognize and manage conflicts of interest • 1.5 Exhibit professional behaviors in the use of technology-enabled communication
• 2. Demonstrate a commitment to society by recognizing and	• 2.1 Demonstrate accountability to patients, society, and the profession by responding to societal expectations of physicians

responding to societal expectations in health care	• 2.2 Demonstrate a commitment to patient safety and quality improvement
• 3. Demonstrate a commitment to the profession by adhering to standards and participating in physician-led regulation	• 3.1 Fulfill and adhere to the professional and ethical codes, standards of practice, and laws governing practice • 3.2 Recognize and respond to unprofessional and unethical behaviors in physicians and other colleagues in the health care professions • 3.3 Participate in peer assessment and standard-setting
• 4. Demonstrate a commitment to physician health and well-being to foster optimal patient care	• 4.1 Exhibit self-awareness and manage influences on personal well-being and professional performance • 4.2 Manage personal and professional demands for a sustainable practice throughout the physician life cycle • 4.3 Promote a culture that recognizes, supports, and responds effectively to colleagues in need

The Objectives & Goals of the Inpatient Psychosomatic Medicine Rotation:

In this rotation, the fellow will work to develop the knowledge and skills necessary to gain the core of psychosomatic medicine. Fellows will work under the supervision of a consultant to understand and manage a variety of medical conditions and their effects on patients, families, and medical teams from a psychosomatic medicine perspective. It is of paramount importance that the fellow should achieve the pertinent CanMEDS competencies of psychosomatic medicine, as detailed below:

Duration:

12 blocks

In the first year, the fellow will be devoted to inpatient services, and in the second year the fellow will have inpatient overlap with the subspecialty OPD that will be distributed by the training committee in the training center.

Setting:

Adult inpatient hospital wards including but not restricted to ICU, surgical, medical, and obstetric wards.

Learning opportunities:

- ✓ First-year fellow (F1): Fellows will focus on obtaining fundamental knowledge of psychosomatic medicine. Fellows will be able to evaluate patients by themselves and discuss cases with consultants, as well as supervising history taking and reviewing cases of junior physicians and students.
- ✓ Second-year fellow (F2): Fellows will focus on applying knowledge to provide appropriate clinical care. Fellows will be able to lead clinical rounds and discussions, to be moderators for academic activities, lead teams, and arrange meetings with patients, families, and medical professionals. Fellows will be prepared as consultants.

❖ The Objectives and Goals of the Outpatient Psychosomatic Medicine Rotation:

Fellows will attend the Specialized Psychosomatic Medicine Clinics and Subspecialized Psychosomatic Medicine Clinics, including but not restricted to neuropsychiatry, bariatric-psychiatry, psycho-nephrology, psycho-oncology, traumatic brain injury, diabetes-psychiatry, transplant, psycho-cardiology, and other subspecialized psychosomatic medicine clinics. The goals and objectives of the Specialized and Subspecialized Psychosomatic Medicine Outpatient Clinic include all of the major goals and particular objectives of the seven CanMEDS competencies, as well as the following unique supplementary objectives:

1 Psychosomatic Medicine Specialized Clinics:

Goal: Fellows will learn how to use a combination of psychopharmacology and psychotherapy to identify and treat the primary and secondary mental illnesses seen in medical/surgical patients.

Objectives:

- ✓ In an outpatient setting, fellows will gain experience evaluating and treating a variety of psychosomatic illness manifestation.

- ✓ Fellows will learn how to successfully communicate and interact with other experts involved in patient care.
- ✓ Fellows will receive expertise with the commencement and care of patients with various medical comorbidities, as well as drug-drug interactions.

2 Psychosomatic Medicine Subspecialized Clinics:

a) Neuropsychiatry Clinics

Goal: Fellows will gain knowledge of the psychiatric and psychological aspects of neurological disorders.

Objectives:

- ✓ Fellows will be able to provide a comprehensive assessment of psychiatric presentations linked to neurological disorders.
- ✓ Fellows will be proficient at using psychopharmacological agents in the setting of neurological disorders.
- ✓ Fellows will be able to identify the role of a multidisciplinary team in evaluating and assisting patients in this setting.

b) Bariatric-Psychiatry Clinic:

Goal: Fellows will be knowledgeable regarding the major domains addressed during the psychological evaluation of bariatric surgery candidates.

Objectives:

- ✓ Fellow will gain knowledge to deal with the psychological concerns that are typical in bariatric surgery candidates.
- ✓ Fellows will be able to conduct a psychiatric evaluation with a focus on the challenges that this unique demographic faces.
- ✓ Fellows will gain knowledge of how to use treatment options including pharmacotherapy and psychotherapy in this patient population both pre- and post-surgery.

- ✓ Fellows will be able to work effectively with a multidisciplinary team, including making appropriate referrals, supervising different therapy interventions, and collaborating with other members of treating team.

c) Psycho-Oncology Clinics:

Goal: Fellows will be knowledgeable in the comprehensive psychiatric evaluation and assessment of patients with cancer at all stages of their illness, encompassing initial diagnosis, therapy, recurrence, chronic sickness, advanced cancer, end-of-life care, and cancer survival.

Objectives:

- ✓ Fellows will be skillful in the evaluation and treatment of mental disorders and psychosocial issues affecting cancer patients, their families, and caregivers, including palliative care and grief.
- ✓ Fellows will be skillful in the use of nonpharmacologic techniques in the treatment of psychiatric symptoms and syndromes in cancer patients, including detailed understanding of individual psychotherapies.

d) Traumatic Brain Injury (TBI) Clinic:

Goal: Fellows will be up to date on current thinking on how to diagnose and treat TBI and related cognitive impairment, including the neurosequalae of TBI and major psychiatric symptom presentations.

Objective:

- ✓ Fellows will be able to undertake a mental evaluation of TBI patients, which will include assessing psychiatric illnesses, functional capacity, and daily living activities.
- ✓ Fellows will be able to evaluate social support in depth, as well as the impact of prescribed medications on mental health and mild cognitive impairment.
- ✓ Fellows will be able to recognize and understand the therapeutic management of psychiatric problems, with a focus on the medical difficulties associated with the use of psychotropic drugs in the TBI population.

e) Transplant-Psychiatry Outpatient Clinic

Goal: Fellows will be aware of the latest state of knowledge and practice in cardiac, renal, lung and liver transplant surgery, including the selection of suitable patients and the treatment of common problems.

Objectives:

- ✓ Fellows will be able to conduct a mental examination for organ transplant candidates, as well as appraise and select eligible transplant candidates.
- ✓ Fellows will be conversant with the psychiatric difficulties that arise in transplant patients before and after surgery, as well as the proper diagnostic and treatment options.
- ✓ Fellows will gain the knowledge of the usual adverse effects of medication used in transplant including immunosuppressants and anti-rejection drugs, as well as their interactions with psychiatric medications.
- ✓ Fellows will gain the necessary knowledge of different Psychiatric treatment techniques in patients with end-stage liver and renal illnesses.
- ✓ Fellows will assess and treat transplant patients while admitted to inpatient areas of the hospital when relevant.

f) Other Subspecialized Psychosomatic Medicine Clinics:

Goal: Other Subspecialized Psychosomatic Medicine Clinics, such as psycho-nephrology, diabetes-psychiatry, and psycho-cardiology, it can be designed as part of the Fellowship Training Program and it should include all of the major goals and particular objectives of the seven CanMEDS competencies of the program, but an extra step is required to be established inform of specific extra aims and objectives will be agreed upon by the program director and trainee, as well as any clinic supervisory faculty.

Objectives:

- ✓ Prior to commencing the specialty experience, the program director, the clinical supervisor, and the trainee will agree on the curriculum goals for knowledge acquisition.

- ✓ Fellows will become knowledgeable with psychiatric topics that are important to the specialty clinic population, and will indeed be able to evaluate those very specialty patients with special expertise in these issues, and will be familiar with therapeutic and treatment modalities that may be influenced by medical factors that are relevant to the clinical population.

Duration:

12 blocks

- ➢ In the first year of the fellowship program, the fellow will attend the Psychosomatic Medicine Specialized Clinic only (1–2 clinics per week), as the fellows will devote their time to psychosomatic medicine inpatient services.
- ➢ In the second year of the fellowship program, the fellow will have five clinics per week (two psychosomatic medicine specialized clinics and three psychosomatic medicine subspecialized clinics) in different areas such as psycho-oncology, neuropsychiatry, bariatric surgery, and transplant psychiatry.
- ➢ The psychosomatic medicine outpatient rotations will overlap with psychosomatic medicine inpatient services during the 1st and 2nd years of the fellowship program in a ratio to be determined by the training committee at the assigned training center.

Setting:

Specialized Psychosomatic Medicine Clinics and Subspecialized Psychosomatic Medicine Clinics.

Learning opportunities:

- ✓ First-year fellow (F1): Fellows will focus on obtaining fundamental knowledge of psychosomatic medicine. Fellows will be able to evaluate patients by themselves and discuss cases with consultants, as well as supervise history taking and review cases of junior physicians and students.

- ✓ Second-year fellow (F2): Fellow will focus on specialized areas of psychosomatic medicine, including but not restricted to neuropsychiatry, bariatric-psychiatry, psycho-nephrology, psycho-oncology, traumatic brain injury, diabetes-psychiatry, transplant, psycho-cardiology, and other subspecialized PSM clinics. Fellows will be able to put what they learned in the first year of the fellowship to good use and deliver adequate clinical treatment.

IX. CONTINUUM OF LEARNING

This involves learning that should occur at each crucial stage of the specialty's progression. Trainees are reminded that continuous professional development (CPD) is a lifelong process. To fulfill the demands of their essential profession, trainees should keep in mind the importance of CPD for every healthcare worker. The table below depicts how the role is likely to evolve over time at the junior, senior, and consultant levels of practice.

Specialty General Practice	F1 (Junior Level)	F2 (Senior Level)	Consultant sub specialist
Subspecialty Non-practicing	Dependent/supervised practice	Dependent/supervised practice	Independent practice/provide supervision
Learn the fundamentals of health science and core specialty knowledge.	Obtain basic knowledge of psychosomatic medicine's core clinical problems.	Apply knowledge to deliver appropriate clinical care for psychosomatic medicine's core clinical problems.	Acquire comprehensive and up-to-date knowledge of psychosomatic medicine's core clinical problems.
Internship to the practice of discipline	Apply clinical skills such as those that are related to psychosomatic medicine's core presenting problems.	Analyze and evaluate clinical findings in order to develop accurate differential diagnoses and a patient management plan.	Develop expanded differential diagnoses and management approaches by comparing and evaluating challenging, contradictory findings.

X. TEACHING METHODS:

Teaching Method

The teaching process in the adult psychosomatic medicine fellowship-training program is based mainly on the principles of adult learning theory. The trainees will feel the importance of learning, playing an active role in learning content, and the process of their own learning. The training programs implement the adult learning concept on each feature of the activities where the residents are responsible for their own learning requirements and the following three formal training activities time are included:

Program Specific Learning Activities

Universal topics

General Learning Opportunities

1. Program-Specific Learning Activities

Program-specific activities are educational activities specifically designed and intended for trainees. The trainees are required to attend these activities, and non-compliance can subject trainees to disciplinary actions. The attendance and participation in these activities are linked to continuous assessment tools (see the formative assessment section below).

A) Program Academic half-day:

At least 2-4 hours of formal training time per week (commonly referred to as academic half day) are allotted for inculcating the optimum utilization of current resources and optimizing the exchange of expertise. Time will be reserved for other teaching methods, such as journal club and clinical/practical teaching. It will be held on every Monday morning. The academic half day covers the core specialty topics that are determined and approved by the specialty's scientific council, aligned with the special-ty-defined competencies and teaching methods. The core specialty subjects will

ensure that important clinical issues in the specialty are covered thoroughly. The core specialty topics will ensure that important clinical problems of the specialty are well taught. It is recommended that lectures be conducted in an interactive, case-based discussion format. The learning objectives of each core topic need to be clearly defined. It is preferable to use pre-learning material. Whenever applicable Workshops, team-based learning, and simulation should be included in core specialized subjects to build and improve skills in fundamental procedures.

Please see the Appendix-C for the topics that illustrate the half day activities.

B) Practice-based learning:

Training exposure during bedside, lab, surgery, and other work-related activities represent excellent targets for learning. Trainees are expected to build their capacity for self-directed learning. Furthermore, practice-based learning allows educators to supervise trainees to become competent in the required practical skills, which ensures fulfilling knowledge, psychomotor, and/or attitude-learning domains.

2. Universal Topics

Universal topics are educational activities developed by SCFHS that are intended for all specialties. Priority is given to topics that are:

- High value
- Interdisciplinary
- Demonstrative of expertise that might be beyond the availability of the local clinical training sites

Universal topics have been developed by SCFHS and are available via e-learning, with personalized online access for each trainee. Each universal topic will have a self-assessment at the end of the module. As indicated in the Executive Policies of Continuous Assessment and Annual Promotion, universal topics are a mandatory component of the criteria for the annual promotion of trainees. Universal topics will be distributed over the entire training period. The following is a list of universal topics for trainees:

Module 1: Introduction

1. Safe drug prescribing
2. Hospital-acquired infections
3. Sepsis; SIRS; DIVC
4. Antibiotic stewardship
5. Blood transfusion

Safe drug prescribing: At the end of the learning unit, you should be able to

a) Recognize importance of safe drug prescribing in healthcare
b) Describe various adverse drug reactions with examples of commonly prescribed drugs that can cause such reactions
c) Apply principles of drug-drug interactions, drug-disease interactions, and drug-food interactions in common situations
d) Apply principles of prescribing drugs in special situations such as renal failure and liver failure
e) Apply principles of prescribing drugs in elderly, pediatric age group patents, and in pregnancy and lactation
f) Promote evidence-based cost-effective prescribing
g) Discuss the ethical and legal framework governing safe-drug prescribing in Saudi Arabia

Hospital-acquired infections (HAI): At the end of the learning unit, you should be able to

a) Discuss the epidemiology of HAI with special reference to HAI in Saudi Arabia
b) Recognize HAI as one of the major emerging threats in healthcare
c) Identify the common sources and set-ups of HAI
d) Describe the risk factors of common HAIs such as ventilator-associated pneumonia, MRSA, CLABSI, and vancomycin-resistant enterococcus (VRE)
e) Identify the role of healthcare workers in the prevention of HAI
f) Determine appropriate pharmacological (e.g., selected antibiotic) and non-pharmacological (e.g., removal of indwelling catheter) measures in the treatment of HAI

g) Propose a plan to prevent HAI in the workplace

Sepsis, SIRS, and DIVC: At the end of the learning unit, you should be able to

a) Explain the pathogenesis of sepsis, SIRS, and DIVC
b) Identify patient-related and non-patient-related predisposing factors of sepsis, SIRS, and DIVC
c) Recognize a patient at risk of developing sepsis, SIRS, and DIVC
d) Describe the complications of sepsis, SIRS, and DIVC
e) Apply the principles of management of patients with sepsis, SIRS, and DIVC
f) Describe the prognosis of sepsis, SIRS, and DIVC

Antibiotic stewardship: At the end of the learning unit, you should be able to:

a) Recognize antibiotic resistance as one of the most pressing public health threats globally
b) Describe the mechanism of antibiotic resistance
c) Determine the appropriate and inappropriate use of antibiotics
d) Develop a plan for safe and proper antibiotic usage plan including right indications, duration, types of antibiotics, and discontinuation.
e) Appraise the local guidelines in the prevention of antibiotic resistance

Blood transfusion: At the end of the learning unit, you should be able to:

a) Review the different components of blood products available for transfusion
b) Recognize the indications and contraindications of blood product transfusion
c) Discuss the benefits, risks, and alternatives to transfusion
d) Undertake consent for specific blood product transfusions
e) Perform steps necessary for safe transfusion
f) Develop an understanding of special precautions and procedures necessary during massive transfusions
g) Recognize transfusion-associated reactions and provide immediate management.

Module 2: Cancer

1. Principles of management of cancer
2. Side-effects of chemotherapy and radiation therapy
3. Oncologic emergencies
4. Cancer prevention
5. Surveillance follow-up of cancer patients

Principles of management of cancer: At the end of the learning unit, you should be able to:

a) Discuss the basic principles of staging and grading of cancers

b) Enumerate the basic principles, (e.g., indications, mechanism, types) of

   a. Cancer surgery

   b. Chemotherapy

   c. Radiotherapy

   d. Immunotherapy

   e. Hormone therapy

Side-effects of chemotherapy and radiation therapy: At the end of the learning unit, you should be able to:

a) Describe important side-effects (e.g., frequent or organ/life-threatening) of common chemotherapy drugs

b) Explain the principles of monitoring side-effects in a patient undergoing chemotherapy

c) Describe pharmacological and non-pharmacological measures available to ameliorate the side-effects of commonly prescribed chemotherapy drugs

d) Describe important (e.g., common and life-threatening) side-effects of radiation therapy

e) Describe pharmacological and non-pharmacological measures available to ameliorate the side-effects of radiotherapy

Oncologic emergencies: At the end of the learning unit, you should be able to:

a) Enumerate important oncologic emergencies encountered in both hospital and ambulatory settings

b) Discuss the pathogenesis of important oncologic emergencies
c) Recognize oncologic emergencies
d) Institute immediate measures when treating a patient with oncologic emergencies
e) Counsel the patients in an anticipatory manner to recognize and prevent oncologic emergencies

Cancer prevention: At the end of the learning unit, you should be able to:

a) Conclude that many major cancers are preventable
b) Identify smoking prevention and life-style modifications that are major preventable measures
c) Recognize cancers that are preventable
d) Discuss the major cancer prevention strategies at the individual as well as national level
e) Counsel patients and families in a proactive manner regarding cancer prevention, including screening

Surveillance and follow-up of cancer patients: At the end of the learning unit, you should be able to:

a) Describe the principles of surveillance and follow-up of patients with cancers
b) Enumerate the surveillance and follow-up plan for common forms of cancer
c) Describe the role of primary care physicians, family physicians, and similar others in the surveillance and follow-up of cancer patients.
d) Liaise with oncologists to provide surveillance and follow-up for patients with cancer

Module 3: Diabetes and Metabolic Disorders

1. Recognition and management of diabetic emergencies
2. Management of diabetic complications
3. Comorbidities of obesity
4. Abnormal ECG

Recognition and management of diabetic emergencies: At the end of the learning unit, you should be able to:

a) Describe the pathogenesis of common diabetic emergencies including their complications
b) Identify risk factors and groups of patients vulnerable to such emergencies
c) Recognize a patient presenting with diabetic emergencies
d) Institute immediate management
e) Refer the patient to the appropriate next level of care
f) Counsel patient and families to prevent such emergencies

Management of diabetic complications: At the end of the learning unit, you should be able to:

a) Describe the pathogenesis of important complications of Type 2 diabetes mellitus
b) Screen patients for such complications
c) Provide preventive measures for such complications
d) Treat such complications
e) Counsel patients and families with special emphasis on prevention

Comorbidities of obesity: At the end of the learning unit, you should be able to:

a) Screen patients for the presence of common and important comorbidities of obesity
b) Manage obesity-related comorbidities
c) Provide dietary and life-style advice for the prevention and management of obesity

Abnormal ECG: At the end of the learning unit, you should be able to

a) Recognize common and important ECG abnormalities
b) Institute immediate management, if necessary

Module 4: Medical and Surgical Emergencies

1. Management of acute chest pain
2. Management of acute breathlessness

3. Management of altered sensorium
4. Management of hypotension and hypertension
5. Management of upper GI bleeding
6. Management of lower GI bleeding

For all the above, the following learning outcomes apply.

At the end of the learning unit, you should be able to:

a) Triage and categorize patients
b) Identify patients who need prompt medical and surgical attention
c) Generate preliminary diagnosis-based history and physical examination
d) Order and interpret urgent investigations
e) Provide appropriate immediate management to patients
f) Refer the patients to the next level of care, if needed

Module 6: Frail Elderly

1. Assessment of frail elderly
2. Mini-Mental State Examination
3. Prescribing drugs in the elderly
4. Care of the elderly

Assessment of frail elderly: At the learning unit, you should be able to

a) Enumerate the differences and similarities between the comprehensive assessment of the elderly and the assessment of other patients
b) Perform a comprehensive assessment, in conjunction with other members of the health care team, of a frail elderly with special emphasis on social factors, functional status, quality of life, diet and nutrition, and medication history
c) Develop a problem list based on the assessment of the elderly

Mini-Mental State Examination: At the end of the learning unit, you should be able to

a) Review the appropriate usages, advantages, and potential pitfalls of Mini-MSE
b) Identify patients suitable for mini-MSE

c) Screen patients for cognitive impairment through mini-MSE

Prescribing drugs in the elderly: At the end of the Learning Unit, you should be able to

a) Discuss the principles of prescribing in the elderly
b) Recognize polypharmacy, prescribing cascade, inappropriate dosages, inappropriate drugs, and deliberate drug exclusion as major causes of morbidity in the elderly
c) Describe physiological and functional declines in the elderly that contribute to increased drug-related adverse events
d) Discuss drug-drug interactions and drug-disease interactions in the elderly
e) Demonstrate familiarity with Beers criteria
f) Develop a rational prescribing habit for the elderly
g) Counsel elderly patients and families on safe medication usage

Care of the elderly: At the end of the learning unit, you should be able to:

a) Describe the factors that need to be considered while planning care for the elderly
b) Recognize the needs and well-being of care-givers
c) Identify the local and community resources available in the care of the elderly
d) Develop, with inputs from other healthcare professionals, individualized care plans for elderly patients

Module 7: Ethics and Healthcare

1. Occupational hazards of HCW
2. Evidence-based approach to smoking cessation
3. Patient advocacy
4. Ethical issues: transplantation/organ harvesting; withdrawal of care
5. Ethical issues: treatment refusal; patient autonomy
6. Role of doctors in death and dying

Occupation hazards of health care workers (HCW): At the end of the learning unit, you should be able to:

a) Recognize common sources and risk factors of occupational hazards among the HCW
b) Describe common occupational hazards in the workplace
c) Develop familiarity with legal and regulatory frameworks governing occupational hazards among the HCW
d) Develop a proactive attitude to promote workplace safety
e) Protect yourself and colleagues against potential occupational hazards in the workplace

Evidence-based approach to smoking cessation: At the end of the learning unit, you should be able to:

a) Describe the epidemiology of smoking and tobacco usage in Saudi Arabia
b) Review the effects of smoking on the smoker and family members
c) Effectively use pharmacologic and non-pharmacologic measures to treat tobacco usage and dependence
d) Effectively use pharmacologic and non-pharmacologic measures to treat tobacco use and dependence among special population groups such as pregnant women, adolescents, and patients with psychiatric disorders

Patient advocacy: At the end of the learning unit, you should be able to

a) Define patient advocacy
b) Recognize patient advocacy as a core value governing medical practice
c) Describe the role of patient advocates in the care of the patients
d) Develop a positive attitude toward patient advocacy
e) Be a patient advocate in conflicting situations
f) Be familiar with local and national patient advocacy groups

Ethical issues: transplantation/organ harvesting; withdrawal of care: At the end of the learning unit, you should be able to:

a) Apply key ethical and religious principles governing organ transplantation and withdrawal of care
b) Be familiar with the legal and regulatory guidelines regarding organ transplantation and withdrawal of care

c) Counsel patients and families in the light of applicable ethical and religious principles

d) Guide patients and families to make informed decisions

Ethical issues: treatment refusal; patient autonomy: At the end of the learning unit, you should be able to:

a) Predict situations where a patient or family is likely to decline prescribed treatment

b) Describe the concept of a "rational adult" in the context of patient autonomy and treatment refusal

c) Analyze key ethical, moral, and regulatory dilemmas in treatment refusal

d) Recognize the importance of patient autonomy in the decision-making process

e) Counsel patients and families declining medical treatment in the light of the best interests of patients

Role of doctors in death and dying: At the end of the learning unit, you should be able to:

a) Recognize the important role a doctor can play during the dying process

b) Provide emotional as well as physical care to dying patients and their families

c) Provide appropriate pain management in a dying patient

d) Identify suitable patients and refer patients to palliative care services

3. General Learning Opportunities

Formal training time should be supplemented by other practice-based learning (PBL), such as

- **Journal Club**

Fellows in adult psychosomatic medicine are expected to present a new article to the Journal Club related to adult psychosomatic medicine at least once every two months.

- **Grand rounds**

Fellows in adult psychosomatic medicine are expected to organize and present monthly presentations on relevant adult psychosomatic medicine topics or updates on recent guidelines/national or international policies, depending on training center regulations regarding grand rounds.

- **Research project**

Fellows in the adult psychosomatic medicine, by the end of their fellowship, should have completed a research project.

- The topic should be relevant to the care of adults or old patients in medical setting.
- By end of first year, the fellow should have IRB approved research protocol and started the data collection. Also, to provide the training committee a copy of the IRB approved protocol and a summary of what have been done so far).
- By end of second year, the fellow should have the final manuscript sent for publication or presentation as a poster (this will be assessed by the training committee in the center). Also, presented the data of his research in the training center (this will be evaluated by the training committee in the center).

- **Continuous professional activities (CPD) relevant to specialty**

Fellows in adult psychosomatic medicine are optionally expected to attend one international conference relevant to adult psychosomatic medicine OR one local adult psychosomatic medicine conference during fellowship program.

Learning resources

1) Journals: Major general psychiatry and specialized journals in psychosomatic medicine field
2) Textbooks:

- Psychosomatic Medicine Fellowship Program Manual.
- Fogel BS, Greenberg DB editors. Psychiatric Care of the Medical Patient. Oxford University Press, USA; 2015.

- Levenson JL, editor. The American Psychiatric Association Publishing Textbook of Psychosomatic Medicine and Consultation-Liaison Psychiatry. American Psychiatric Pub 2018 Aug 6.
- Stern, TA. Massachusetts General Hospital Handbook of General Hospital Psychiatry.
- Amos JJ, Robinson RG (eds). Psychosomatic Medicine: An Introduction to Consultation-Liaison Psychiatry. Cambridge University Press; 2010.
- Levenson JL, Ferrando SJ editors. Clinical Manual of Psychopharmacology in the Medically Ill. American Psychiatric Pub.; 2016.

XI. ASSESSMENT AND EVALUATION

1. Purpose of Assessment

Assessment is critical to the success of postgraduate education. Trainees and trainers will be guided through assessment to meet established standard, competencies and learning outcomes.

Conversely, the assessment will provide feedback to learners and faculty regarding teaching approaches, curriculum development, and quality of the learning environment. A reliable and valid assessment is an excellent tool for assessing curriculum alignments between objectives, learning methods, and assessment methods. Finally, assessment assures patients and the public that health professionals are safe and competent to practice.

Assessment can serve the following purposes:

a. Assessment for learning: Trainers use information from trainees' progress to help them enhance their learning. It enables educators to use information about trainees' knowledge, understanding, and skills to provide feedback to trainees about learning and how to improve.

b. Assessment as learning involves trainees in the learning process, which enables them to monitor their own progress. Trainees use self-assessment and educators' feedback to reflect on their progression. It develops and supports trainees' metacognitive skills. Assessment as learning is crucial in helping residents/fellows become lifelong learners.

c. Assessment of learning is used to demonstrate the trainee's achievement of learning. This is a graded assessment and usually counts toward the trainee's end-of-training degree.

d. Feedback and evaluation for assessment of outcomes are going to represent quality measures that can enhance the learning experience.

2. Formative Assessment

General Principles

As adult learners, trainees should strive for feedback as they progress from "novice" to "mastery" levels of competency. Formative assessment (also known as continuous assessment) is a type of assessment that occurs over the course of an academic year with the primary goal of providing trainees with valuable feedback.

At the end of the year, information from the overall formative assessment tools will be used to determine whether individual trainees will be promoted from their current training level.

During training, trainees should take an active role in obtaining feedback. Simultaneously, trainers are expected to give formative and timely assessments.

The following formative assessment tools should be used to assess fellows during the training process:

- First Year of Fellowship F1

Learning domain	Formative assessment tools	Important details (e.g., frequency, specifications related to the tool)
Knowledge	➢ End-of-first-year written examination ➢ Structured academic activities	➢ End-of-first-year written examination • The examination will include a written cognitive assessment (MCQ and/or MEQ). • The Commission's website contains information about the examination as well as a blueprint. www.scfhs.org.sa ➢ Structured academic activities Once per week

Skills	➢ Logbook ➢ Mini-CEX: Mini-Clinical Evaluation Exercise ➢ Research activities	➢ Logbook Reviewed by Program Director every 3 months ➢ Mini-CEX: 2–4Mini-CEX every 6 months ➢ Research activity: ➢ By end of first year: • IRB-approved research protocol • Started data collection. ➢ Provide a written summary for the Training Committee of what has been done so far before the end-of-first-year written examination
Attitude	ITER: In-Training Evaluation Report	➢ ITER: Done every 3 months

- **Second Year of Fellowship F2**

Learning domain	Formative assessment tools	Important details (e.g., frequency, specifications related to the tool)
Knowledge	➢ Structured academic activities	➢ Structured academic activities: Once per week
Skills	➢ Logbook ➢ Mini-CEX: Mini-Clinical Evaluation Exercise ➢ Research activities	➢ Logbook: Reviewed by program director every 3 months ➢ Mini-CEX: 2–4 Mini-CEX every 6 months ➢ Research activity: By end of the second year: - Have final manuscript sent for publication or poster presentation. - Provide presentation for the Training Committee in the training center about the research data before the final written exam.
Attitude	➢ ITER: In-Training Evaluation Report	➢ ITER: (Done every 3 months)

The evaluation of each component will be based on the following equation:

Percentage	< 50%	50–59.4%	60–69.4%	> 70%
Description	Clear fail	Borderline fail	Borderline pass	Clear pass

To achieve unconditioned promotion, the candidate must score a minimum of "borderline pass" in all six components.

- The program director can still recommend the promotion of candidates if the above is not met under certain conditions:
- If the candidate scored “borderline failure” in a maximum of one or two components, and these scores should not belong to the same area of assessment (for example, both borderline failures should not belong to Skills).
- The candidate must have passed all the other components and scored a minimum of “clear pass” in at least two components.

3. Summative Assessment

Summative assessment is a type of assessment that aims at making informed decisions about a trainee's competency. Summative evaluation, unlike formative assessment, is not intended to provide constructive feedback.

At the end of each academic year, each fellow obtains a summative evaluation report. The summative evaluation report may involve clinical or oral examinations, an objective structured practical examination, or an objective structured clinical examination.

A trainee must receive Certification of Training-Completion in order to sit for the final exams.

Final In-Training Evaluation Report (FITER)

In addition to the supervisory committee's approval of the completion of clinical requirements, program directors prepare a FITER for each fellow at the end of his or her final year of training. This report shall be the basis for obtaining the Certificate of Training-Completion, and the qualification to set for the final specialty examinations.

Certification of Training-Completion

Each trainee must receive a Certification of Training-Completion in order to sit for the final specialty examinations.

Trainees will be issued Certification of Training-Completion whenever the following conditions are met, according to the Training Bylaws and Executive Policy (see www.scfhs.org).

A. Successful completion of all training rotations

A. Successful completion of all training rotations

C. Clearance from SCFHS training affairs, ensuring that tuition fees are paid, and universal topics are completed.

According to SCFHS policies, the local supervisory committee or its equivalent will issue and approve the Certification of Training Completion.

Final Specialty Examinations

The final specialty examination has two elements:

a. Final written exam: to be eligible for this exam, trainees are required to receive the Certification of Training-Completion.

b. Final clinical exam: to be eligible to sit for the final clinical exam, trainees must pass the final written exam.

The final examination consists of two parts:

1. Written Examination

This exam assesses a trainee's theoretical knowledge and problem-solving skills in the field of psychosomatic medicine. It is held at the end of the fellowship and is delivered in MCQ format.

According to the Commission's training and examination rules and regulations, the number of examination items, eligibility, and passing scores are defined.

Details of the examination, as well as a blueprint, are available on the Commission's website, www.scfhs.org.sa.

2. Oral Clinical Examination

A structured oral exam (SOE) is used to evaluate a variety of high-level clinical skills, such as data gathering, communication, patient management, and counseling.

The exam is conducted as a structured oral exam (SOE) in the form of patient management concerns (PMPs) at least once a year.

Eligibility and passing scores are established in accordance with the Commission's training and examination rules and regulations. Examination details and a blueprint are published on the Commission website, www.scfhs.org.sa.

According to the Commission's training and examination rules and regulations, the eligibility and passing scores are defined.

Details of the examination, as well as a blueprint, are available on the Commission's website, www.scfhs.org.sa.

Blueprints of the final written and clinical/practical structured oral exams (SOEs) are shown in the following table:

Final Written Exam:

No.	Sections	Percentage (%)
1	General principles of evaluation and management in psychosomatic medicine	10
2	Delirium and other neurocognitive disorders; aggression, suicidality, and depression in the medical setting	10
3	Anxiety and related disorders, psychosis, mania, catatonia in the medical setting	10
4	Somatic symptom and related disorders, chronic fatigue and pain syndromes, factitious disorders and malingering	10
5	Other psychiatric disorders in the medical setting: Substance-related disorders; eating disorders; sleep disorders; sexual disorders; others	9
6	Psychosomatic related issues in heart diseases, lung diseases, gastrointestinal diseases, renal diseases, endocrine and metabolic diseases	9
7	Psychosomatic-related issues in neurology and neurosurgery, rheumatology, infectious diseases and HIV/AIDS	9
8	Psychosomatic-related issues in oncology, palliative care, hematology, obstetrics and gynecology, surgery and organ transplantation	9
9	Psychopharmacology and other treatments like ECT in the medically ill	10
10	Psychotherapy in the medically ill	10
Research, Ethics and Professionalism, and Patient Safety		4
Total		100%

Note:

This table is for demonstration only, and a new blueprint will be published on the SCFHS website before the exam.

The blueprint distributions of the examination may differ by up to +/−3% in each category.

Clinical/Practical Structured Oral Exam (SOE):

		DIMENSIONS OF CARE			
		Health Promotion & Illness Prevention 1±1 Station(s)	Acute 5±1 Station(s)	Chronic 3±1 Station(s)	# Station(s)
DOMAINS FOR INTEGRATED CLINICAL ENCOUNTER	Patient Care 7±1 Station(s)	1	4	2	7
	Patient Safety & Clinical Skills 1±1 Station(s)		1		1
	Commun ication & Interpersonal Skills 2±1 Station(s)			1	1
	Professional Behaviors 0±1 Station(s)	1			1
	Total Stations	2	5	3	10

Learning Domain	Summative Assessment Tools	Passing Score
Knowledge	- Final Written Examination	Passing score will be decided by the exam committee according to the standard setting method
Skills	- Structured Oral Examinations (SOE)	At least borderline pass in each station in accordance with the standard setting method used by the executive administration of assessment.
Attitude	- FITER: In-Training Evaluation Report	Successfully pass FITER

Completion

A certificate of completion of the Saudi psychosomatic medicine subspecialty will be awarded by the Saudi Commission for Health Specialties upon satisfactory completion of the requirements of the program, which includes passing the required examinations.

XII. PROGRAM AND COURSE EVALUATION

SCFHS applies variable measures to evaluate the implementation of this curriculum. The training outcomes of this program will undergo assessment within the quality assurance framework endorsed by the Central Training Committee at the SCFHS. Trainees' assessment (both formative and summative) results will be analyzed and mapped to curriculum content. Other indicators that will be incorporated are as follows.

- Reports from trainees' evaluation of faculty members.
- Reports from trainees' evaluation of rotations.
- Data available from program accreditations.

Goal Based Evaluation: The intended achievement of milestones will be evaluated at the end of each stage to assess the progress of curriculum delivery, and any deficiency will be addressed in the following stage utilizing the time devoted to trainee-selected topics and professional sessions.

In addition to subject-matter opinion and best practices from benchmarked international programs, SCFHS will apply a robust method to ensure that this curriculum will utilize all the data that will be available during the revision of this curriculum in the future.

XIII. POLICIES AND PROCEDURES

This curriculum represents the means and materials that outline the learning objectives with which trainees and trainers will interact to achieve the identified educational outcomes. The Saudi Commission for Health Specialties (SCFHS) has a full set of "General Bylaws" and "Executive Policies" (published on the official SCFHS website) that regulate all training-related processes. The general bylaws of training, assessment, and accreditation, as well as executive policies on admission, registration, continuous assessment and promotion, examination, trainees' representation and support, duty hours, and leave are examples of regulations that need to be implemented. Under this curriculum, trainees, trainers, and supervisors must comply with the most up-to-date bylaws and policies, which can be accessed online (via the official SCFHS website).

XIV. APPENDICES

Appendix A

Junior-Senior-Level Competency-Matrix: to map competencies, learning domains, and milestones

Training Year level	Competency Roles (with annotation of learning domains involved: K: Knowledge, S: Skills, A: Attitude)	Professional Activities Related to Specialty				
		Performs comprehensive diagnostic interviews	Assesses and manages high-risk behaviors	Develops bio-psycho-social formulations for medically ill patients.	Utilizes psychotherapeutic principles to help patients with their adaptation to illness and treatment.	Compliance with documentation and proper reporting standards
F1	Professional Expert	Masters gathering essential information through review of pertinent records and interviews of patients, their family members, caregivers, and	Demonstrates the knowledge competencies for a multitude of psychiatric problems with high risk behaviors that present in a wide range of medical-	Integrates medical /surgical characteristics into the bio-psycho-social understanding and management of	Demonstrates knowledge and competency in psychotherapeutic interventions for medically ill patients. K, S	Relevant documentation of daily patient care, prescriptions, discharge summaries K, S, A

		other healthcare professionals K, S	surgical-obstetrical patients K, S, A	medical/surgical patients K, S		
	Communicator	Effectively communicates with patients and their family K, S, A	Effectively communicates with patients, their family, and other team members K, S, A	Effectively communicates with patients, their family, and other team members K, S, A	Effectively communicates with patients, their families, and other team members K, S, A	Writing, dictation, and presentation skills K, S
	Collaborator	Works effectively with allied health team members to provide a multifaceted plan SA	Works effectively with allied health team members to provide a multifaceted plan S, A	Multidisciplinary, team work S, A		Interprofessional communication S, A
	Advocate	Holistic approach and preventive medicine K, S, A	Patient safety K, S, A	Patient safety K, S, A	Patient safety K, S, A	Quality improvement K, S, A
	Leader	Time management S	Manages and Allocates health care resources in an efficient manner K, S, A	Manages and allocates health care resources in an efficient manner K, S, A	Time management S	Quality assurance K, S, A
	Scholar		Evidence-based practice K, S	Evidence-based practice K, S	Evidence-based practice K, S	

	Professional	Confidentiality, interprofessional relations S, A	Confidentiality, interprofessional relations S, A	Confidentiality, interprofessional relations S, A	Confidentiality, interprofessional relations S, A	Interprofessional relations S, A
F2	Competency-Roles (with annotation of learning domains involved: K: Knowledge, S: Skills, A: Attitude)	Professional Activities Related to Specialty				
		Completes a comprehensive psychosomatic assessment in a timely manner K, S, A	Runs a multi-disciplinary team meeting K, S, A	Manages psychosomatic disorders K, S, A	Preforms a comprehensive and advanced psychosomatic assessment K, S, A	Conducts a family meeting for seriously ill patients K, S, A
	Professional Expert	Manages major psychiatric disorders in inpatient and OPD setting using combined psychopharmacology and psychotherapy, and delivers best practices in clinical care K, S, A	Establishes and maintains rapport and an effective therapeutic alliance, using motivational interviewing methods K, S, A	Uses all specialized psychosomatic procedural and scales in assessing and treating patients with psychiatric disorders in a proficient manner K, S, A	Delivers best practices in clinical care of patients with psychiatric disorders. K, S, A	Shows ability to communicate with caregiver to provide collateral information and assess caregiver stress and burnout S, A
	Communicator	Demonstrates the highest level of professionalism and respect while communicating with colleagues and allied health care workers S, A	Effectively communicates with parents and team members S, A	Obtains informed consent. Develops a trusting and therapeutic relationship with patients and their families. S, A	Elicits and synthesizes pertinent information and perspectives from patients and their families, colleagues, and other professionals with accuracy. K, S, A	Deliver pertinent information and explanations to patients and their families, colleagues, and other professionals accurately. K, S, A

	Collaborator	Works effectively with allied health team members to provide a multifaceted plan S, A	Multidisciplinary teamwork S, A	Participates in an inter-professional healthcare team effectively and appropriately S, A	Seeks support from senior physicians when needed. S, A	Works Effectively with other health professionals to negotiate, prevent, and resolve inter-professional conflicts. S, A
	Advocate	Identifies barriers preventing patients from receiving their health care rights and advocates on their behalf to secure them S, A	Responds to individual patient issues and needs as part of patient care. S, A	Identifies the determinants of health within the populations that they serve. S, A	Implements quality improvement and enhances the health of patients, communities, and populations. S, A	Maintains patient safety. S, A
	Leader	Manages and allocates health care resources in an efficient manner S, A	Works efficiently in a sophisticated health care system S, A	Demonstrates leadership in managing psychosomatic medicine services in diverse settings S, A	Leads the situation for the patient's best interests S, A	Manages and allocates health care resources in an efficient manner S, A
	Scholar	Participates in an annual continuous improvement program focused on psychosomatic medicine updates K, S, A	Maintains and enhances professional activities through ongoing learning K, S, A	Evaluates information and its sources critically before applying it to practical decisions. K, S, A	Applies evidence- based practices K, S, A	Assists patients, families, students, residents, other health professionals, the public, and others in their learning. K, S, A

	Professional	Practices evidence-based medicine and adheres to professional guideline recommendations for best practices K, S, A	Demonstrates a commitment to patients, profession, and community through ethical practices S, A	Demonstrates commitment to physicians' health and sustainable practices K, S, A	Practices evidence-based medicine and adheres to professional guideline recommendations for best practices K, S, A	Practices evidence-based medicine and adheres to professional guideline recommendations for best practices K, S, A

Appendix B

The following table presents example topics that illustrate half-day activities over the course of one year (or cycle of teaching if more than one year is required to cover all the topics).

Academic week	Section	Date	Time	Sessions	presenters
1.	Introduction to psychosomatic medicine (history taking and mental status examination)	Jan 03	13:00–14:00	Journal Club	A.
			14:00–16:00	Topic	B.
2.	Delirium	Jan 10	13:00–14:00	Journal Club	C.
			14:00–16:00	Topic	D.
3.	Depression and anxiety in medically ill patients	Jan 24	13:00–14:00	Journal Club	E.
			14:00–16:00	Topic	F.
4.	Suicide assessment & management in general hospitals	Feb 14	13:00–14:00	Journal Club	G.
			14:00–16:00	Topic	H.
5.	Agitation and aggression in medically ill patients	Feb 21	13:00–14:00	Journal Club	I.
			14:00–16:00	Topic	J.
6.	Pharmacotherapy of adult psychosomatic medicine and mental illness	Feb 28	13:00–14:00	Journal Club	K.
			14:00–16:00	Topic	L.
7.	Pharmacotherapy of adult psychosomatic medicine mental illness —pregnancy and lactation	Mar 07	13:00–14:00	Journal Club	M.
			14:00–16:00	Topic	N.

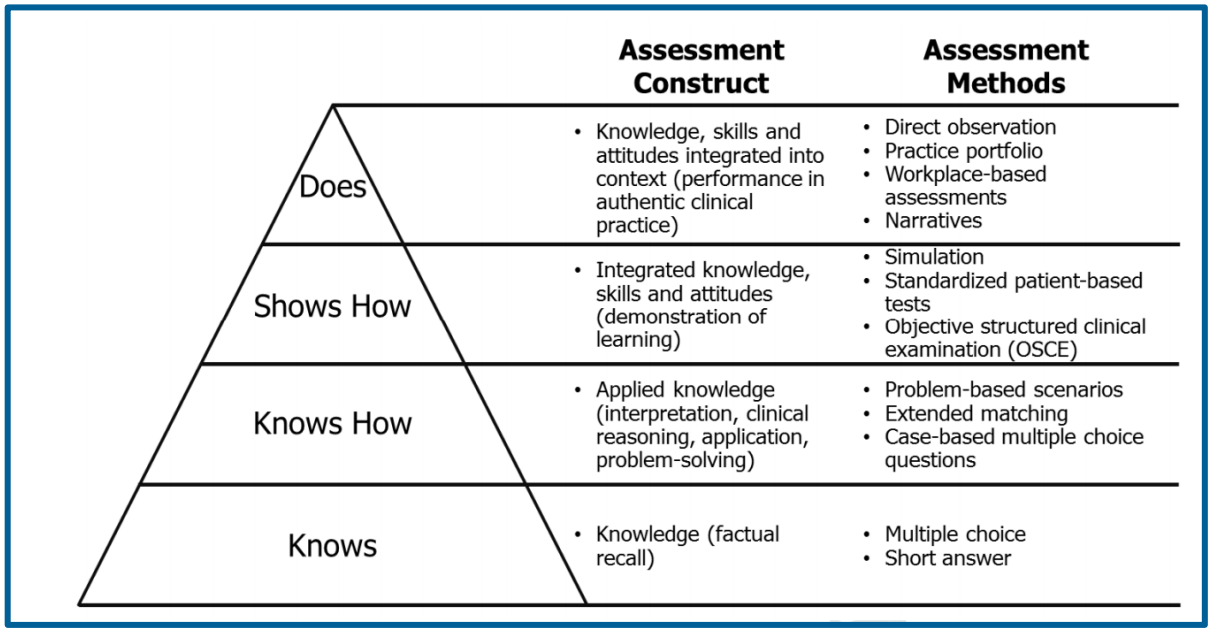
8.	Psychotherapy in medically ill patients	Mar 21	13:00–14:00	Journal Club	O.
			14:00–16:00	Topic	P.
9.	Somatic symptoms and related disorders	Mar 28	13:00–14:00	Journal Club	Q.
			14:00–16:00	Topic	R.
10.	Eating disorders and bariatric surgery assessment	Apr 04	13:00–14:00	Journal Club	S.
			14:00–16:00	Topic	T.
11.	Psychiatric manifestations of traumatic brain disease	Apr 11	13:00–14:00	Journal Club	U.
			14:00–16:00	Topic	V.
12.	Psycho-oncology	Apr 18	13:00–14:00	Journal Club	W.
			14:00–16:00	Topic	X.
13.	Stroke-related psychiatric manifestations	Apr 25	13:00–14:00	Journal Club	Y.
			14:00–16:00	Topic	Z.
14.	Seizure disorders and psychiatry	May 02	13:00–14:00	Journal Club	a.
			14:00–16:00	Topic	b.
15.	Psychiatric aspects of Parkinson's disease	May 09	13:00–14:00	Journal Club	c.
			14:00–16:00	Topic	d.
16.	Neuropsychiatry of MS and autoimmune disease	May 16	13:00–14:00	Journal Club	e.
			14:00–16:00	Topic	f.
17.	Dementia specially in the medical setting	May 23	13:00–14:00	Journal Club	g.
			14:00–16:00	Topic	h.
18.	Psychiatry and psychopharmacology of renal failure	May 30	13:00–14:00	Journal Club	i.
			14:00–16:00	Topic	j.
19.	Transplant psychiatry	Jun 06	13:00–14:00	Journal Club	k.
			14:00–16:00	Topic	l.
20.	Psychiatric management of patients with cardiac disease	Jun 13	13:00–14:00	Journal Club	m.
			14:00–16:00	Topic	n.
21.	Psychiatric issues in GI disorders, hepatitis & liver damage in medically ill patients	Jun 20	13:00–14:00	Journal Club	o.
			14:00–16:00	Topic	p.

22.	Psychiatric issues in surgical pt. including trauma & burn	Jun 27	13:00–14:00	Journal Club	q.
			14:00–16:00	Topic	r.
23.	Sleep disorders and pulmonary disease	Jul 04	13:00–14:00	Journal Club	s.
			14:00–16:00	Topic	t.
24.	Legal issues, e.g., capacity and other forensic-psychiatric-related issues	Jul 18	13:00–14:00	Journal Club	u.
			14:00–16:00	Topic	v.
25.	Substance abuse, intoxication, and withdrawal in medically ill patients	Jul 25	13:00–14:00	Journal Club	w.
			14:00–16:00	Topic	x.
26.	Psychiatric evaluation & management of pain	Aug 08	13:00–14:00	Journal Club	y.
			14:00–16:00	Topic	z.
27.	Psychosis in medically ill patients	Aug 15	13:00–14:00	Journal Club	A.
			14:00–16:00	Topic	B.
28.	Bipolar disorder in medically ill patients	Aug 29	13:00–14:00	Journal Club	C.
			14:00–16:00	Topic	D.
29.	Personality disorders in medically ill patients	Sep 05	13:00–14:00	Journal Club	E.
			14:00–16:00	Topic	F.
30.	Neuroleptic malignant syndrome (NMS), serotonin syndrome (SS), and catatonia	Sep 12	13:00–14:00	Journal Club	G.
			14:00–16:00	Topic	H.
31.	Dermatology & psychiatry	Sep 19	13:00–14:00	Journal Club	I.
			14:00–16:00	Topic	J.
32.	Metabolic disorders and psychiatry	Oct 03	13:00–14:00	Journal Club	K.
			14:00–16:00	Topic	L.
33.	Endocrine disorders and psychiatry	Oct 10	13:00–14:00	Journal Club	M.
			14:00–16:00	Topic	N.
34.	HIV & AIDS psychiatric complications	Oct17	13:00–14:00	Journal Club	O.
			14:00–16:00	Topic	P.
35.	Palliative care and end of life	Oct 24	13:00–14:00	Journal Club	Q.
			14:00–16:00	Topic	R.

36.	Difficult patients	Oct 31	13:00–14:00	Journal Club	S.
			14:00–16:00	Topic	T.
37.	Psychological factors affecting medical conditions	Nov 07	13:00–14:00	Journal Club	U.
			14:00–16:00	Topic	V.
38.	Coping with illness	Nov 14	13:00–14:00	Journal Club	W.
			14:00–16:00	Topic	X.
39.	Death, dying, and bereavement	Nov 21	13:00–14:00	Journal Club	Y.
			14:00–16:00	Topic	Z.
40.	Neuropsychiatry of SLE & other rheumatological diseases	Nov 28	13:00–14:00	Journal Club	a.
			14:00–16:00	Topic	b.

Appendix C

Miller's Pyramid of Assessment provides a framework for assessing the trainees' clinical competences which acts a road map for the trainers to select the methods of the assessment to target various clinical competencies including "knows," "knows how," "shows how," and "does".



(Figure 1: Miller's Pyramid)

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Appendix D

Glossary

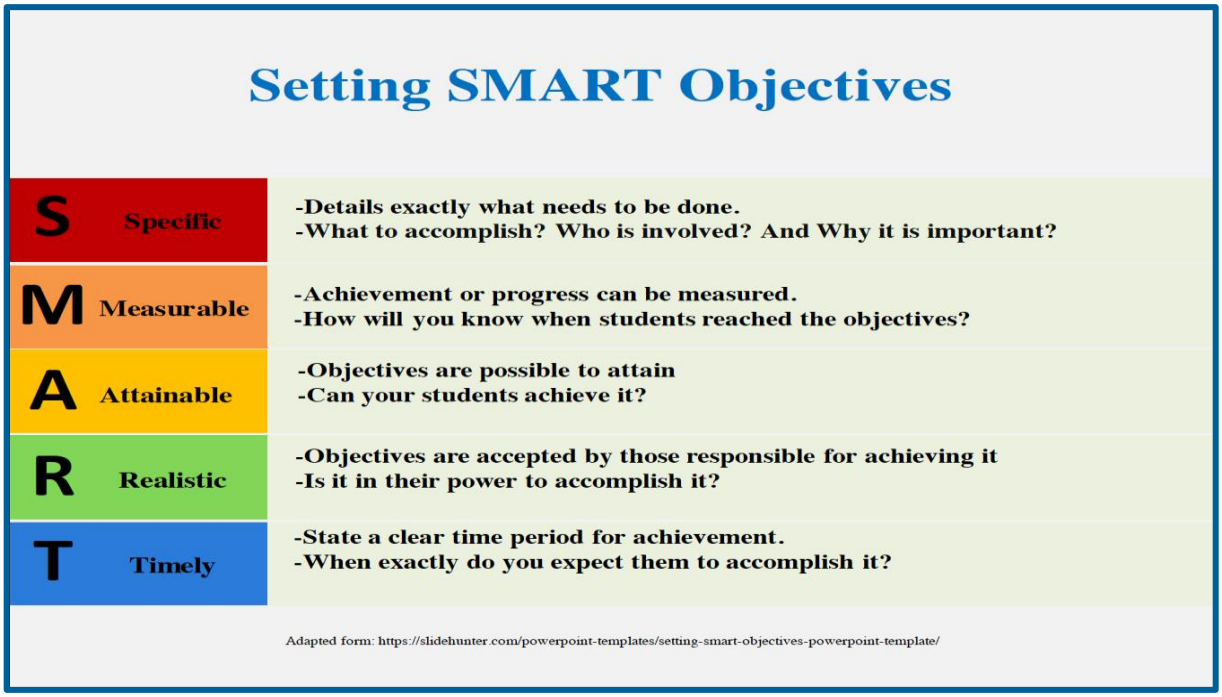
Glossary	
Blueprint	Description correlating educational objectives with assessment contents. For example, a test blueprint defines the proportion of test questions assigned to each learning domain and/or topic.
Competency	Capability to function within a defined professional role, implying entrustment of a trainee by graduation of the program with the required knowledge, skills, and attitude needed to practice unsupervised.
Specialty Core Content (skills, knowledge, and professional attitude)	A specific knowledge or skill, as well as a professional attitude that is specific and integral to the given specialty.
Formative assessment	An assessment that is used to inform the trainer and the learner, respectively, of what has been taught and learned in order to improve learning. The outcomes of formative assessment are usually communicated to the learner through feedback. Formative assessments aren't meant to be used to make decisions or judgments (though it can be as a secondary gain).
Mastery	Exceeding the minimum level of competency to the proficient level of performance indicating rich experience with possession of great knowledge, skills, and attitude.

Portfolio	A collection of evidence of progression toward competency. It may include both constructed components (defined by mandatory continuous assessment tools in curriculum) and unconstructed components (selected by the learner).
Summative Assessment	An assessment that describes the performance of the development of a learner at a specific point in time and is used to guide judgment and make decisions about the level of learning and certification.
Universal Topic	A knowledge, skill, or professional behavior that is not specific to a particular specialty but universal to the general practice of a particular healthcare profession.

Appendix E

How to write objectives in SMART style

1) SMART objectives



Appendix F

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