American Psychiatric Association
Report to the AADPRT/AACDP

Date: May 2010

American Psychiatric Association, Division of Education
Deborah J. Hales, MD, Director
Sandra Sexson, MD, Chair, Council on Medical Education and Lifelong Learning

Council on Medical Education and Lifelong Learning charge

The Council works to provide resources and programs for psychiatric education at every level in the United States and globally. It includes premedical education, medical education, and graduate medical education for residents in psychiatry (both basic education and subspecialty areas including, but not limited to, child and adolescent psychiatry, psychiatry, geriatric psychiatry, psychoanalysis, administrative psychiatry, public health, epidemiology and community psychiatry, psychotherapy and pharmacotherapy), psychiatric aspects of graduate medical education for other medical specialists and post-graduate continuing medical education and lifelong learning.

Office of Graduate and Undergraduate Education

- The Council on Medical Education, chaired by Sandra Sexson, with the help of Nancy Delanoche and Division of Research staff member, Diana Clarke, PhD, has completed an online research literacy course. This course will be available online later this year in the new Learning Management System (LMS).

  APA has purchased a new LMS, which will give the APA more flexibility and capacity to mount and host online webcasts and educational programs, including streaming video. It will also be very helpful to psychiatrists keeping records for Part 2 of MOC (Lifelong Learning and Self Assessment). It will keep records of psychiatrists' CME credits, activities and self-assessment exams, as well as keeping copies of CME certificates that can be printed. We are in the process of developing programs for Part 4 of MOC, performance in practice modules and a patient safety module, SAFEMD, written by our Patient Safety Committee (including Drs Geetha Jayaram, Al Herzog and Carl Greiner).

  Free for APA members, this CME recorder service will be available to non-members for a fee, and will be able to give secure data of an individual's 10 year CME activities to the ABPN prior to recertification.

- The 7th APA Chief Resident Leadership Program will be held on May 24 during the APA Annual Meeting in New Orleans. The program, sponsored through an unrestricted educational grant from Eli Lilly, brings psychiatry chief residents from across the US and Canada for a day of leadership training prior to beginning their chief year. Over 160 chief residents are registered to participate in this year's conference.

- The Office continues to support Psychiatry Student Interest Group Network (PsychSIGN) and the medical student leaders. Their annual conference is held in conjunction with the APA Annual Meeting. This year in New Orleans on Saturday May 22. PsychSIGN is run by medical students to serve students interested in psychiatry. In addition, PsychSIGN promotes the establishment of new psychiatry student interest groups (PsychSIGs), encourages activity in existing groups, and provides resources to pursue a broad range of psychiatry-related activities in medical schools, including community service projects. Visit www.psychsign.org for more information.

- The 4rd Annual MindGames resident competition will be held May 23, 2010 at the APA Annual Meeting in New Orleans. Over 90 Residency teams throughout the US and Canada participated in the online qualifying test and the top three teams with the highest score and times advanced to the final live competition to be held at the APA Annual Meeting. Dr. Glen Gabbard will host the competition between the finalists: Boston University Medical Center, Brown University (Butler Hospital) and Carilion Clinic - Virginia Tech Carilion School of Medicine.

Continuing Medical Education

ACCME Self-Study

The APA submitted its self-study to the ACCME for accreditation review. The self-study covers the CME activities of the APA for the past 6 years, with new requirements for documentation of "learning Gaps" and practice outcomes of our participant learners.

FOCUS: The Journal of Lifelong Learning in Psychiatry and the FOCUS Self-Assessment Program

- APA is developing tools that provide a method to self-assess the physician's practice and compare it to practice guidelines and/or quality measures. Performance in Practice tools provide CME, and are developed from recognized learning gaps. Interested APA members can access the Performance in Practice tools for PTSD and Major Depression on the APA website, Lifelong Learning section. FOCUS 2010 will cover Psychotherapy, Genetics and Genomics, Personality and Temperament and Psychopharmacology.

- The 2010 FOCUS Self-Assessment Examination will be published as the fall supplement to the journal. The FOCUS SA Exam allows subscribers to earn an additional 20 CME credits – taken either online or on paper, and gives the individual's score as compared to other test takers. The FOCUS Self-Assessment Examination is approved by the ABPN as a self-assessment activity that fulfills the requirement of psychiatrists applying for and taking the recertification examination. It is also approved for Section 3 of the Maintenance of Certification program of the Royal College of Physicians and Surgeons of Canada.

eFOCUS

- eFOCUS, is a clinical decision-making exercise delivered to APA members by email. A case vignette with a survey of treatment choices allows a clinician to think about how he or she would assess and care for a patient as described by the vignette and compare and contrast it with expert opinion and with the approach of other colleagues. As members respond to the question, a graph illustrating the proportion of members who chose each option will appear, allowing them to see instantaneously how their responses compare to colleagues around the country. Three weeks later, an expert in the topic reviews and discusses the responses. The next eFocus is on Anorexia Nervosa.

- Approximately 700 physicians completed our eFOCUS survey on Panic Disorder; 430 also clicked into the linked Practice Guideline for Panic Disorder to learn more. The vignette and survey were followed by a second email providing results of the survey and an analysis by Bruce Lydiard, MD.

Annual Meeting Evaluation Highlights

- The Department of CME conducted the evaluation of the 2009 Annual Meeting. 5,714 participants completed the General Evaluation for an overall response rate of 41%, from last year's rate of 36%. APA members accounted for approximately 43% of registrants,

1,276 registrants were international members (9% of registrants). Overall, international attendance in all registration categories in San Francisco increased from the previous year.

- The APA presented four new master courses at the Annual Meeting in San Francisco: Board Review course to prepare PGY-4 residents for the ABPN Part 1 exam in 2009 and three Clinical Knowledge and Skills series courses on cognitive-behavioral therapy, psychodynamic psychotherapy, and neuropsychiatry. These new interactive courses received positive feedback and were well attended.

- Improvements were made to the overall 2009 Annual Meeting program. There was an increased use of Audience Response Systems (ARS), providing an interactive format of learning. The APA took a "greener" approach by offering online course materials in a digital format prior to the meeting and by supplying the syllabus and new research abstracts on CDs.

Maintenance of Certification – Part 4. Performance-in-Practice Clinical Module

- The American Board of Psychiatry and Neurology (ABPN) has a Performance-in-Practice (PIP) requirement in its Maintenance of Certification (MOC) program. The PIP component of MOC, evaluates how well a physician demonstrates practice improvement over the 10-year MOC cycle through chart review. Two sample performance-in-practice tools have been created in collaboration with the APA Division of Research and Practice Guidelines.

  Using participant feedback collected over recent months, the Department of Education – Continuing Medical Education division has been evaluating the efficacy and user-friendliness of the PIP Tool for Patients with Major Depression and the PIP for PTSD. The majority of the participants expressed satisfaction with the program and praised the various elements of the program that would assist them in the complete care of a patient (i.e. diagnosis, evaluation, and treatment).

  The PIP sample survey program is available as a CME material in the CME section of the APA website. To review the Sample Performance-in-Practice Tools go to: http://www.psych.org/MainMenu/EducationCareerDevelopment/LifeLongLearning/APAOnlineCME_1/PerformanceinPracticeclinicalmodule.aspx

CME Credit for APA Activities

- APA Department of CME in the Division of Education directly sponsors a variety of activities for psychiatrists to obtain CME credit. The APA offers CME for Practice Guideline courses on the APA website, developing questions for the ABPN Test Writing program, and opportunities to review manuscripts for the Peer Review program. Department of CME also provides credit for programs published in AJP, the online APPI Subspecialty Self-Assessments, the annual meeting, IPS, APA department programs, and jointly sponsored programs with District Branch members of the Joint sponsorship subcommittee. The APA oversees credit for all CME activities and assiduously complies with ACCME criteria by remaining up to date with new procedures for all CME programs.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 23, 2010

Date: 5/14/10

Committee or Liaison Group Name: Information Management

Chair/Representative's Name: Bob Boland MD

Goal(s) or tasks to be completed in 2010-2011:

- Old/ongoing items:
  - Update of website. Virtually complete. I am still checking for broken links, and sent a rather long "to do" list to Rick and Shan recently.
  - Collection of annual meeting information. Nearly complete, few stragglers.

- New projects:
  - Electronic conflict of interest form.
  - Electronic Submission for Model Curricula

- Potential ideas
  - Improvement of membership database (allowing members to upload info, pics). This would be the first step in efforts to make the web site more interactive, and to give members more of a stake in the site.
  - "Virtual tour" of website. Would be in form of short narrated video, accessible from home page. I did a pilot one a while back, but did not post as we were about to change the site. Would this be of use now?

Report/Updates of Importance & Pertinence:

- Discussion item: People REALLY like posting positions (both faculty, fellow and resident) on the list serve. Lucille and I are constantly reminding people of the policy, apparently to no avail. Should we reexamine our policy barring this? Seems a little odd to prohibit something that members seem to want/find useful. Potential approaches: (1) open up the site for this, (2) create another list serve just for that purpose (and put all members in with info in how to opt out), (3) use some kind of fancy filtering to flag such items when submitted and automatically remove/reconsider them.

- Most communication has been email, as I have been out of country a good deal. I will make it a priority going forward to involve other committee members more in the process.

Action Items:

Need approval for the projected additional expenses for the year, beyond the standard fee budgeted.

- Model Curriculum - $2,175
- Conflict of Interest - $825
- Turbo charge membership directory - $1800

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 23, 2010

Date: May 19, 2010

Committee or Liaison Group Name: Pre-meeting Advisory Task Force

Chair/Representative's Name: Sid Zisook & Deb Cowley

Goal(s) or tasks to be completed in 2010-2011: Planning and implementing 1 day workshop for the series: Teaching Scholarly Activity in Psychiatric Training. For the 2011 meeting, the topic will be: "Evidence-based Approaches to Suicide Risk Assessment and Prevention: Insights from the Neurosciences and Behavioral Sciences for use in Psychiatry Residency Training". In addition, to finalize the membership of the Advisory Board and begin communicating through an email list-serve and at least 1 teleconference.

Report/Updates of Importance & Pertinence: This series has completed its first 5 year NIMH funding cycle. Dr. Pato has stepped down from her role as PI of this series and Dr. Zisook has agreed to function as PI for the competitive renewal. We have applied to the NIMH for 5 additional years of funding, requesting about $50,000 to fund meetings in 2011, 2013 and 2015. AADPRT will fund meetings in 2012 and 2014. The NIMH review of the project is scheduled for October 2011. Therefore, we need to establish 2 budgets - one if funded (already done) and 1 if not funded (see below).

Action Items: If the project is funded, we will be provided funds for a data manager (4%) and a project manager (5%); for 3 plenary speakers (Drs. John Mann, Paula Clayton and Marie Oquedo); and 8 residents and fellows to attend the conference; and for food and miscellaneous expenses.

If not funded, we need to cut expenses. In order to maximize attendance (and maintain our contract with the hotel regarding number of attendees) we should keep costs for attendees at a minimum. Therefore, we propose the following two options for costs:

Advisory Board Dinner (evening before)	≈ <$1,000	≈$0
Breakfast	≈$3,000	≈$0
AM Break	≈$1,000	≈$1,000
Lunches for 150 participants	≈$7,000	≈$0
PM Break	≈$1,000	≈$1,000
AV	≈$2,000	≈$2,000
Misc (handouts, nametages, etc.)	≈$2,000	≈$2,000
Speakers and workshop leaders	≈$0	≈$0
TOTAL	**≈ $17,000**	**≈ $6,000**

If we chose to have the conference paid for by attendees, we would need to charge between $6,000/150= $40 each to $17,000/150= $133 each (assuming 150 attendees). However, given the harsh economic times we are in, we doubt we will reach our goal of

150 participants. We propose instead that the costs either be shared by AADPRT or totally underwritten by AADPRT (possibly by using meeting cost savings resulting from eliminating the Sunday morning session and/or Neuroscience fund and/or a small increase in the meeting registration fee).

To keep the costs down to less than $20,000, we propose eliminating the resident/fellow scholarships, the data manager and project manager (although eliminating this category puts more strain on the shoulders of Lucille and her staff) and disinviting at least 2 of the plenary speakers (saving on honoraria, travel and per-diem). All plenary speakers and small group leaders would come from AADPRT membership and be "labors of love". One of the invited plenary speakers, Dr. Marie Oquedo, is a member of AADPRT and likely will be willing to participate with or without external support. To save money, we propose replacing Drs. Clayton and Mann with some combination of Joan Anzia, Ellen Haller and Sid Zisook. Another option would be to invite an NIMH speaker. We shouldn't have difficulty arranging for small group leaders to be drawn from AADPRT's membership. If we decide to go this route, I should let our plenary speakers know as soon as possible that we will not be able to confirm our ability to provide travel and modest honoraria until October and ask them to hold the date until that time.

Other cost savings possible would include reducing/eliminating lunch and/or breakfast, although our contract to the hotel may obligate us to $4,000-$5,000 of banquet expenses for the pre-meeting day (rather than the $2,000 specified in our second option).

Inter-residency Transitions:
Transfers and Entry into Child/Adolescent Psychiatry and Subspecialty Fellowships

This document is the product of an American Association of Directors of Psychiatric Residency Training (AADPRT) initiative with regard to the residency and fellowship application process. The goal is to provide guidance regarding the application process to applicants, Training Directors, faculty, Directors of Medical Student Education, Program Coordinators, and others closely involved in the resident application process. It considers opportunities to improve and enhance the application process. Through this community it is hoped that the qualities that are consistent with the ideals of our profession--fairness, justice, authenticity, humility, and honesty--are promoted in a fashion that creates the best opportunity for applicants to find a program that fits their particular interest and that residencies have qualified applicants join their program.

We further hope that this information will be broadly distributed to applicants, AADPRT members, program coordinators, and Departments of Psychiatry faculty.

Chris Varley, M.D.
Chair Work Group on Resident Application Process

David Kaye, M.D.
President, AADPRT 2009-10

Inter-residency Transfers

These recommendations have been made to optimize the process of resident transfers from one program to another, including moving from one general psychiatry residency to another, from another specialty into psychiatry, and from a general psychiatry residency to a child and adolescent psychiatry (CAP) residency or another subspecialty fellowship. Care must be taken to ensure these practices comport with Federal Trade Commission regulations.

It is most important that meaningful information about a resident who wishes to transfer from one program to another is communicated to the program to which the resident is applying. AADPRT strongly recommends that the "receiving" training director contact the "sending" training director to discuss the applicant's performance prior to offering a position. It also is important that the resident's current program have reasonable notice of the resident's intent to leave the program.

Recommendations regarding transfer of residents between programs are:

1. A general psychiatry or other resident who wishes to transfer should notify the current program director (PD) as early as possible in the academic year. Residents interested in CAP training should notify the general psychiatry PD as early as possible to allow for the planning necessary to ensure a smooth transition.
2. General psychiatry residents wishing to transfer should not begin formal negotiations with another program until they have informed their present Program Director of their intentions.

3. The Program Director at the "receiving" Department must verify with NRMP R3 System Applicant Match History that the resident does not have a concurrent year match commitment for which a waiver from NRMP is required. **If a resident does have a concurrent match commitment the resident must receive a waiver from NRMP before they are offered an interview.**
4. If a resident does not have a concurrent match commitment a resident may be offered an interview. However, before offering a position, the Program Director of the "receiving" Department should independently confirm that the resident's current Program Director is aware of the resident's wish to transfer. AADPRT recommends that PDs discuss in person or by phone the applicant's credentials and qualifications.
5. Although the resident's current Program Director may make a "best case" explanation of why the resident should remain in the program, the resident should not be intimidated in any manner.
6. Applicants who are offered positions as a transfer (i.e. outside the Match) should not be pressured into accepting a position. Applicants should be given a minimum of 2 weeks to accept or reject an offer.

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Admission Criteria for CAP Residency and Fellowships

There are a number of elements that CAP and fellowship program directors and admission committee members consider in an applicant to their program. The following list reflects the order of priorities for many programs, but applicants should be aware that there may be differences between programs.

1. **Performance during general psychiatry residency.** For most CAP and fellowship PDs this is the most important source of information about an applicant. It captures the applicant's most recent and relevant performance and is generally reflected in the letter of recommendation from the Director of the general psychiatry residency program. Most often CAP or fellowship directors will also speak directly with the PD for an assessment of the applicant's performance. Other letters of reference also may address the applicant's recent performance, but the general psychiatry PD's evaluation is paramount.

2. **Curriculum Vitae.** The applicant's CV offers crucial information about the applicant, including accomplishments, interests, awards, research experience, publications, and so forth. Applicants should follow a standard outline and are advised to review their CV with trusted faculty at their current program before sending it to other programs as part of an application. The CV is expected to accurately reflect the applicant's own work. Inaccuracies are unprofessional and may be grounds for immediate dismissal if discovered.

3. **Application.** Programs may use their own application or, in the case of CAP programs, the Common CAP Application, available at www.aadprt.org. The application contains information similar to the CV but also includes information about USMLE scores, CSV exams passed, malpractice claims, disciplinary actions, and any gaps in training. PDs will ask about any gaps in training, malpractice, or disciplinary actions and applicants should be prepared to discuss these matters in a straightforward manner. Applicants

should be aware that these do not automatically disqualify an applicant. The applicant's perspective and discussion of these incidents is generally of much greater importance.

4. **The Personal Statement -** The personal statement is also an important component of the application. It allows the applicant to let the program know about them as an individual, to define what is important to him/her, and to communicate information about unique personal experiences that might make her/him an attractive candidate. Residency programs especially look to understand the motivation, interests, future career ideas, and perspective of the applicant. The personal statement also provides information about the applicant's writing skills. In addition to the content, training directors look for personal statements that are well organized and well written, with attention to details such as spelling and grammar. Although it is a good idea to have colleagues and faculty advisors review the personal statement before it is sent, it should be the applicant's own work. Plagiarizing or using material written by someone else without proper attribution as part or all of one's personal statement is unprofessional and may be grounds for immediate dismissal if discovered.

5. **Letters of Recommendation (LOR) -** Letters of recommendation are best when written by faculty members who have direct knowledge of the applicant's performance during general psychiatry residency. Although there is some variability, CAP or fellowship programs generally will expect 2 letters of recommendation in addition to the general psychiatry PD's letter. For residents entering CAP programs an additional letter is required from the general psychiatry PD documenting completed residency training experiences, any unfulfilled requirements and documentation of completed CSV exams. Although CAP PDs prefer that applicants have passed 3 CSV exams, this generally is not required. Applicants should inquire of the CAP program whether there is a requirement for passing a specified number of exams before beginning the program. Training directors generally place more value on a highly enthusiastic letter from a faculty member who knows the applicant well than on a more generic letter from a nationally or internationally renowned faculty member who is less familiar with and enthusiastic about the applicant's work.

6. **USMLE Scores** – Many programs require that applicants have passed Step III prior to acceptance into a CAP or fellowship program. Others require passing Step III prior to beginning the program, and still others will have only a recommendation that Step III be passed. Specific scores on USMLE exams are generally integrated with other application materials and, for most programs, are not seen as stand-alone, "make or break" factors. In general, scores are especially noted by programs if they are outstanding or demonstrate particular difficulty passing examinations. If offered an interview, applicants should be prepared to discuss any difficulties with these exams.

7. **Other Activities -** Research, volunteer activities, work experiences, community service, leadership, teaching, and other life experiences, particularly those related to psychiatry and mental health care systems, are important and are considered as well. Training

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directors will especially be interested in activities that involve substantial and sustained investment of an applicant's time and energies.

8. **Medical School Performance –**Although crucial for admission to a general psychiatry residency program, this is of less importance for CAP or fellowship programs because there has been additional, more recent experience with the applicant in the general psychiatry residency training program. Documentation of satisfactory completion of medical school is required by all program, although the form (i.e. transcript, diploma, certified diploma, etc.) may vary from program to program. Residents are encouraged to utilize centralized documentation services (e.g. Federal Credentialing Verification Services) early in their careers to be able to efficiently forward previous credentials needed in the future e.g. employment, state licensure, insurance panels, hospital privileges, etc.

   Take home points:
   1. **Programs look at the totality of an individual's application, taking into account the applicant's performance during residency, CV, application, personal statement, LORs, USMLE scores, and other activities to decide whether to offer an interview.**
   2. **For most programs the applicant's performance during general psychiatry training is the single most important piece of information.**
   3. **The application and CV are crucial documents and should be approached with the same degree of seriousness as any other legal record.**

The Match in Child/Adolescent Psychiatry

The National Resident Matching Program oversees the Match process for child/adolescent psychiatry fellowships. The NRMP Match Participation Agreement (http://www.nrmp.org/fellow/policies/map_sms.html) governs the process; however, a few issues have been sources of difficulty and bear emphasizing.

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1. The ACGME recommends institutions to be "in the Match" if one is offered in that specialty. At this time over 85% of child/adolescent psychiatry programs participate in the Match. Programs in the Match may make offers outside the Match prior to the July 1 before the resident is to start CAP training. After July 1, if a program participates in the Match, no offers should be made outside of the Match process.
2. Applicants and programs participating in the National Resident Matching Program may express interest in each other, but cannot establish a contract or expectation of a contract any time prior to the Match. Programs may chose to communicate how they will rank a candidate but cannot ask applicants how they plan to rank their institution. Further, programs may not pressure an applicant into revealing the programs at which they plan to interview or into making a decision or declaration. Pressure may be ambiguous but programs may not ask applicants how or whether they plan to rank the program. Applicants should feel under no obligation to communicate to programs whether or where they will rank specific programs. By the same token applicants should not provide misleading communications about how they plan to rank specific programs.

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3. After an applicant has visited a program there can be ongoing communication between the applicant and the residency program director, as well as with other relevant faculty and residents. This process can further inform the applicant and programs about each other. To reiterate, applicants and programs can express their interest in one another, but cannot violate NRMP rules by creating a sense of obligation or any other form of pressure on each other.
4. For applicants who are offered positions outside a Match (including transfers into another general psychiatry program), programs should not pressure applicants into accepting a position. Aside from the "scramble" after the Match has occurred when decisions must be made quickly, it is suggested that applicants be given a **minimum** of 2 weeks to accept or reject an offer.

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AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 23, 2010

Date: May 11, 2010

Committee or Liaison Group Name: **RRC Task Force**

Chair/Representative's Name:
Gene Beresin, Chair
Adrienne Bentman, Chair General Psychiatry Committee
Jeff Hunt, Chair Child Psychiatry Committee

Goal(s) or tasks to be completed in 2010-2011:

1. The Task Force will develop and send survey to the AADPRT membership about the Program Specific Essentials for General and Child Psychiatry (done first two weeks of May through Survey Monkey). The Survey was Beta tested by the two Task Force Committees and approved by the AADPRT Steering Committee.
2. The Task Force will analyze the results of the survey: Each Committee will review the results and break the responses into categories under each section of Program Requirements.
3. The Task Force will collate results and send a summary of the findings to the Steering Committee and the Membership .
4. The Task Force will work closely with Pam Derstine, PhD and the RRC to collaborate with this process. The results will be sent to them, and used in the first draft of the revised Program Requirements that will come back to AADPRT for second review. During the process of revision the Task Force will be in close communication with the RRC.
5. The Task Force will review the first Draft and send it out in survey form to the AADPRT membership for responses. The Task Force will conduct the same analysis as previously and send an organized summary to the membership, and Steering Committee for approval before responding to the RRC.

Report/Updates of Importance & Pertinence:

1. Survey sent April 30th and closed May 12, 2010
2. Data in process of analysis by the Task Force Committees.

Action Items:

1. Survey data summary will be presented to EC

AADPRT RRC SURVEY: ADULT SUMMARY

Survey sent to:
322 Adult TDs/AAs
184 Adult TDs
138 Adult AAs

Percentages below based upon 123 respondents:
76 Adult TDs
26 Adult AAs
15 Fellowship TDs
3 Vice Chairs
3 Chairs
13 Other

Requirement	Keep As is % (Actual)	Modify % (Actual)	THEMES FOR MODIFICATIONS (Number of respondents)
Q1: Intro/Definitions	**80 (99)**	**20 (24)**	**All residents must complete 4 years Adult training before CA or fellowship (7)** **Entering PG2's must complete 3 years of training before CA or fellowship (2)** **Residents may pursue CA or fellowship after 3 years training (8)**
Q2: PGI Year	**80 (100)**	**20 (23)**	**Increase primary care to > 4 months (6).** **Mandate > 1 month primary care on inpatient service (2).** **Give PG1's transferring from any non-psych residency credit for PG1 year (5).** **Give PG1's transferring only from clinical residencies credit for PG1 year (1)**
Q3: Participating Sites	**93 (114)**	**7 (9)**	**Allow teleconferencing and other electronic means of distance learning to count as didactic participation at primary site (6).**
Q4: Program Director	**81 (99)**	**19 (24)**	**More protected time for program directors (12)**
Q5: Faculty	**94 (115)**	**6 (8)**	**None**
Q6:Other personnel	**74 (91)**	**26 (32)**	**More protected time for assist/associate PD's and coordinators (12).** **Coordinator job description (5).**
Q7: Resources	**90 (111)**	**10 (12)**	**None**
Q8:Resident Appointments	**94 (115)**	**6 (8)**	**None**

Q9: Patient care	**89 (109)**	**11 (14)**	**None**
Q10: Adult ->CA	**89 (100)**	**11 (13)**	**See Q1**
Q11: Rotations	**60 (74)**	**40 (49)**	**Forensics – eliminate requirement for written report (8).** **Geri – increase to 2 months (7).**
Q12: Medical Knowledge	**85 (104)**	**15 (19)**	**None**
Q13: PBL/IPC/Prof	**94 (116)**	**6 (7)**	**Eliminate log (5)**
Q14: SBP	**93 (114)**	**7 (9)**	**None**
Q15: Evaluation	**82 (101)**	**18 (22)**	**Combine ABPN CSV & RRC annual exams (5)**
Q16: Prog Eval/ ABPN Pass Rate	**80 (98)**	**20 (25)**	**Eliminate ABPN written exam requirement (11)** **For ABPN written exam, specify who is a graduate**
Q17: Supervision /Oncall	**89 (110)**	**11 (13)**	**Eliminate 1 Hr individual supervision requirement except for advanced residents in psychotherapy supervision (12)**
Integ CA/Adult **102 Adult/AA TDs** **53 CAP/AA TDs** **4 Vice/Chairs** **10 Other**	**82 (144)**	**18 (32)**	**Eliminate CA training in PG1 year (15: Adult-10, CA-5)**

AADPRT RRC SURVEY: CAP SUMMARY

Percentages based upon 66 respondents:

53 CAP TDs/AA TDs
6 Gen TDs/AA TDs
3 Gen/CAP TDs
4 Chairs/Vice Chairs

REQUIREMENT	***KEEP AS IS*** % (Actual)	***MODIFY*** % (Actual)	***THEMES FOR MODIFICATIONS*** ***(Number of respondents: 2 or >)***
Introduction/Definitions	**88% (58)**	**12% (8)**	**2 years Gen and 2 years CAP (3)**
Introduction B.	**77% (51)**	**23% (15)**	**Eliminate RRC approval for research electives (8)**
Sponsoring Institutions	**95% (63)**	**5% (3)**	**none**
Program Director	**79% (52)**	**21% (14)**	**Need more than 50% time for TD (4)** **Need less than 50% time for TD (4)** ***(2 were Chairs/Vice chairs & 2 were CAP TDs of smaller programs)***
Faculty Resources	**94% (62)**	**6% (4)**	**none**
Other program personnel	**89% (59)**	**11% (7)**	**Define and Protect coordinator time (3)**
Education Policy Committee and resources	**89% (59)**	**11% (7)**	**Up-to-date AV equipment and IT access (2)**
Resident appointments	**86% (57)**	**14% (9)**	**Reduce minimum number of residents required to 3 (5)**
Patient care competency	**92% (61)**	**8% (5)**	**Reduce inpatient requirement (2)**
Medical knowledge competency	**89% (59)**	**11% (7)**	**none**
Practice Based Learning and Improvement	**92% (61)**	**8% (5)**	**Refine or Eliminate requirement for documenting resident teaching ability (3)**
Systems based practice	**92% (61)**	**8% (5)**	**none**
Professionalism competency	**94% (62)**	**6% (4)**	**none**
Resident Scholarly Activity	**91% (60)**	**9% (6)**	**none**
Resident evaluation	**80% (52)**	**20% (13)**	**Modify or eliminate ABPN pass requirement (13)**
Moonlighting	**94% (61)**	**6% (4)**	**none**

AADPRT ANNUAL MEETING REGISTRATION STATISTICS
2005-2010

Year	2010	2009	2008	2007	2006	2005
Meeting Locations	Disney	Tucson	NOLA	San Juan	San Diego	Tucson
Categories						
Members	336	316	285	271	271	272
Non-members	64	51	53	44	44	52
Residents	56	48	49	52	46	38
Awardees	13	15	16	16	16	13
Coordinators	127	115	129	88	90	87
Fee Waived-invited	11	15	10	19	13	17
Exhibitors	5	7	7	5	2	6
Guests ($160)	28	40	26	73	33	38
Total Attendance	640	607	575	568	515	523

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 23, 2010

Date: May 18, 2010

Committee or Liaison Group Name: Development Committee

Chair/Representative's Name: Michael Jibson, MD, PhD (Co-Chair), Art Walaszek, MD (Co-Chair)

Goal(s) or tasks to be completed in 2010-2011:

1. Review the implementation of the Guidelines for Selecting Exhibitors at the March 2010 Annual Meeting.
2. Ensure smooth execution of the new policy regarding conflict of interest (COI) for AADPRT leadership.
3. Explore the possibility of donation-based funding for the Ginsberg and IMG Fellowships.

Report/Updates of Importance & Pertinence:

1. COI Policy for Exhibitors

In September 2009, the Executive Council approved the "Guidelines for Selecting Exhibitors for the AADPRT Annual Meeting." We used these guidelines in vetting exhibitors for the 2010 Annual Meeting. At the meeting, the exhibitor space was separate from educational space, and exhibitors were not allowed to offer gifts or food to attendees.

Following the meeting, we solicited feedback from attendees regarding the appropriateness of the exhibitor space:

- 89% (376 of 421) agreed that the exhibitor space did not interfere with their ability to attend educational sessions.
- 97% (398 of 410) agreed that the displays and vendors in the Exhibitor Space were appropriate and unlikely to influence practices.
- 96% (394 of 410) agreed that AADPRT did not appear to endorse any particular vendor in the exhibitor space.

2. COI Policy for AADPRT Leadership

In March 2010, the Executive Council approved the "AADPRT Conflict of Interest Policy" for the organization's leadership. Since then, an on-line disclosure form based on the policy has been developed [see attachment]. Lucille Meinsler will collect initial COI

forms electronically, with a deadline of June 30. Members will be able to update their COI forms over the course of the year via the website.

After June 30, a report will be generated with all the declared disclosures. We will submit this report to the Steering Committee to review and address any potential conflicts of interest. A final listing will be created for publication in the 2011 Annual Meeting brochure by early February 2011.

3. Donation-based Funding for Ginsberg and IMG Fellowships

AADPRT's funding of the Ginsberg and IMG Fellowships from general revenue may not be sustainable in the long-term. We are exploring an alternate model of funding the fellowship, namely by soliciting donations from members and others interested in psychiatric education.

Action Items: none

Attachment: Conflict of Interest disclosure form

Conflict of Interest Declaration for AADPRT Executive Council Members, Committee Chairs, Task Force Chairs, Presidential Appointees

Definition: A conflict of interest is a conflict, or the appearance of a conflict, between the official responsibilities of an individual in an AADPRT leadership position (primary interests) and her or his private interests (secondary interests). AADPRT requires disclosure of the following actual, perceived or potential conflicts of interest.

Name:

Role in AADPRT:

Academic affiliations and full titles:

Are any of the following true or were they true regarding you, your spouse/partner or your dependent children?

Yes	No	Ownership of, investment interest in, or compensation by any commercial entity involved in clinical psychiatry (e.g., pharmaceutical firm or device manufacturer), involved in psychiatric education, or involved in dissemination of psychiatric information (e.g., book publisher)
Yes	No	Leadership role in other professional medical associations or other entities with an interest in psychiatric education (e.g., ABPN, ACGME, NBME)
Yes	No	Other financial connections or support, such as employment, consultancies, honoraria, expert testimony, personal relationships, patent licensing arrangements and grant support, that might raise the question of bias

If you answered **Yes** to any of the above items, please describe below, e.g., 'I have 5% ownership interest in an education software firm, I own stock in Pfizer...'

1. _____
2. _____
3. _____
4. _____

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 23, 2010

Date: May 14, 2010

Committee or Liaison Group Name: Task Force on Psychotherapy

Chair/Representative's Name: Lee Ascherman, MD

Goals of Committee, Task Force, Caucus:
ADPRT Psychotherapy Task Force Goals for 2010 -2011

1. The task force is interested in developing a model curriculum for early training years building on the psychotherapy common factors developed last year. We discussed how this could be approached in our meeting in Orlando in March. The group was concerned that just organizing a syllabus with readings could be too remote and vulnerable to not be used. Alternatively, the members thought that collecting best practices for models of teaching early psychotherapy skills focusing on the therapeutic alliance would be a better, more lively initial approach. We are beginning to do this amongst ourselves, and an inquiry to AADPRT members for models we are not aware of is being developed.

2. The task force is interested in developing additional competencies akin to those developed for the CSV, focusing on Formulation, Differential Diagnosis and Treatment Planning.

3. The current competencies developed for the CSVs will be adapted for child and adolescent training directors focusing on development and additional issues relevant to child and adolescent psychiatry including interviewing parents or guardians, and interviewing children at different developmental stages. The goal is that these documents can be useful towards calibrating faculty to a relatively common understanding of what is being looked for when considering the alliance, interviewing skills, and presentation of the history.

Report/Updates of Importance & Pertinence: See Attached

Action Items: Completed CSVA Competencies for parts I, II, III. Developing child versions. Also developing CSV competencies for formulation, differential diagnosis and treatment planning.

Competency in Case Presentation

Attitude

1. The resident's presentation reflects empathy and basic respect for the patient.

2. The resident's presentation is free from bias regarding race, ethnicity, gender, marital status, age and sexual orientation.

3. The resident's presentation avoids presumptions about the patient not evidenced by the information obtained in the interview.

4. The resident's presentation includes all available information relevant to the ultimate understanding of the patient from a biopsychosocial perspective. There is no omission or minimization of any aspect of the information obtained based on the resident's lack of sensitivity to the patient's communications, the resident's personal biases about the relevance of information provided by the patient, or the resident's emotional reactions to the information provided by the patient.

Knowledge

1. The resident's presentation reflects adequate knowledge of the key categories for organizing information obtained in a clinical interview:

   Identifying Information (including relevant social history)
   Chief Complaint
   History of Present Illness
   Past Psychiatric History
   Past Medical History
   Family Psychiatric History
   Mental Status Examination

2. The resident demonstrates knowledge of the components of the Mental Status Examination

   General Appearance
   Mood
   Affect
   Speech and Language
   Thought Processes
   Content of Thought
   Sensorium and Intellect
      Orientation
      Concentration
      Immediate recall
      Recent Memory
      Remote Memory
      Abstraction
      Insight
      Judgement
      Clinical estimate of intelligence

3. The resident demonstrates knowledge of how elements of the Sensorium and Intellect examination can be derived from their interview if not tested directly.

4. The resident demonstrates knowledge of how attunement to non verbal information conveyed by facial expression, body language, affective tone, and the patient's use of language can be of value for understanding components of the history and mental status.

Skills

1) The resident's case presentation accurately reflects the patient's story, avoiding significant omissions, misinformation, or information the patient did not provide.

2) The resident demonstrates the capacity to discern most relevant information from less relevant information, avoiding more circumstantial details obtained from the patient that are not inherently relevant to the core understanding of the case.

3) The resident demonstrates the ability to appropriately integrate non verbal information into the presentation without losing focus on the overall structure of the presentation. (facial expression, body language, speech).

4) The resident demonstrates the ability to organize the information obtained in the interview into accurate categories for presentation.

5) The resident demonstrates the capacity to present in a logical, concise, and coherent fashion.

6) The resident demonstrates in their presentation adequate attention to pertinent positive and negative findings.

7) The resident demonstrates in their presentation their ability to include all relevant biological, psychological and social factors obtained in the interview that are ultimately relevant to an integrated understanding of the patient.

8) The resident demonstrates the ability to present the components of the Mental Status Evaluation in a coherent, systematic fashion.

9) The resident demonstrates the ability to present the findings of the Mental Status Examination accurately, including pertinent negative findings.

10) The resident demonstrates through their presentation their ability to accurately attune to and discern the information necessary for an accurate assessment of the patient's risk to self and others (dangerousness).

11) By the conclusion of the resident's presentation they have successfully been able to convey a clear and coherent portrait of the patient necessary for the development of an accurate biopsychosocial formulation, differential diagnosis, and treatment plan.

Competency in Conduct of the Interview

Attitude

1. The resident will convey genuine interest in the patient and sufficient empathy for their situation in ways that facilitate the progress of the interview.

2. The resident will demonstrate tolerance that a patient may not respond to inquiries with clear, direct responses that they would like.

3. The resident will demonstrate awareness that difficulties encountered in the interview may actually be sources of important information about the patient (i.e.cognitive limitations, avoidance of emotionally charged areas, defensive style or character structure of the patient) and/or their approach to the patient.

4. The resident will demonstrate a respectful, collaborative approach to the patient that facilitates the progress of the interview.

5. The resident will demonstrate a non-judgmental attitude towards the patient that facilitates the progress of the interview.

6. The resident will demonstrate tolerance of difficult aspects of the patient's story or the patient's expression of affect in ways that facilitate the progress of the interview rather than constrict it.

7. The resident will demonstrate tolerance of the patient's conflicts and external dilemmas by avoiding the interjection of their own opinion or judgment in the diagnostic interview.

8. The resident will demonstrate an ability to contain their own emotional reactions to the patient in the service of maintaining an attitude of respect and protecting the progress of the interview.

9. The resident will demonstrate awareness that assumptions about a patient based on past diagnosis, race, ethnicity, gender, marital status, and sexual orientation can limit important areas of exploration in the diagnostic interview.

10. The resident will demonstrate appreciation of the importance of biological, psychological, and social forces shaping the presentation of the patient as reflected in their avenues of inquiry.

11. The resident will demonstrate appreciation of the usefulness of self observation and self awareness including one's personal reactions to the patient for maintaining the integrity of the diagnostic interview and signaling important areas for exploration.

Knowledge

1. The resident will demonstrate understanding that the challenges experienced in the interview of the patient can be a useful source of information about the patient and/or their approach to the patient.

2. The resident will demonstrate understanding that their conduct of the interview (i.e. pace, sequence of areas of exploration, level of language used, degree of structure imposed) must be shaped to the acute status of the patient including symptoms, character structure, and cognitive capacities of the patient.

3. The resident will demonstrate an understanding that symptoms and behaviors can have multiple, complexly determined sources and meanings that may not be readily apparent to the patient or the interviewer.

4. The resident will demonstrate an understanding of the relevance of an individual's history and experiences on perceptions, thoughts, patterns in thinking, feelings, attitudes, behavior, and overall psychic development.

5. The resident will demonstrate understanding of the potential influence of the patient's perceptions, emotional reactions, and thoughts about the resident on the course of the interview.

6. The resident will demonstrate understanding of the basic components of the diagnostic interview.

7. The resident will demonstrate understanding of the basic components of the mental status examination.

Skills

1. The resident will demonstrate an ability to engage the patient in exploration of his or her history, experiences, and symptoms.

2. The resident will demonstrates an ability to respond empathically to the patient to maintain an alliance and facilitate the progress of the interview.

3. The resident will demonstrate the ability to conduct the diagnostic interview strategically based on the patient's responses to them and their evolving understanding of the patient.

4. The resident will demonstrate an ability to effectively listen to and observe the patient as evidenced in their recognition and use of nuance, indirect communication, and non-verbal communication from the patient to facilitate the interview.

5. The resident will demonstrates an ability to manage time effectively, balancing sensitivity to the patient with a need to structure the interview sufficiently to attempt to cover areas of importance.

6. The resident will demonstrate an ability to use verbal and non verbal cues from the patient as indicators for probes that deepen exploration of important areas.

7. The resident will demonstrate an ability to communicate effectively with the patient using tact, clarity, and avoiding jargon.

8. The resident will demonstrate sufficient ability to use open ended question to facilitate the the progress, depth, and overall quality of the interview.

9. The resident will demonstrate an ability to modulate the degree to which they structure the interview based on the profile and needs of the patient.

10. The resident will demonstrate an ability to manage transitions and redirection of the patient with sufficient tact and sensitivity in order to facilitate the progress of the interview.

11. The resident will demonstrate the ability to cover key areas of the diagnostic interview obtaining sufficient information to present the basic components of the history and mental status examination, and to ultimately construct a biopsychosocial formulation, assessment of risks, differential diagnosis, and preliminary treatment plan.

12. The resident will demonstrate an ability to perform an adequate mental status examination attuned to the patient's profile or can adequately comment to what aspects of the mental status examination that was not conducted could be derived from their interview and observations.

13. The resident will demonstrate an ability to identify, tolerate and manage their affective reactions to the patient in order to facilitate the progress of the diagnostic interview.

Competency in Physician Patient Relationship

Attitude

1. The resident will demonstrate an attitude of basic respect for the patient reflected in their sensitivity to the patient's history and circumstances and attunement to the patient's vulnerabilities.

2. The resident will demonstrate genuine interest in the patient as an individual reflected in an interview that conveys a sense of the patient as a whole person with a history and relevant symptoms.

3. The resident will demonstrate a capacity for empathy for the patient's external and internal experiences and their relevance to the patient's symptoms.

4. The resident will demonstrate an attitude of non-judgmental acceptance of the patient based on awareness that the patient's presentation and symptoms reflect an amalgam of their biological, social, and psychological strengths and vulnerabilities.

5. The resident will demonstrate a capacity to accept their reactions to the patient and the patient's reactions to them.

6. The resident will demonstrate respect for the patient's gender, ethnicity, culture, religion, cognitive and educational level, and socioeconomic status.

7. The resident will demonstrate an overall professional presence conveyed in dress, posture, language, and eye contact - all relevant to the comfort of the patient and the maintenance of rapport.

8. The resident will demonstrate awareness of respectful interpersonal boundaries.

Knowledge

1. The resident will demonstrate understanding of the relevance of an adequate alliance with the patient (rapport) to the quality of the interview and the quality of information obtained.

2. The resident will demonstrate understanding of the relevance of professional conduct including respect for appropriate boundaries to the establishment and maintenance of rapport that facilitates the diagnostic interview, in addition to understanding the overarching ethical principles upon which professionalism is based.

3. The resident will demonstrate understanding of the relevance of the arrangement of the interview room (arrangement of chairs, sensitivity to interpersonal space) to the establishment of sufficient comfort in the patient to facilitate the interview.

4. The resident will demonstrate understanding of the importance of orienting the patient to the purpose and structure of the diagnostic interview as relevant to the establishment and maintenance of rapport that facilitates the interview.

5. The resident will demonstrate understanding of the relevance of sensitivity to gender, ethnicity, culture, religion, cognitive and educational level, and socioeconomic status to the establishment of an alliance with the patient that ultimately influences the quality of the interview.

6. The resident will demonstrate an understanding of the importance of using language gauged to the level of the patient's understanding in order to engage the patient, facilitate the progress of the diagnostic interview, and enhance the accuracy of information obtained.

7. The resident will demonstrate understanding of the importance of word choice and timing (tact) attuned to the content and affective tone of the patient's communication in order to maintain rapport with the patient, facilitate the progress of the diagnostic interview, and enhance the accuracy of information obtained.

8. The resident will demonstrate understanding of the need to adjust or adapt their interview strategy based on the content of the patient's communications, the patient's expressed affect, and/or the patient's cognitive level.

8. The resident will demonstrate understanding that the challenges a patient may pose to efforts to interview them including the patient's reactions to the resident may contain important diagnostic information about the patient.

9. The resident will demonstrate understanding that their own reactions to the patient may contain important diagnostic information about the patient.

Skills

1. The resident will demonstrate the ability to provide a safe interview environment that promotes the patient's comfort and the progress of the interview.

2. The resident will orient the patient to the purpose and structure of the interview.

3. The resident will demonstrate the interpersonal skills needed to build rapport with the patient evidenced in an alliance based on respectful inquiry into the patient's history, circumstances, and inner life.

4. The resident will demonstrate an ability to communicate effectively with the patient by being tactful, using language at the level of the patient's understanding, and avoiding jargon.

5. The resident will demonstrate an ability to attune to the patient as evidenced in careful, active listening to the patient's communication.

6. The resident will demonstrate an ability to attune to the patient as evidenced in careful, active observation of the patient's affective experience as manifested not only in the patient's expressed emotions but also through facial expression and body language.

7. The resident will demonstrate an ability to engage the patient in respectful exploration of their history, experiences, and perceptions to inform their diagnostic understanding of the patient.

8. The resident will demonstrate sufficient ability to recognize issues pertaining to the gender, ethnicity, religion, cognitive and educational level, and socioeconomic status relevant to the patient and to use their understanding of these issues to inform their conduct of the interview so that optimal rapport is established.

9. The resident will demonstrate the capacity to tolerate the patient's communication of difficult aspects of their history recognizing the importance of such tolerance towards the maintenance of rapport and facilitation of the interview.

10. The resident will demonstrate the capacity to tolerate the patient's expressions of affect recognizing the importance of such tolerance towards the maintenance of rapport and facilitation of the interview.

11. The resident will demonstrate an ability to demonstrate acceptance of the patient's communications by avoiding responses suggestive of judgment or intolerance.

12. The resident will demonstrate the capacity to empathically and effectively listen and observe the patient's more subtle and indirect verbal and non verbal communications relevant to the establishment and maintenance of rapport.

13. The resident will demonstrate the capacity to tolerate their own reactions to the patient using such reactions to inform their understanding of the patient and to adapt their interview in the interest of maintaining rapport.

14. The resident will demonstrate the capacity to tolerate the patient's reactions to them, using these reactions to inform their understanding of the patient and to adapt their interview in the interest of maintaining rapport.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 23, 2010

Date: Spring 2010

Committee or Liaison Group Name: Subspecialty Caucus Group

Chair/Representative's Name: Catherine Woodman, MD

Goal(s) or tasks to be completed in 2010-2011:

Improve attendance at the AADPRT meeting for subspecialty fellowship directors

Report/Updates of Importance & Pertinence: We had good attendance at the Psychosomatic subspecialty caucus, with 7 program directors in attendance. There were no Substance Abuse fellowship directors and 5 each for Geriatrics and Forensics.

Challenges:

1. Geriatrics meeting is in conflict with the AADPRT meeting
2. Fellowship directors attend their subspecialty meetings, which have a group for them to work with each other, and network.
3. Funding constraints for meeting attendance
4. Lack of specific content for them.

Action Items:

1. Substance Abuse Caucus leader identified by Sheldon Benjamin—John Renner, MD
2. Meet with subspecialty leadership to discuss their support for getting fellowship directors to AADPRT
3. Send out personal invitations to fellowship directors for next AADPRT annual meeting.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 23, 2010

Date: May 14, 2010

Committee or Liaison Group Name: Task Force on Combined Training Accreditation

Chair/Representative's Name: Mark Servis, MD

Goal(s) or tasks to be completed in 2010-2011:

1. Connect with leaders in professional organizations in internal medicine, family practice, pediatrics and neurology and with their representatives at OPDA to inform them of the issues in combined training program accreditation and approval.
2. Work with the APA leadership to address these issues with the ACGME and the ABPN.
3. Develop potential solutions for both the ACGME and the ABPN.

Report/Updates of Importance & Pertinence:

1. We have had one conference call as a task force and have reached out to OPDA, APDIM, ABFP, and the APA.

Action Items:

1. Distribute white paper on combined training accreditation/approval for possible distribution as an educational tool.

AADPRT White Paper on Combined Training Program Accreditation/Approval

Problem:

The ABPN in 2009 announced an indefinite moratorium on their approval of new combined residency training programs involving psychiatry. The ABPN is now considering withholding board eligibility for residents who begin combined training in already established programs, though residents presently enrolled in these programs will remain board eligible for psychiatry upon graduation. The reason for the ABPN action is concern generated from at least two state licensing boards who have questioned combined graduate eligibility for licensure by virtue of their not having graduated from "an accredited residency program." Apparently this has not yet become an issue with other ABMS boards.

The ACGME does not separately accredit combined training programs, with the exception of internal medicine/pediatrics, which has its own RRC. The ACGME posted on its website a list of "non-accredited combined specialties" approximately one year ago, and now includes combined residents in calculations for resident complement. The following language from the ACGME website regarding combined training speaks to the current oversight of combined training programs (except for internal medicine/pediatrics):

> Combined training consists of a coherent educational experience in two or more closely related specialty or subspecialty programs. The educational plan for combined training is approved by the specialty board of each of the specialties to assure that resident physicians completing combined training are eligible for board certification in each of the component specialties. Each specialty or subspecialty program is separately accredited by ACGME through its respective specialty review committee. The duration of combined training is longer than any one of its component specialty programs standing alone, and shorter than all of its component specialty programs together.

The ACGME is not interested in establishing separate RRCs and independent accreditation mechanisms for combined programs. The ABPN action under consideration, to withhold eligibility from new residents entering combined training programs, will have a negative and ultimately fatal impact on recruitment to combined programs.

Background:

Combined residency training is not unique to psychiatry. There are currently 19 different specialties that support 112 combined residency programs. Of these programs, four different specialties and 40 combined residency programs include training in psychiatry. They are peds/psych/child psych ("triple board", 10

programs), internal medicine/psychiatry (14 programs), family medicine/psychiatry (8 programs), and neurology/psychiatry (8 programs). At this time, all of these programs are "approved" by their respective specialty boards to assure that resident physicians completing combined training are eligible for board certification in each of the component specialties.

Rationale for Combined Residency Training:

Combined programs provide unique training experiences that blend the competencies of two or more specialties to create clinicians able to simultaneously use the clinical skills of two disciplines. Combined graduates occupy several specialized niches including a number of settings where there is a workforce shortage and in areas of mental health disparity. Closure of these unique programs will result in worsening morbidity and mortality among those with mental illness and an increased workforce shortage, particularly in the areas of child and adolescent psychiatry, primary care delivery, rural health care delivery, and neurological / general integrative care within the psychiatric patient care population.

There have been several studies, reviews and publications concerning combined training, including several in psychiatry. These studies have been largely positive and supportive of combined training, both in implementation and in outcomes. A bibliography of the literature of the past five years on combined residency training is provided below.

Kessler CS, Stallings LA, Gonzalez AA, Templeman TA. Combined residency training in emergency medicine and internal medicine: an update on career outcomes and job satisfaction. *Acad Emerg Med*. 2009 Sep;16(9):894-9.

Gleason MM, Fritz GK. Innovative training in pediatrics, general psychiatry, and child psychiatry: background, outcomes, and experiences. *Acad Psychiatry.* 2009 Mar-Apr;33(2):99-104.

Wild DM, Tessier-Sherman B, Jekel JF, Ahmadi R, D'Souza S, Nawaz H. Experiences with a combined residency in internal and preventive medicine. *Am J Prev Med*. 2008 Oct;35(4):393-7.

Warner CH, Morganstein J, Rachal J, Lacy T. Perceptions and practices of graduates of combined family medicine-psychiatry residency programs: a nationwide survey. *Acad Psychiatry*. 2007 Jul-Aug;31(4):297-303.

Woolridge DP, Lichenstein R. A survey on the graduates from the combeind emergency medicine/pediatric residency programs. *J Emerg Med*. 2007 Feb;32(2):137-40. Jan 29.

Melgar T, Chamberlain JK, Cull WL, Kaelber DC, Kan BD. Training experiences of U.S. combined internal medicine and pediatrics residents. *Acad Med*. 2006 May;81(5):440-6.

Lacy T, Flynn J, Warren D. Supervision and boundaries in a combined family practice and psychiatry residency training program: the National Capital Consortium experience. *Acad Psychiatry.* 2005 Nov-Dec;29(5):483-9.

Rachal J, Lacy TJ, Warner CH, Whelchel J. Characteristics of combined family practice-psychiatry residency programs. *Acad Psychiatry*. 2005 Nov-Dec;29(5):419-25.

Servis M. Combined family practice and psychiatry residency training: a 10-year appraisal. *Acad Psychiatry*. 2005 Nov-Dec;29(5):416-8.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 23, 2010

Date: 5/14/10

Committee or Liaison Group Name: Resident Safety Taskforce

Chair/Representative's Name: Isis V. Marrero

Goal(s) or tasks to be completed in 2010-2011:

1. Collect/review model prevention/post-vention protocols
2. Collect/review model safety curricula
3. Create webpage on AADPRT site with resources on the subject
4. Create Resident Safety Guidelines for Psychiatry Training Programs
5. Present workshop at AADPRT annual meeting 2011
6. Consider recommendations for RRC regarding Resident Safety

Report/Updates of Importance & Pertinence:

1. Taskforce members have been selected. There is the possibility of adding one more person to the taskforce but as of today, the group includes:
    a. Sheldon Benjamin, M.D. (ex-officio member)
    b. Sarah Johnson, M.D.
    c. Ze'ev Levin, M.D.
    d. Gail Manos, M.D.
    e. Isis Marrero, M.D.
    f. Ann Schwartz, M.D.
    g. Christopher Thomas, M.D.

2. The first call conference occurred on 5/11/10. At that time, the group decided the taskforce goals for the year, the deliverables for the EC meetings and the action items.

3. On 4/29/10, a message was posted on the AADPRT list serve asking members for data and resources already used in their programs to address trainee safety. A number of responses were received and the taskforce is in the process of reviewing these materials.

Action Items:

1. The group decided to form subcommittees with specific assignments:

    a. Summarizing and creating guidelines for Prevention Policies
    Ann Schwartz
    Isis Marrero

b. Summarizing and creating guidelines for Post-vention Policies
   Ze'ev Levin
   Sarah Johnson

c. Collecting relevant references and creating guidelines for Resident Safety Curricula
   Gail Manos
   Chris Thomas

d. Uploading resources to AADPRT webpage
   Isis Marrero
   AADPRT IT team

2. Submit abstract for workshop to be presented at annual meeting by end of November 2010

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 23, 2010

Date: May 14, 2010

Committee or Liaison Group Name: Professionalism and the Internet Taskforce

Chair/Representative's Name: Sandra DeJong ("DeYoung"), MD

Goal(s) or tasks to be completed in 2010-2011:
1) Review existing policies, guidelines and articles to elucidate the problem and identify existing resources.
2) Establish a web page linked to the AADPRT website to act as a clearinghouse for recommended resources (e.g. model policies, teaching tools, annotated bibliography).
3) Develop a sample curriculum covering legal, ethical and clinical issues that can arise from online behaviors by psychiatric residents, faculty, administrators and patients.

Report/Updates of Importance & Pertinence:
The use of Internet technology such as blogs, social networking sites (e.g. Facebook), email, and searches engines among psychiatric professionals and their patients is skyrocketing; however, few standards exist regarding its use, and concerning behaviors regarding Internet use are increasingly in evidence: In a recent survey of US medical schools (JAMA, 2009), 60% of schools reported incidents of students posting unprofessional online content. A recent survey of psychiatric training directors and residents by Dr. DeJong found that 91% of respondents had posted personal content on the Web, but about 80% reported being unaware of having received any policies or instruction about this issue. Such evidence suggests that psychiatric residents, educators and administrators need guidelines and education about the potential professional pitfalls of Internet use, including possible clinical, ethical and legal ramifications.

Action Items:
1) A Presidential Task Force has been formed with the following members: Joan Anzia, MD, Sheldon Benjamin, MD, Bob Boland, MD, Sandra DeJong, MD, (Chair), Nadyah John, MD, (child fellow), Jim Lomax, MD, and Tony Rostain, MD.
2) The Taskforce will meet monthly by conference call, starting May 12th.
3) By the fall 2010 Executive Council Meeting, a webpage linked to the AADPRT will be set up as a clearinghouse for resources approved by the taskforce.
4) By the March 2011 Executive Council meeting, the Taskforce will have developed a developmental curriculum for the teaching of appropriate online behaviors to psychiatric residents to be made available to AADPRT members online.

AADPRT Committee Chair/Liaison Representative Report

Executive Council Meeting
AADPRT APA Meeting
May 23, 2010

Committee or Liaison Group Name: Workforce

Chair/Representative's Name: Steve Schlozman

Members:
Aurora Bennett
Cindy Pristach
Paula Del Regno
Geri Fox
Mike Scharf

Conference Call to be discussed at meeting

Goal(s) or tasks to be completed in 2010-2011

Generally, we seek to increase awareness and attractiveness of psychiatry among medical students and those looking to chance specialties. We hope to accomplish this goal by examining existing data about how and why students choose their areas of specialty, and by then implementing and promoting better, more effective, and when possible evidence based outreach programs to better represent psychiatry to those who are deciding what field to practice. This leads to more specific goals.

Admittedly grandiose (perhaps even manic), we must organize ourselves such that we can:

1. OBTAIN A STATEMENT FROM SOMEONE AT THE AAMC TO SUPPORT THE GOALS OF HAVING MEDICAL EDUCATION BETTER REFLECT THE PRACTICE OF PSYCHIATRY (details below)? I HAVE SPOKEN TO DARREL KIRCH REGARDING STIGMA, BUT WHAT ABOUT ASKING HIM TO HELP WITH AN AAMC STATEMENT OF CONSENSUS.

2. OBTAIN A STATEMENT OR A CONSENSUS STATEMENT FROM ALL OF THE ANCILLARY ORGANIZATIONS INVOLVED WITH PSYCHIATRY ASKING FOR CURRICULAR CHANGES THAT FOSTER GREATER AND MORE ACCURATE PSYCHIATRIC EXPERIENCE?

3. OBTAINCA A STATEMENT OR CONSENSUS STATEMENT FROM THE NIH OR THE NIMH OR BOTH THAT MEDICAL EDUCATION IN GENERAL

IS SUBSTANTIALLY BETTER SERVED IF OUR CANNON OF EDUCATION MORE ACCURATELY REFLECTS MODERN PSYCHIATRY.

Report/Updates of Importance & Pertinence:

I. **Changes in the National Health Service Corps Loan Repayment and Scholarship Programs**
   a. Difficult to tease out – can call many times and get different answers. Web Site is somewhat confusing: http://nhsc.hrsa.gov/index.htm
   b. From what I can tell based on discussions with the NHSC and recipients of both scholarships (i.e. money up front) and loan repayment (money later) there are three changes worth noting.

Change Worth Noting #1: There are more opportunities to utilize these programs based on increased funding from stimulus money

Change Worth Noting #2: A person may, with little or no resistance and the relative blessing of the federal government pursue child psychiatry and not have their scholarship placed in jeopardy. They must do this as a function of the five year program. (i.e. they have to short track). I don't know about triple board.

Change Worth Noting #3: Sites where one must practice to qualify for either program are scored. The lower the number, the less the perceived need for the field of medicine the scholarship or loan repayment recipient wants to practice. Many psychiatrists feel that these numbers do not accurately reflect psychiatric need, though psychiatry is officially among the disciplines for which one may receive scholarships or loan repayment. For example, rural areas tend to have high scores (based on the lack of primary care, and, as we know, psychiatric care) whereas urban areas have lower scores as there appears to be ample primary care. HOWEVER, we are aware that urban areas often lack psychiatric care, and yet this is not reflected in the overall score. It looks like this is changing – that urban areas are increasingly being allowed for recipients seeking psychiatric positions in order to accomplish scholarship obligations and to a lesser extent loan repayment. This is a function of stimulus money and a change in attitudes at the NHSC.

Why this matters:

1. **We can advise students that these financial assistances are viable options for psychiatry**
2. **We can advise students that they will not be forced to choose among a relatively small number of sites**
3. **All of this could change.**

II. **NRMP Data (2009) Regarding Reasons Applicants Choose a Given Specialty (note that this is not why they choose one field over another. This is data that discus what they value within fields that applicants choose)**

a. Comparisons – lets looks at psychiatry (our field), Neurology and Family Medicine (potential competitors) and Dermatology (still among the most popular fields)
    i. Overall Rankings - 1= not at all important, 5 = very important
    1rst number = US grads, 2nd Number = Independent grads

	Faculty Commitment to Resident Education	Work/Life Balance	Salary
Overall	4.6 & 4.5	3.9 & 4.3	3.0 & 2.7
Psychiatry	4.5 & 4.6	4.0 & 4.0	3.0 &3.0
Neurology	4.5 & 4.6	3.8 & 4.3	2.9 & 3.0
Family Medicine	4.5 & 4.6	4.0 & 4.5	3.1 & 2.9
Dermatology	4.4 & 4.6	3.9 & 4.3	2.6 &2.5

b. Salary Comparisons from Rand McNally/LA Times Poll 2006
http://www.allied-physicians.com/salary_surveys/physician-salaries.htm

	Years 1-2	Year 3	Max Salary	
Psychiatry	128 K	168 K	292 K	
Neurology	180 K	204 K	241 K	
Family Med w/ OB	182 K	204 K	241 K	
Family Med w/o OB	161 K	135 K	239 K	
Dermatology	195 K	308 K	452 K	

Why this Matters:
Among our main competitors, people seem to rate equally the things that matter to them when choosing a field. This does not match with what students report, according to the literature, to believe about psychiatry. For example, research suggests that students feel psychiatrists make very little money, and that work/life balance is not that different from other fields.

If we wanted to, we could work at getting across the message across that:

1. **Training in Psychiatry is Unique and Involves Lots of Mentorship – more than is typical of other fields**
2. **Psychiatrists don't starve**
3. **We have the potential for outstanding work/life balance – better than applicants seem to appreciate**

III. Literature Review of Data from US, Canada, Italy, the UK, and other Western Nations with variety of health care delivery options show:

a. that students choose psychiatry because of:
    i. Mentorship in Medical School
    ii. Appreciation for the Ambiguity and Hence the Remaining Riddles to be Solved

iii. Doctor-Patient Relationship
iv. Longitudinal Experience

b. students opt against psychiatry because of
   i. Perception that Patients do not get better
   ii. Stigma
   iii. Poor reimbursement

Why this matters:
We need to better at getting students into psychiatry based on the positives and dispensing with the negatives

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Grandiose Action Items:
Given→white papers in every Western nation stating the need for more psychiatrists and more psychiatric knowledge in other fields.

Given → curricular modifications in medical school and possibly hence recruitment has been relatively unchanged or gotten worse in terms of time allotted to medical cannon

Given → students are much more likely to appreciate psychiatry if the clerkship were more representative of psychiatry as a field and if they could enjoy longitudinal mentorship. A greater number would potentially choose the field, and a greater number who do not opt for psychiatry would not teach our students the ongoing misperceptions that seem to be reflected in the curriculum and in student reports.

We need buy-in and leverage from non-psychiatric organizations directly involved in medical education. The Surgeon General would seem to have leverage, and yet there have been reports on mental health and child mental health care in the last decade or so and no real change among medical curricula or policy issues that would foster workforce.

CAN WE GET A STATEMENT FROM SOMEONE AT THE AAMC TO SUPPORT THIS? I HAVE SPOKEN TO DARREL KIRCH REGARDING STIGMA, BUT WHAT ABOUT ASKING HIM TO HELP WITH AN AAMC STATEMENT OF CONSENSUS.

CAN WE GET A STATEMENT OR A CONSENSUS STATEMENT FROM ALL OF THE ANCILLARY ORGANIZATIONS INVOLVED WITH PSYCHIATRY ASKING FOR CURRICULAR CHANGES THAT FOSTER GREATER AND MORE ACCURATE PSYCHIATRIC EXPERIENCE?

CAN WE GET A STATEMENT OR CONSENSUS STATEMENT FROM THE NIH OR THE NIMH OR BOTH?

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 23, 2010

Date: 5/7/10

Committee or Liaison Group Name: Academic Psychiatry Governance Board

Chair/Representative's Name: Bruce R. Levy, MD

Goal(s) or tasks to be completed in 2010-2011: To be determined at our next meeting on 6/15/10.

Report/Updates of Importance & Pertinence: None

Action Items: None