39th Annual Meeting

American Association of Directors of Psychiatric Residency Training

The Mindful Leader in Changing Times

March 11 – 14, 2008

The Contemporary Resort
Disney World, Orlando Florida

Kathy M. Sanders, MD
Program Chair

David L. Kaye, MD
President

Plenary Speakers
(DRAFT)

George Vaillant, MD

Director, Study of Adult Development,
Harvard University Health Services

Professor of Psychiatry, Harvard Medical School

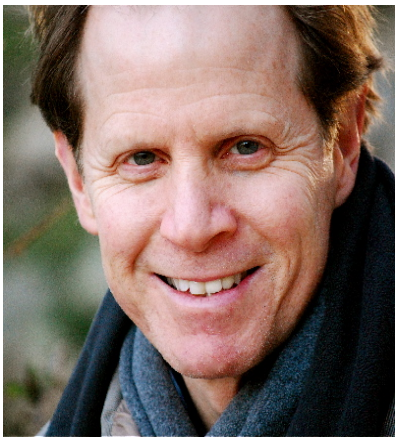
Steering Committee, Positive Psychology

"Positive Psychotherapy"

Dr. Vaillant is a Professor of Psychiatry at Harvard Medical School and the Department of Psychiatry, Brigham and Women's Hospital. Dr. Vaillant has spent his research career charting adult development and the recovery process of schizophrenia, heroin addiction, alcoholism, and personality disorder. He has spent the last 35 years as Director of the Study of Adult Development at the Harvard University Health Service. The study has prospectively charted the lives of 824 men and women for almost 70 years. His published works include over 252 peer reviewed published articles and eight books. His books include: *Adaptation to Life, 1977*, *The Wisdom of The Ego, 1993, The Natural History of Alcoholism-Revisited, 1995,* and *Aging Well*, 2002. His most recent book on the positive emotions, *Spiritual Evolution: How We Are Wired For Faith, Hope And Love* was published by Doubleday Broadway in 2008.

A graduate of Harvard College and Harvard Medical School, Dr. Vaillant did his residency at the Massachusetts Mental Health Center and completed his psychoanalytic training at the Boston Psychoanalytic Institute. Among many positions of leadership during his career, he spent eight years as a residency training director at the Harvard programs Cambridge Hospital and the Mass Mental Health Center. He has been a Fellow at the Center for the Advanced Study in the Behavioral Sciences, is a Fellow of the American College of Psychiatrists and has been an invited speaker and consultant for seminars and workshops throughout the world. A major focus of his work in the past has been individual adult development; more recently he has been interested in positive emotions and their relationship to community development. He is a past Class A trustee of Alcoholics Anonymous and is currently on the Steering Committee of Positive Psychology.

Dr. Vaillant has received the Foundations Fund Prize for Research in Psychiatry from the American Psychiatric Association, the Strecker Award from The Institute of Pennsylvania Hospital, and the Jellinek Award for research in alcoholism. Most recently he received The Distinguished Service Award from the American Psychiatric Association.



Daniel Siegel M.D.

Executive Director, Center for Human Development and Mindsight Institute

Medical Director, Lifespan Learning Institute, Los Angeles, CA

Co-Director, UCLA Mindful Awareness Research Center

"Integrating Mind, Relationships, and Brain into the Foundations of Psychiatric Education"

Dan Siegel received his medical degree from Harvard University and completed his postgraduate medical education at UCLA with training in pediatrics and child, adolescent and adult psychiatry. He served as a National Institute of Mental Health Research Fellow at UCLA, studying family interactions with an emphasis on how attachment experiences influence emotions, behavior, autobiographical memory and narrative.

An award-winning educator, he formerly directed the training program in child psychiatry and the Infant and Preschool Service at UCLA. He is the recipient of the psychiatry department's teaching award and several honorary fellowships. He is currently an associate clinical professor of psychiatry at the UCLA School of Medicine where he is on the faculty of the Center for Culture, Brain, and Development. He is also the Director of the Mindsight Institute, an educational organization that focuses on how the development of insight and empathy in individuals, families and communities can be enhanced by examining the interface of human relationships and basic biological processes.

Dr. Siegel is the co-editor of a handbook of psychiatry and the author of numerous articles, chapters, and the internationally acclaimed text, *The Developing Mind: Toward a Neurobiology of Interpersonal Experience* (1999). This book introduces the idea of interpersonal neurobiology and has been of interest to and utilized by a number of organizations, including the U.S. Department of Justice, The Vatican's Pontifical Council for the Family, the Council on Technology and the Individual, early intervention programs and a range of clinical and research departments worldwide. Dr. Siegel serves as the Founding Editor-in-Chief for the Norton Series on Interpersonal Neurobiology. His book with Mary Hartzell, M.Ed., *Parenting from the Inside Out: How a Deeper Self-Understanding Can Help You Raise Children Who Thrive* (2003) explores the application of this newly emerging view of the mind, the brain, and human relationships. His recent book, *The Mindful Brain: Reflection and attunement in the cultivation of well-being*, explores the nature of mindful awareness as a process that harnesses the social circuitry of the brain as it promotes mental, physiologic, and relational health. His next book will be released at the end of 2009 and is entitled: *Mindsight: The New Science of Personal Transformation.*

Dr. Siegel's integrated and accessible developmental approach has led him to be invited to local, national and international organizations to address groups of educators, parents, public administrators, healthcare providers, policy-makers, clergy, and neuroscientists. The overall goal of these educational efforts is to provide a scientifically grounded view of human experience to a wide audience that can help facilitate the development of psychological well-being and emotional resilience across the lifespan.

Ronald Epstein, MD

Professor of Family Medicine, Psychiatry and Oncology, University of Rochester Medical Center

Director of the Rochester Center to Improve Communication in Health Care

Director of the Dean's Teaching Fellowship Program

"Self-Monitoring and Mindfulness: Challenges for Medical Educators"

Dr. Epstein is Professor of Family Medicine, Psychiatry and Oncology at the University of Rochester Medical Center, and board-certified in Family Medicine and Hospice and Palliative Medicine. He serves as Director of the Rochester Center to Improve Communication in Health Care and as Director of the Dean's Teaching Fellowship Program for junior and mid-career faculty.

Dr. Epstein's NIH-, AHRQ- and foundation-funded studies have added to our understanding of the impact of patient-physician relationships and communication on health, the process of care and health care costs. In particular, his research has focused on patient-centered care, patient influence on clinicians' practice patterns, and clinician mindfulness and self-awareness as applied to stigmatized topics and under-studied populations (e.g. AIDS, somatization, life-limiting illness).

He has developed innovative educational programs in mindful practice, communication skills, the patient-physician relationship, physician self-awareness and assessment of professional competence, including peer assessment. His influential educational papers have outlined the habits of mind of master clinicians, including influential papers on mindful practice (*Journal of the American Medical Association*, 1999), professional competence (*Journal of the American Medical Association*, 2002) and assessment (*New England Journal of Medicine*, 2007). He has consulted to and produced monographs on patient-centered care for the National Cancer Institute (2007) and American Board of Internal Medicine (2008). He has recently demonstrated the effects of a "mindful communication" program on physician empathy, burnout and clinical care. He has over 100 peer-reviewed publications relating to communication in medicine and medical education, and an additional 60 chapters, editorials and monographs.

Dr. Epstein graduated from Wesleyan University (1976) and Harvard Medical School (1984). Among his accomplishments, he was named the first George Engel and John Romano Dean's Teaching Scholar at the University of Rochester, and received the Lynn Payer Award from the American Academy on Communication in Healthcare. He has been a Fulbright scholar at the Institute for Health Studies in Barcelona, Spain and a visiting scholar at the University of Sydney, and continues collaborations with both institutions. He is an accomplished harpsichordist, and an avid cyclist and cross-country skier. His wife, Deborah Fox is a freelance lutenist and founding artistic director of Pegasus Early Music. They have two children, Malkah (16) and Eli (19).

Sunday Morning Plenary

Healthcare Reform, Residency Education and Psychiatric Leadership

With the national debate about the imperative need for healthcare reform and the pending changes in the financial structure of healthcare, residency training cannot be forgotten. We plan a panel with three national leaders in medicine who are on the forefront of this debate to bring us their perspectives in the funding of residency training in a future of evolving healthcare reform.

PreMeeting 2010

Treating ADHD Across the Life Cycle: What to Learn and How to Teach it.

In this year's pre-meeting for AADPRT we have decided to focus on treatment issues in treating ADHD across the life cycle from childhood into adulthood. As always it is our goal to teach new teaching techniques at the pre-meeting as well. So in this year we will make a special effort to do this by introducing the concept of Team-Based Learning (TBL), in addition to our usual format, Teaching in Large and Small groups (TLS). To truly measure the impact of TBL on learning we will randomize all those who sign up for the pre-meeting into one of the two groups, TBL or TLS. Yet no matter which group you end up in, at the end of the day we will have a large group lecture on TBL and what it can teach for everyone who attends.

Future AADPRT Meeting Dates & Locations

2011
Hilton Austin
Austin Texas
Wednesday, March 2, 2011 – Saturday, March 5, 2011
Guaranteed room rate for 2011: $229

2012
Hilton San Diego Bayfront
San Diego, CA
Wednesday, March 7, 2012 – Saturday, March 10, 2012
Guaranteed room rate for 2012: $220

2013
Hilton Fort Lauderdale Marina
Fort Lauderdale, FL
Wednesday, March 5, 2013 – Saturday, March 9, 2013
Guaranteed room rate for 2013: $229

Executive Council Report

Our work group has completed our document which describes a number of aspects of the application process to psychiatry residency programs with particular attention to some of the irregularities that have been noted in the last couple of years. The issues to be discussed by the EC are to consider any edits to the document which is attached, and to also decide about how to best disseminate the information enclosed herein. Options would be to post it on the AADPRT website, to convey it individually to members or to distribute to prospective applicants. Other possibilities could be considered. It would be helpful if EC members were able to review the document prior to the meeting.

Christopher K. Varley M.D.

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 for both applicants as well as program directors. It considers opportunities to improve and enhance the application process. The hope is that this information will be broadly distributed: to applicants, to AADPRT members, to medical school offices of student affairs and to ERAS (our partner in the application process) through CareerMD which is a part of ERAS available to medical students as a guide to selecting training programs.

This issue has been reviewed by a number of AADPRT members who have made meaningful contributions to the document. Members commented that almost no medical school is advising students in an organized way about the process or etiquette of interviewing. There was interest in providing information to medical students as part of their training during the application process. There was also interest in providing information to medical schools about experiences that have occurred in the interviewing process, both positive and also negative experiences, such as applicants canceling interviews with short notice, or not appearing at all.

Part I

Residency application process

The first issue to be discussed is the application process for psychiatry residency programs for an R1 or an R2 position. There are a number of elements that psychiatry program directors and residency admission committee members consider in an applicant to their program. These are listed below. The weighting of each of these elements may vary between programs, so this list is not intended to necessarily be in order of importance.

1. **Medical School Performance -** Probably the overall most important dimension for consideration is how the applicant has performed in medical school. What was their overall performance? Where do they stand in relationship to their peers at their own medical school? Was there evidence of a positive trajectory over time in medical school performance, particularly in regard to the applicant's performance on clerkships as compared to the first two years in classroom activities? How did the applicant perform in the core psychiatry clerkship or any subsequent subspecialty psychiatry clerkships such as child and adolescent psychiatry or consultation liaison?

2. **The Personal Statement -** The personal statement of the applicant is also an important component. It provides an opportunity for an applicant to define what is important to them and to communicate information about unique personal experiences that might make them attractive candidates. The most important component of the personal statement is that it is in fact personal and tells the reader something of importance about the applicant, specifically in relation to their motivation for and interests within psychiatry. The personal statement also provides information about the applicant's writing skills. These personal statements should be written with care. It is a good idea to have colleagues and faculty advisors review them before they are sent.

3. **Letters of Recommendation -** Letters of recommendation are best if written by faculty who are familiar with the applicant's performance in medical school. There is no right number of letters of recommendation, but three or four letters in addition to the Dean's letter (MSPE) are usually sufficient. Applicants should consult the application procedures of specific programs to which they are applying for any requirements regarding number of letters, how many should be from psychiatrists, whether a Psychiatry Chair's letter is required, etc. Applicants should clarify from faculty members whether they think they can write a supportive and knowledgeable letter. It is more important to have letters from people who can be highly enthusiastic about the applicant, than it is to obtain letters from nationally or internationally renowned faculty less familiar with and enthusiastic about the applicant's work.

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

5. **USMLE Scores** – USMLE scores are noteworthy if they are outstanding or demonstrate particular difficulty passing examinations. It is also important that there is timely completion of the USMLE as some programs require completion of Step One and Step Two before entry into residency training, even if the applicant's medical school does not. If this is not accomplished by the time of the interview it may compromise the applicant's chances.

6. **Interviews** - Interviews provide an opportunity for applicants to explore whether a particular program, is a good fit for them, if the goals and ways of learning are compatible with the applicant's own style, and whether the community where the residency is located suits the applicants interest. Applicants have the opportunity to meet to the program director, faculty, and residents in training. It is important for the applicant to be able to gather information from all of these sources. Reciprocally, the applicant's visit provides an opportunity for the program faculty and residents to meet the applicant and consider their fit in the program. Applicants should be aware that everything about them is considered in the interview process, not just the interviews themselves. This includes less formal interactions as well as how the applicant interacts with support staff.

An applicant's appearance and dress are also relevant. The application visit is also an opportunity for an applicant to convey their interest, and noteworthy experiences relevant to their functioning as a resident, including participation in research, prior work experience, and relevant volunteer activities. Importantly, the visit is also an opportunity to communicate what they hope to bring to a program and to clarify any past performance problems and stressful life circumstances that might have influences their medical school performance.

The Match

Applicants and programs participating in the National Residency Matching Program may express interest in each other, but can not establish a contract or expectation of a contract

any time prior to the Match. In addition, programs can not ask applicants how they plan to rank their institution or pressure an applicant into making a decision or declaration.

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 extend the learning experience about a program for an applicant further informing the applicant and program. Applicants and programs can express their interest in one another, but can not violate NRMP rules by creating a sense of obligation or any other form of pressure on each other.

Past Problems

Unfortunately, in the recent past, there have been a small but significant number of problems with the application process. Some personal statements were found to be plagiarized. Mechanisms such as through Google searches can help identify these. As noted above, the personal statement is best when it truly is personal. Plagiarism is unacceptable and certainly breaches document and raises questions about the applicant's integrity and professionalism.

There have also been discoveries of publications claimed by applicants, which are proven to be inaccurate and even misrepresented. It is incumbent on the applicant to make sure that all information in the application accurately portrays what the applicant has done.

Another concern in recent years is an increasing number of applicants, particularly towards the close of the application season, are giving very short notice of cancellation of their visit or are not appearing at all. It is an appropriate courtesy that barring exceptional circumstances, applicants would provide at least two to three weeks notice of cancellation if they do not intend to or are unable to come to an interview. This would allow other qualified applicants to be interviewed.

If programs have applicants cancel with short notice or frankly not appear they can and should report this to ERAS. ERAS has indicated that they can send out a reminder notice to applicant one month prior to scheduled interviews informing them how to withdraw their application from a particular program and to do so in a timely fashion. When an applicant withdraws, that information is available right away to program directors when they visit the ERAS PROGRAM DIRECTOR'S WORK STATION. Information can also be available to medical schools to inform them when an applicant from their school has not cancelled a scheduled interview appointment in a timely manner. By the same token, it is incumbent on program directors to respond as quickly as possible to applicants, regarding whether an applicant will be invited for an interview and what dates are available for interviewing, as well as to respond to applicant queries after they have visited.

A tool is available through the ERAS system, "ERAS investigations," (erasinvestigationsamc.org), which program directors can contact if they note irregularities in an application. ERAS will investigate and send their proposed response to the applicant. The applicant will have the option to respond and subsequently both the

ERAS findings and the student's response, if any, will be forwarded to all the programs to which an applicant has applied.

We recommend that medical schools formally advise medical students about the process of applying for and interviewing at residency programs. There is also an opportunity for AADPRT to partner with Careers in Medicine, a career planning program of the Association of American Medical Colleges (AAMC), designed to help medical students choose a medical specialty and select and apply to a residency program.

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.

Part II

Inter-residency Transitions –

Recommendations have also been made to optimize the process of residents transferring between one program and another. This would include moving from one general psychiatry residency to another and also from a general psychiatry residency to a child and adolescent psychiatry residency or to another subspecialty fellowship. Care has to be taken so as not to have these suggested considerations be construed as a restraint of trade. The practice must comport with Federal Trade Commission regulations.

It is most important that meaningful information about a resident who is considering transferring from one program to the other is communicated to the program to which the resident is applying. It is also important that the program where the resident is in training has reasonable notice of the intent of a resident to leave their program.

Proposed suggestions regarding transfer of residents between programs are as follows:

1. A resident who wants to transfer to another program should make their current program director aware of this as early in the year as possible.
2. Residents wanting to transfer to another program should not begin formal negotiations with the program that they wish to transfer to until they have informed their present Program Director of their intentions.
3. The Program Director of the Department that the resident wishes to transfer to should independently confirm that the resident's current Program Director is aware of the resident's wish to transfer before beginning formal interviews.
4. The resident's current Program Director should not intimidate the transferring resident in any manner to attempt to get him/her to stay. The current Program Director may make his/her best case for the resident to stay in the current program.

Part III

Consideration is underway whether as to there can be a common application for Child and Adolescent Psychiatry residency programs through ERAS or a similar mechanism. There is currently no cost for programs to participate in ERAS. Applicants pay a modest fee based on the number submitted.

ERAS requires a critical mass of programs within a specialty to agree to participate in order to assure applicants a good number of programs to which they can apply. They have settled on a 75-80% threshold. For child & adolescent psychiatry, that would be 75% of 122 programs or 92 programs to participate.

Since ERAS has in a complete class for 2010 Child & Adolescent Psychiatry could next join ERAS in 2011. Applicants begin applying July 2010 and match in Jan 2011 and begin training in July 2011. A decision to join would need to be made by November 1, 2009.

Reference:

Iserson KV: Getting into a Residency- A Guide for Medical Students 4th Edition. Galen Press. Tucson, Arizona 1996.

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
September 10-11, 2009

Date: August 23, 2009

Committee or Liaison Group Name: **Fellowship Planning Taskforce**

Chair/Representative's Name: Sheldon Benjamin

Report/Updates of Importance & Pertinence:

At the request of EC a conference call was held July 17th with Sahana Misra (representing the Ginsberg Fellowship), Fe Festin (representing the IMG Fellowship), David Kaye, Sheldon Benjamin, and Lucille Meinsler. We reviewed the various ideas suggested by the financial planning taskforce both for economy and efficiency of the fellowship programs.

It was agreed that covering one less meeting hotel night would compromise the integrity of the fellowships. However there was agreement with converting the fellowship dinner to a reception on Friday evening and with taking 5 fellows rather than 7 to both the Ginsberg and IMG programs. Several models for selecting five fellows were discussed. The one garnering most support involves looking at fellowship applications by region and combining the 4 regions with the lowest number of applicants into 2 groups or combine with larger groups to allow a more or less balanced number of applicants in each of 5 groups for each award. Further discussion of the goals of the IMG Fellowship and the best way to achieve them was deferred.

Action Items:

1. Decrease the Ginsberg and IMG Fellowship programs from 7 to 5 fellows each

2. Convert the Friday fellowship dinner to an hors d'oeuvres reception to allow more networking

3. Continue to cover three hotel night nights for fellows

4. Using the 7 regions as they are, determine the 4 regions with the fewest applicants for each fellowship program and combine them into 2 applicant groups (or combine with larger groups) to create as equitable of applicant distribution as possible.

Guidelines for Selecting Exhibitors for the AADPRT Annual Meeting

updated 8/20/09

Background

Offering space to exhibitors at the Annual Meeting serves as a revenue stream that could be expanded to offset the cost of the Annual Meeting and Fellowships. In 2008, exhibitors provided $5600 in revenue, while the expected amount for 2009 is $8000. Exhibitors have included publishers, other professional medical associations (e.g., APA, ACP, TAGME), educational services (e.g., ERAS, Tarrytown conference) and educational products (e.g., audience response system vendor).

AADPRT must ensure that conflict of interest between exhibitors' interests and attendees' educational needs are minimized. These guidelines describe the process of conscientiously expanding the pool of exhibitors for the Annual Meeting.

Process

Before the Annual Meeting. The Development Committee and Executive Office will be jointly responsible for identifying and vetting exhibitors for the Annual Meeting, using the Conflict of Interest Policy below. Funds collected from exhibitors will be pooled with other revenues and not earmarked for specific educational activities or fellowships.

During the Annual Meeting. The space for exhibitors will be kept separate from space for educational presentations, such that attendees may choose to ignore the former. The exhibitor space should not in the obligate path to an educational session. Exhibitors will not be allowed to offer gifts or food to attendees. AADPRT will not endorse any particular product or service. No company logos should appear on any materials AADPRT distributes to attendees.

After the Annual Meeting. As part of the survey of attendees of the Annual Meeting, the Development Committee will solicit feedback regarding the appropriateness of the exhibitor space.

Conflict of Interest Policy

Potential exhibitors will be evaluated for the potential to influence clinical and educational practices. Exhibitors will be stratified as follows:

1. exhibits that could influence patient care
    a. pharmaceutical companies
    b. clinical device manufacturers
    c. other proprietary clinical interventions
    d. publishers with one product (or suite of products) targeted at a specific diagnosis or intervention

    e. physician recruiters
2. exhibits that could influence the training of residents
    a. educational technologies, e.g., audience response systems, on-line evaluation or curriculum systems, Epocrates, etc.
    b. educational services endorsing a specific topic or methodology, e.g., Tarrytown
    c. professional medical associations or organizations with a specific clinical or educational interest, e.g., subspecialty society, GWISH
3. exhibits with minimal or no conflict of interest
    a. publishers with a wide variety of titles (many diagnoses, many types of interventions)
    b. professional medical associations representing broad constituencies, e.g., APA, AMA

The Development Committee will review exhibitors in categories 1 and 2 on a case-by-case basis to ensure their appropriateness. Exhibitors in category 3 will be allowed without specific review, unless objections are raised by attendees.

The Development Committee and Executive Office will attempt to solicit multiple vendors within the same category of products or services. The members of the Development Committee will not have any financial ties to the exhibitors.

Separation between Marketing and Educational Activities

The process of determining the content of the Annual Meeting, of determining selection criteria for the Fellowships, and of selecting Fellows will be distinct from the process involved in selecting exhibitors. Specifically, the Development Committee will be responsible for selecting exhibitors and ensuring that the Conflict of Interest Policy is followed, whereas the Program Committee and Fellowship Committees will determine program content and fellowship criteria and awardees.

References

Rothman DJ et al, “Professional medical associations and their relationship with industry: a proposal for controlling conflict of interest.” *JAMA* 2009; 301 (13): 1367-72.

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
September 10-11, 2009

Date: 8/29/09

Committee or Liaison Group Name: **Membership**

Chair/Representative's Name: Adrienne Bentman
Tami Benton

Report/Updates of Importance & Pertinence:

1. Membership Guidelines/Renewals for 7/2009-6/30/2010:
    a. Membership renewal message went out in July with follow up reminders in August and September.
    b. Renewals: Institutions: 188
        Members: 647 total individual members (increasing yearly)
        Coordinators: 303 (increasing yearly)
    c. Unpaid as of 8/31/09 for 2010:
        Institutions: 72
        Individuals: 365
    d. Membership renewals more prompt this season. Some PD's (same ones Yearly) continue to pay individual dues but not institutional dues. Plan To notify that the dues deadline is the same.

2. New Training Directors Symposia Feedback from 2008-2009 annual meeting
    a. Feedback from symposia-80 evaluations returned (? participants?).
    b. Ratings overall good (1-poor-5 excellent)
        i. Speakers :(range 3.5-3.75) -generally liked speakers but wanted more focused and specific content. The topic ratings were better (4-.75) suggesting that the workshop structure, content, speaker effectiveness and AV aids were good and that the workshop was useful and effective.
        ii. Comments: Themes: More specific information desired
            -smaller discussion groups and fewer
            Returning training directors with the goals
            Of facilitating more discussion for new
            Training directors

Action Items:

1. Follow up contacts again via email in September for unpaid institutions and individuals by Lucille, Adrienne and Tami.

2. Reorganize presentations for NTD symposia:

Issues: Many NTD's arriving with smaller basic skill sets who have different needs than in previous years. How can we organize the NTD's program to meet those needs?

Proposed solutions:

a. NTD lectures which provide the basics of RRC/ ACGME/ABPN/GMEC?
b. More and smaller breakout groups. Can we obtain more room?
c. Have breakout group leaders lead follow up sessions
d. Have ongoing mentorship program for NTD
e. More elementary workshops for NTD provided by AADPRT
f. Should AADPRT develop a NTD manual?
g. Posting calendars and manuals on website prior to the meeting for NTD

AADPRT MEMBERSHIP REPORT
as of August 31, 2009

	A	B	C	D	E	F	G
1	**Type of Membership**	**2009-2010 (as of 8/31/09)**		**2008-2009**		**2007-2008**	
2	Membership year runs July 1 - June 30						
3							
4	**Institutions**	**188**		**190**		**194**	
5							
6	**Individual Members**						
7	Adult/General Psych TDs	183		179		188	
8	Child & Adol Psych TDs	118		119		110	
9	Asst/Assoc TDs-General	134		133		122	
10	Asst/Assoc TDs-C&A	29		26		18	
11	Addictions TDs	22		21		20	
12	Forensic TDs	17		21		20	
13	Geriatric TDs	33		32		39	
14	Psychosomatic TDs	24		21		20	
15	Combined/Psych Med	7		7		4	
16	Combined/Psych/Family	2		2		2	
17	Other Subspecialties	12		10		11	
18	Dept Chair/Vice Chair	45		44		44	
19	Affiliate Members	16		12		4	
20	Division Chief-C&A	4		5		4	
21	Fee Waived	1		1		1	
22	Total Individual Members	647		633		607	
23							
24	Coordinators (no fee)	303		300		280	
25							
26	**Membership Paid/Not Paid**	**Paid (as of 8/31/09)**	**Not Paid (FY10)**	**Paid-09**	**Not PaidFY09**	**Paid**	**Not Paid FY08**
27	Institution (400)	116	72	185	1	188	6
28	Individual (150)	282	365	625	6	559	37
29	Affiliate (300)	7	9				

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
September 10-11, 2009

Date: 8/25/09

Committee or Liaison Group Name: **Child Caucus**

Chair/Representative's Name: Dorothy Stubbe

Report/Updates of Importance & Pertinence:

ABPN Clinical Skills Verification Evaluation:

The Child Psychiatry Clinical Skills Verification Committee, made up of members from AADPRT, AACAP and ABPN members (Preschool: Don Bechtold (ABPN), David Kaye (AADPRT), Sandra Sexson (AACAP), & Harry Wright (ABPN). Grade School: Steve Cuffe (ABPN), Cindy Santos (ABPN), Dorothy Stubbe (AADPRT), & Chris Varley (AACAP). Adolescence: Gene Beresin (AADPRT), Jeff Hunt (AACAP), Paramjit Joshi (ABPN), & Jack O'Brien (ABPN) completed a CSV rating form (copied liberally from the terrific work of the AADPRT Clinical Skills Task Force).

A meeting of a subgroup, including Dorothy Stubbe, David Kaye, Chris Varley, Gene Beresin, Jeff Hunt, Cynthia Santos, Sandra Sexson, Beth Ann Brooks, and Larry Faulkner (with Pat Janda and Dorothea Juul) scheduled for September 9th and 10th (immediately prior to the AADPRT EC meeting) in Kansas City, has the following agenda:

1) Review present CSV products and plans (assessment forms, FAQs, etc), and consider any supplementary forms (parent interview for preschoolers, etc) that we may want to suggest.
2) Curricula for trainees
3) Models for implementation (within rotations, "mock boards", etc)
4) Faculty training
5) Possible research project

An update of the work from this meeting will be discussed at the EC.
Our thanks to ABPN for their tremendous support (financial, arrangements, ideas and enthusiasm for the project). It is planned to have a training module in draft development for the AACAP annual meeting Training Forum in late October. Thanks also to Michael Jibson, who has been extremely productive and creative in his work on training faculty. We wish to borrow liberally from his pilot work, as well. Child Psychiatry begins the CSV credentialing evaluation July of 2010.

Action Items: Organize the work from the CAP CSV meeting in September and produce a training module to be presented at the AACAP Annual meeting Training Forum. A submission for the AADPRT Annual meeting is planned.

Request:

1) *Follow-up conference calls to implement the action items. We will request ABPN funding for these conference calls.*
2) *Permission to utilize the materials put together by the AADPRT Task Force and Michael Jibson to jump-start the CSV training in Child Psychiatry is requested.*
3) *Consideration of a joint project for CSV training with child psychiatry training directors and faculty.*
4) *Request for a larger forum for a CSV training workshop at the AADPRT Annual Meeting (possibly two workshops, but with larger rooms—suggestions welcome about venues by which to provide child psychiatry program directors the training required to begin CSV in July).*

Post-Pediatric Portal Update—

There are now 4 programs that have implemented the 3-year post pediatric psychiatry and child and adolescent psychiatry program (Penn, Creighton, and Cleveland, Maine). The newest program (Maine) has just been approved. We need 2 more for the pilot to continue. This portal has been a focus of recruitment for pediatricians interested in re-tooling in CAP. Those programs that are participating have been very pleased with the quality of trainee. Funding remains an obstacle for many programs.

Action Items: Continue to recruit programs to develop a Post-Pediatric Portal. This is a new and innovative pilot, but it will need more programs to participate before it is permanently approved. Congratulations to Maine program, and the Caucus sent a welcome and offer for help with administrative program issues.

Request

1) It is requested that the EC assist with promotion to programs -- specifically, an e-mail to all members advertising the program and how to apply.

Common Application

The Child and Adolescent Psychiatry Caucus has implemented a Common Application Form (on the website). Use of the form is optional by all programs. It is hoped that the form will decrease duplication of work by applicants, and will provide more consistency to the application format for programs. Thanks to Lucille for her work on this project.

Action Items: The Common Application has been put on the Web. We will survey child psychiatry program directors on its use and any modifications needed.

Nominating Committee Proposal to Select Child Caucus Chair

The 2010 meeting will be the final meeting which I will chair. I have requested that we implement a nominating committee method of recommending candidates to the President for appointment.

"The Child Caucus is dedicated to optimizing the inclusiveness and transparency of the leadership selection process in the Caucus. The Child Caucus utilizes a nominating committee process to select the Chair. This Nominating Committee consists of three members of the Child Caucus. At least 3 months prior to the AADPRT annual meeting in which the sitting Child Caucus Chair will be completing his/her term, the Child Caucus Chair recommends members of the Nominating Committee to the President, who appoints the Committee and selects a Chair. The Nominating Committee solicits nominations, vets the nominations with peers in the field and discusses interest in the position with the top nominees. At least one month prior to the annual meeting the nominating committee recommends the Child Caucus Chair candidate to the President, who makes the appointment. The incoming Child Caucus Chair is announced at the Annual meeting, and works with the sitting Chair to prepare for assuming the leadership role following the meeting."

I would like to check if this plan requires a change in by-laws or other formal approval. However, the Child Caucus requests formal approval of the EC to implement this policy of choosing the Chair of the Child Caucus. Perhaps other Caucuses would like to utilize this method, as well.

Action Items:

1) *Determine if the plan requires a change in the by-laws or other formal approval.*
2) *Discuss and consider approval to the Child Caucus Nominating Committee plan.*

Respectfully submitted:

Dorothy Stubbe, MD

Sub-Specialty Caucus Report (Geriatrics, Psychosomatic Medicine, Forensic, Addictions)

Problems for AADPRT:

- Poor attendance at the AADPRT meeting
  - Caucuses are small, and rarely have the same attendees
- No momentum for involvement in the organization from the sub specialties
- This is an opportunity to grow the organization that is not being realized

Problems for Sub-Specialties:

- Poor attendance at the AADPRT meeting
  - Sub specialty meetings are not education-oriented, so these fellowship directors are not getting exposed to the things that the general and child training directors are related to ever changing requirements and how they are being met, what kinds of curricular help there is, and how to handle problems and crises.
- Low numbers in sub-specialty training nation-wide (except forensics)
  - May have to do with an additional year of training, but no additional income
  - May be related to rising debt amongst medical school graduates
  - Do not currently have an addictions caucus representative for AADPRT.
- Low numbers of board certified sub specialists recertifying
  - Less frequent ooptions for board recertification

Avenues Explored:

- Attending national meeting for each sub-specialty group, and attending the fellowship director meeting there. These groups are strongly attended, and appear to have a good working relationship with each other, but this has not translated into better attendance at AADPRT meetings

Possible Solutions:

- Reaching out to fellowship directors more directly—have AADPRT /Executive Committee send them information, maybe a letter with a copy of Academic Psychiatry , delineating the workshops that might be of interest to them at the upcoming annual meeting, with an emphasis on the ability to interact with the RRC and the ABPN related to training requirements that apply to fellowships

- Asking the RRC and ABPN to have a workshop related specifically at the AADPRT annual meeting.
- AADPRT could sponsor the attendance of a subspecialty fellow—like the Ginsberg Fellowship.

Workforce Committee Report for AADPRT Executive Council Meeting

Steve Schlozman, MD

September 11, 2009

Membership

After soliciting interest in participation among AADPRT membership, the following individuals expressed a desire to be part of this effort:

-Deborah Hales - who is interested in making APA resources available

-Cynthia Pristach (SUNY-Buffalo)

-Diana Jo Antonacci (ECU)

-Francis Lu – he is especially interested in minority recruitment into psychiatry (UCSF)

-Lee Ascherman (UAB)

-Sid Weissmann (who never really left this workforce!) Northwestern

Additionally, representatives from other organizations have expressed interest

-Geri Fox with AACAP

-Members of the ADMSEP EC amended their position statement with regard to recruitment to more actively include recruitment among the mission of the organization. The position statement now reads:

ADMSEP Position Statement on Recruitment

The Association of Directors of Medical Student Education in Psychiatry is an organization dedicated to championing excellence in medical student education and to providing support, guidance, and resources to medical students and to psychiatric educators. ADMSEP is committed to collaborating with its sister organizations in promoting the field of psychiatry throughout the medical profession. Attracting talented students is essential to the future of the discipline and is a responsibility shared by all faculty members of departments of psychiatry. Excellent teaching is one of the most controllable factors in a student's decision to enter psychiatry. Strong departmental support for education and good faculty morale are essential to this mission. Medical student educators also consider it their responsibility to project a positive image of psychiatry as well as to identify, encourage, and provide resources to students interested in a career in psychiatry. For students who

indicate a preference for medical disciplines other than psychiatry, ADMSEP members will foster and encourage the development of psychiatric skills necessary for successful practice. Although ADMSEP members believe our primary responsibility is to teach principles of good psychiatric care to all future physicians, we recognize the importance of identifying, nurturing, and if possible, increasing the number of talented students choosing a career in psychiatry recognize the importance of identifying, nurturing, and if possible, increasing the number of talented students choosing a career in psychiatry.

ACTION ISSUES WITH REGARD TO MEMBERSHIP OF WORKFORCE INITIATIVE

We will have more success with whatever initiatives we go after if we do so as a group of organizations and not as individual organizations. Should we convene a more formal discussion of workforce initiatives with:

-AAP

-American College of Psychiatrists

-Association for Geriatric Psychiatry

-Association for Psychosomatic Medicine

Others?

Do we have suggestions for contacts? What role might these contacts play?

Changes in National Health Corps Definitions of Psychiatry and Workforce

-I have spoken to National Health Core Officials, one physician who was a national health corp. psychiatry participant (Jess Shatkin), and one who is finishing training (Lauren Sitzer, who is also the resident APA trustee). I also spoke with Sandra Sexson.

-Everyone tells me something different.

-Here is my admittedly shaky understanding:

1. There was a change on the table in which psychiatry would be designated a primary care field. This would presumably make loan forgiveness more possible.

2. It is unclear whether this change occurred. (I called four times, and answers split 50:50)

3. Even with these changes, the rules remain so byzantine and unclear that it is hard to know how to advice students and residents.

CAN SOMEONE SUGGEST WHOM WE (I) MIGHT SPEAK WITH TO GET SOME CLARITY? IT WOULD BE GREAT IF WE COULD HAVE SOME KIND OF BROCHURE OR EVEN ON-LINE REFERENCE THAT MAKES THIS STUFF MORE CLEAR.

NRMP Data

Sid very nicely sent around a link to a 281 page document from the NRMP that, to quote Arlo Guthrie, analyzes the data of this year's match via: "injections, inspections, detections, neglections and all kinds of stuff…"

That means that there are about a zillion graphs and statistics and all are welcome to peruse the document that in the interest of a greener future for my children I decided not to print but have instead put the link here:

www.nrmp.org/data/chartingoutcomes2009v3.pdf

With a zillion graphs and stats and other things, we all get to distill from it what we find most useful. Here's my summary:

-USMLE scores for psychiatry applicants among US seniors are among the lowest. We are roughly equal with physical medicine and family medicine, and just below pediatrics. The highest scores are in plastic surgery and dermatology, with radiology close behind. Scores for psychiatry among independent applicants are even lower for psychiatry. Similarly, successful matches in psychiatry were not characterized by high number of AOA members, and in fact psychiatry has the lowest number of AOA graduates from 2009.

→This matters because research suggests that students view these low scores as indicative of the overall cognitive inability of applicants to psychiatry to pursue or practice other forms of medicine.

-Self report of research experience does not appear to be a factor with regards to whether or not applicants choose to match in psychiatry. For comparison, it appears to be a major factor for Dermatology or Plastic Surgery.

→Do we try to get students more interested in research as a means of recruiting, or does this data suggest that this is a laudable but not necessary aspect of psychiatry workforce recruitment?

-There were limited differences across specialties as to whether applicants had previous work experience in a field. Similarly, psychiatry did not appear too affected by previous volunteer experiences. Internal medicine and pediatrics had the most successful matches as function o f previous experience when compared to other disciplines.

→This matters because psychiatric educators often look to students who have previous work experience in psychiatry as helpful in decreasing stigma, but it seems not to matter according to NRMP self reports. However, it DOES matter for pediatrics and internal medicine. CAN WE CREATE MORE VOLUNTEER EXPERIENCES THAT MORE ACCURATELY MIMIC WHAT WE DO OUTSIDE OF AN INPATIENT SETTING? WOULD THAT MATTER? PRESUMABLY, THE EXPERIENCES IN PEDIATRICS AND PRIMARY CARE ARE LONGITUDINAL ELECTIVES…

My research:

I now have data from one medical school in the Northeast, one in the Midwest, one on the West Coast, and one in the UK. We are waiting for the first results from collaboration with a medical school in Columbia, South America. The results, both qualitatively and quantitatively, are robust among the US schools and suggest a greater degree of negative bias towards psychiatry in this sample (n=216 total US students). With item analysis using a standardized scale designed to measure biased attitudes towards psychiatry , all US students, men more than women, were statistically significantly more likely than were the greater than 300 students at Kings College to view psychiatry or psychiatrists as:

-Not being "real doctors"

-Lacking sound scientific foundation

These were the only significant findings of the 9 items on the scale, and were remarkably similar at three distinct and geographically different U.S medical schools. Qualitative data shows a general sense among US and UK students that psychiatric patients do not get better or rarely get better, and that psychiatrists are not very bright, or, alternatively, among the brightest. (Nobody see's us as average!)

O VERALL ACTION ITEMS based on all of the above:

1. **Collaborate with sister organizations in order to create situations where students can**
    a. **Improve opportunities for medical students to see the breadth of psychiatry. Could students more often shadow residents, for example, in outpatient settings? Students shadow residents in primary clinics.**
    b. **Improve opportunities for medical students to see psychiatry practiced longitudinally**
    c. **Destigmatize by demonstrating scientific validity and redefining what we mean by "scientific pursuit." (I was told this year that we should consider**

not teaching "Attachment" to medical students because it lacks a strong scientific foundation.)

   d. **Allow students to more see patients who are psychiatrically ill but also living relatively normal lives**

2. **NHS stuff**
   a. **Have there been significant changes?**
   b. **If these changes have taken place, we need straight answers that students can use when deciding whether to pursue a given field. Maybe a flier? On-line data?**
3. **Do we care about the USMLE low scores among psychiatry applicants? If so, what do we do?**

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
September, 2009

Date: 9/4/2009

Committee or Liaison Group Name: Information Committee

Chair/Representative's Name: Bob Boland

Report/Updates of Importance & Pertinence:

1. The committee has met via email and phone over the past month. Summer communication was mostly asynchronous emails.

2. Rick and company have been working on upgrades for the web site. Most of the efforts this summer have been towards the annual meeting and basic maintenance. Work is just beginning on upgrading the infrastructure.
    a. Current activity/work on web site:
        i. *Membership tracking upgrades:*
            1. Membership System: he has upgraded the institutional renewal section to track payment year to year
                a. Also, Rick has worked with Lucille to improve the tracking system.
                b. Also has worked with her to change the listing of institutional URL's
            2. Fellowship submission systems: they are still awaiting feedback (from fellowship committee) before proceeding with this year's update.
        ii. *Annual Meeting*
            1. 2010 meeting page: set up page as well as a "save the date: page, also links to Disney micro site for booking.
            2. Abstract Submission System: modification of submitter section and prepare Abstract system for 2010 submissions (completed 8/14 and submissions have started to come in)
        iii. *Basic Maintenance*
            1. News updates
            2. President's site is up and running.
            3. Working on a system for Lucille to directly upload material rather than send to Rick as is currently done.

    b. Plans for rest of year:
        i. Rick and Shan have begun the first steps on the new work. He is going to start on the Content Management System, which is the first and probably most important part of building the new site. There is nothing to show from this just yet, it is happening in the background.
        ii. I will likely have more information on this plan by the time of the exec council and will present orally.

Respectfully Submitted,

Bob Boland

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
September 10-11, 2009

Date: August 31, 2009

Committee or Liaison Group Name:
Assistant/Associate Director Caucus (held March 12, 2009)

Chair/Representative's Name: Melissa Arbuckle, MD, PhD

Report/Updates of Importance & Pertinence:

Most Assistant and Associate Training Directors are new, having been in their positions for less than three years. In addition, many are assuming newly created positions within programs previously structured with a single Training Director. Without formal "job descriptions," many ATDs seek guidance in terms of how to best structure these positions. Common themes include balancing other academic commitments (research or clinical duties) with the administrative tasks of an ATD, working effectively with the training director and finding opportunities for individual mentorship.

Within the caucus, ATDs felt that there were unique issues they faced in these positions and thought that a separate list-serve would be helpful.

A subgroup of ATDs (Adam M. Brenner, MD, Melissa Arbuckle, MD, PhD, Sallie G. DeGolia, MPH, MD, and Karin Esposito, MD, PhD) have developed a survey in order to better understand the current status/structure of ATD positions and to identify key ingredients necessary to build successful positions (with high job satisfaction and an interest in long-term commitment to the field).

Action Items:

Following the Annual Conference, a new ATD list-serve was launched on 5/28/09. All ATDs were invited to join.

The ATD survey was sent out over the months of May and June to approximately 175 ATDs. The response rate was approximately 44%. Data is currently being evaluated with the goal of publishing a paper on these results within the next year.

AADPRT Committee Chair/Liaison Representative Report

Executive Council Meeting
September 10-11, 2009

Date: 8/24/09

Committee or Liaison Group Name: Triple Board Meeting- National Association of Pediatrics, Psychiatry, Child and Adolescent Psychiatry Training Programs

Chair/Representative's Name: Mary Margaret Gleason, MD (Mgleason@tulane.edu)

Report/Updates of Importance & Pertinence:

- Triple Board Website updated to serve as a more effective tool for applicants and current residents (www.tripleboard.org).

- We have developed a triple board Facebook group to facilitate ongoing discussions among residents.

- Academic Psychiatry 33(2) has 3 articles focused on triple board.

    - Gleason MM, Fritz GK (2009), Innovative Training in Pediatrics, General Psychiatry, and Child Psychiatry: Background, Outcomes, and Experiences. *Academic Psychiatry* 33: 99-104
    - Fritsch SL (2009), Memoirs of a triple board pioneer. *Academic Psychiatry* 33: 93-95
    - Larroque CM (2009), A personal perspective on triple board certification. *Academic Psychiatry* 33: 96-98

- The group submitted a presentation for AACAP - four pediatric topics for child psychiatrists (primary care issues, constipation, asthma, and OTC cough medication abuse) and presenters represent Hawaii, Tulane, and Utah. This will be the first Triple Board-focused presentation at a national meeting.

- We are in the process of developing a triple board graduate survey to follow-up on the 2002 report (Warren, JAACAP). Using survey monkey, all graduates will be asked to report the strengths and challenges of their triple board training. IRB submission is underway.

Action Items:

- Ongoing development of website- assignments made for content sections.

- A. Schelesinger is developing AAP proposal for 2010 National Meeting to focus on child psychiatric topics for pediatricians

- MM Gleason to complete graduate survey and distribute. Plan for poster presentation at upcoming meeting.

- Will meet at AACAP meeting to develop further "community building" programs for triple board residents and graduates including networking possibilities and mentoring connections.

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
September 10-11, 2009

Date: 8/31/09

Committee or Liaison Group Name: VA Caucus

Chair/Representative's Name: Rob Daroff, MD

Report/Updates of Importance & Pertinence: A group of 11 AADPRT conference attendees participated in an initial VA discussion group at the 2009 annual meeting to discuss VA specific training issues, determine the need for an ongoing forum on VA related training issues in AADPRT, and discuss ways that AADPRT might be able to support the specific concerns of VA affiliated programs.

Action Items: (1) The formation of a VA specific list serve as a sublist of AADPRT's general list serve was suggested and has subsequently been created and advertised to the wider AADPRT membership.
(2) Formation of a formal VA Caucus was recommended to facilitate ongoing networking and sharing of best practices at annual meetings. This was subsequently given initial approval by AADPRT president Dr. Kaye.
(3) The VA caucus would consider taking responsibility for organizing VA specific presentations at future AADPRT annual meetings.

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
September 10-11, 2009

Date: September 4, 2009

Committee or Liaison Group Name: Psychiatry Residency Coordinators

Chair/Representative's Name: Lucille Meinsler, Lisa Garbo

Report/Updates of Importance & Pertinence:
Currently there are 302 Psychiatry Residency Coordinators registered on the AADPRT membership listing. The listserv continues to be used frequently by the coordinators. There have been requests to develop a listserv specifically for child & adolescent coordinators.

Lisa Garbo, Manager, Education & Training at the Oregon Health & Science University and the coordinator representative to the Information Committee, and I have begun to work on the program for the Coordinators' Symposium at the 2010 meeting. This year Lisa will be posting a request to coordinators to submit a proposal for a workshop for the meeting. We have developed a committee of several coordinators who have expressed interest in being involved in the meeting to review the submissions.

I have also talked with representatives from the Psychiatry RRC of creating a shorter version of their 'orientation for coordinators' workshop' that is presented at the ACGME Education meeting that would cover specific topics for preparing for a site visit.

ABPN and ERAS have also expressed interest in participating in the Coordinators' Symposium.

Lisa has also been working with coordinators who have volunteered to update materials on the coordinators' webpage. This has been a slow process with enthusiasm waning from coordinators once the program has ended. However, the goal is to have the Coordinators' Tool Kit and Calendar updated prior to the meeting

Action Items:

1. Creation of a listserv specifically for Child & Adolescent psychiatry coordinators. (I have discussed this with Rick Brandt and he says this is feasible.)
2. Add additional categories for coordinators on the online membership page…i.e., general, child & adolescent, subspecialty. This will help with future program planning.
3. Request for suggestions from EC members for topics for the Coordinators' Symposium

TAGME
Training Administrators of Graduate Medical Education

2009 TAGME Report
to the
AADPRT Executive Council

TAGME has experienced tremendous growth in 2009. Four new specialties/subspecialties successfully submitted tools for certification: Diagnostic Radiology; Internal Medicine-Pediatrics; Neonatal-Perinatal; and Transitional Year. A total of 16 specialties/subspecialties now have the opportunity to offer national certification for their program coordinators. These include:

Offering Certification

- Diagnostic Radiology
- Emergency Medicine
- Family Medicine
- Internal Medicine-Pediatrics
- Neurology
- Obstetrics & Gynecology
- Pediatrics
  - o Neonatology
- Psychiatry
  - o Child Psychiatry
- Orthopaedic Surgery
- Physical Medicine & Rehabilitation
- Surgery
  - o Vascular Surgery
- Thoractic Surgery
- Transitional Year

Active Taskforces – in development

In 2009, five new specialties/subspecialties petitioned for permission to develop tools for certification: Anesthesiology, Child Neurology, Ophthalmology, Pathology, and Urology. There are a total of eight active task forces currently developing tools for certification. TAGME anticipates have 24 specialties/subspecialties offer certification in the Fall of 2010.

1. Anesthesiology: Goal of completion: January 2010
2. Child Neurology: Goal of completion: July 2010
3. Internal Medicine: Goal of completion: January 2010
4. Neurosurgery: Goal of completion: October 2009
5. Ophthalmology: Goal of completion: February 2010
6. Otolaryngology: Goal of completion: April 2010
7. Pathology: Goal of completion: August 2010
8. Urology: Goal of completion: April 2010

Specialties/Subspecialties Considering Forming a Task Force

The following specialties/subspecialties have indicated an interest in forming a task force to develop tools for certification:

Considering Forming a Taskforce

1. Cardiology
2. Dermatology
3. Forensic Psychiatry
4. Geriatric Psychiatry
5. Psychosomatic Medicine
6. Pathology
7. Dermapathology
8. Pediatric Cardiology
9. Pediatric Critical Care
10. Pediatric Gastroenterology
11. Pediatric Pulmonology
12. Plastic Surgery
13. Sleep Medicine

New Divisions of TAGME

AOA - Program Coordinators

I am pleased to report that AOA program coordinators have contacted TAGME with a strong interest in developing tools for certification. The AOA world is different than the ACGME world; adding AOA would necessitate a new division of TAGME. A strong candidate has been identified to lead a task force. I had a conference call with her and the Chair of TAGME's New Specialty Development Committee to discuss possible models and the best approach given the AOA requirements structure. The leader is in the process of identifying a taskforce and moving the initiative forward.

GME

TAGME is increasingly receiving requests from GME coordinators/managers regarding certification and their desire to get involved. TAGME is holding off on these interests until the AOA initiative is in place; this should allow us to learn from that development process and apply the knowledge gained to GME as it would also be a new division of TAGME.

Survey – Certified Coordinators

In the Fall of 2009 TAGME will undertake a survey of certified coordinators to gather demographic data and to assess the impact certification has had on training administrator careers. The report will be shared via Board of Directors representatives to the various specialty organizations.

TAGME – Psychiatry Update

Psychiatry was the third specialty recognized to offer certification and was the first to have a subspecialty, Child and Adolescent Psychiatry, recognized to offer certification. I was the third President of TAGME, June 2007 – August 2009, and will serve TAGME as Immediate Past President through August 2011.

Psychiatry was been very fortunate to have two excellent program coordinators serve as members-at-large on the Board of Directors for 3-year terms: Maria Kacic, C-TAGME, University of Arizona, and Maggie Petre, C-TAGME, Advocate Lutheran General Hospital. Maria and Maggie made outstanding contributions to TAGME in their roles as members of the Board of Directors and in their service on TAGME Committees. Marie served on the Global Tools Development Committee and Maggie continues to serve as Chair of the New Specialty Development. Their terms of service ended at the conclusion of the 2009 August Board of Directors Meeting.

Angelia (Angie) Powell, C-TAGME, Child and Adolescent Psychiatry, Palmetto Health Alliance, University of South Carolina, has replaced Maggie Petre, and Georgina Rink, Psychiatry, Mayo School of Graduate Medical

Education, has replaced Maria Kacic; each will serve a 3-year term. They will alternative years as the voting member. Angie will serve as the Voting Member 2010 and Georgina will serve as the member-at-large on the Board of Directors. Georgina also serves on TAGME's New Specialty Development Committee; this committee has the all important charge of bringing new specialties to TAGME and mentoring them throughout the tools development process. I'm so proud of Georgina, she's a valued member of the committee, and is currently mentoring the Urology Task Force as they develop their tools. I'm in discussion with Angie to see which national committee will line up with her interests; I know that her contributions will be equally valuable.

Psychiatry has a current total of 29 certified coordinators; six coordinators achieved certification in 2009: Kathleen Bell-Pena, Tamika Williams, Michele Cepparulo, Marylee Gramlich, Michelle Melendez, and Carol York.

Child and Adolescent Psychiatry has 6 certified coordinators: Kathleen Czarniak, Karyn Kitchen, Angelia Powell, Beverly Pernitzke, Georgina Rink (certified in Psychiatry with added certification in Child and Adolescent Psychiatry), and Jacqueline Weatherly. One coordinator plans to retake the Child and Adolescent Psychiatry Monitored Assessment at the 2010 AADPRT meeting.

One psychiatry coordinator is registered for the Fall Open Assessment on September 26, 2009, and several Psychiatry and Child and Adolescent Psychiatry program coordinators have expressed interest in sitting for certification at the 2010 AADPRT meeting.

There are 303 coordinators registered in AADPRT; 11% are certified.

Plans for 2010 are to:

- organize task forces to develop assessment tools for Geriatric Psychiatry, Psychosomatic Medicine and Forensic Psychiatry
- identify leadership potential in certified psychiatry/child and adolescent psychiatry coordinators and recruit them into national TAGME committees
- organize formal meetings of the Psychiatry/Child and Adolescent Psychiatry Review Board and the Assessment Tools Development Committees at the 2010 AADPRT Annual Meeting, possibly holding meetings one day prior to the start of the AADPRT meeting

The Psychiatry Training Administrators Section for Certification (PTASC) has accomplished much in the last three years, at the program, regional, and national levels. None of this would have been possible without the strong support of AADPRT Executive Council, our program directors and chairs. Thank you for your continued support!

Linda Gacioch, C-TAGME
Immediate Past President, TAGME