

# AADPRT Executive Council Meeting Agenda

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**Omni William Penn Hotel**  
**Thursday, September 30-Friday October 1, 2010**

<b>THURSDAY September 30 Delores &amp; Bob Hope Room</b>	<b>Report</b>	<b>Reporter</b>
5:00 – 5:30	Dinner	
5:30 – 6:00	Welcome Introductions Approval of May minutes	Sheldon Benjamin
6:00-6:30	Treasurer's Report Action Item: <i>Decision on dues increase</i>	Don Rosen <i>Report</i>
6:30-6:50	Annual Meeting/Pre-Meeting Update  <u>PreMeeting Action Items:</u> <i>1-Should NIMH funding be secured, we will rapidly develop the mechanism to announce the availability of resident "scholarships" and selection.</i> <i>2-Once we know about funding (should be by mid-October), we will schedule the first teleconference of the Advisory Board to discuss pertinent issues and goals, this year's meeting, and future initiatives.</i>	Chris Varley <i>Report</i>  Sid Zisook <i>Report-not attending</i>
6:50-7:30	Duty Hours Update OSHA Petition Duty Hours Implementation Planning <i>Retask the Duty Hours Task Force to collect best practices of programs to enable compliance with the new standards.</i>	Sheldon <i>Reports</i>
7:30-7:45	APA – Resident Request of AADPRT <i>Approval of letter recommending mental health awareness and support for residents (pending receipt)</i>	Sheldon
7:45-8:00	Development <i>Determine fundraising direction: membership fundraising vs seeking new sources for grant funding</i>	Art Walaszek <i>Report</i>
8:00-8:15	Combined Programs Taskforce <i>How to distribute letter on combined training</i>	Mark Servis (Sheldon) <i>Report</i>
8:15-8:40	Committee Reports <u>Membership</u> Action Items: <i>ACGME-specific Competencies: collating experiences, projects leading to completion of PIF &amp; its supporting materials--Is this deemed a worthy task for AADPRT to take on? If yes, in which Committee or Task Force domain does this lie?</i>	Adrienne Bentman <i>Report</i>

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	<p><u>Workforce</u></p> <p>Action Items:</p> <p><i>Can we get a statement from someone at the AAMC to support 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. I have spoken to Darrel Kirch regarding stigma, but what about asking him to help with an AAMC statement of consensus.</i></p> <p><i>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?</i></p> <p><i>Can we get a statement or consensus statement from the NIH or NIMH or both?</i></p>	Steve Schlozman <i>Report (not attending)</i>
	<p><u>Psychotherapy</u></p> <p>Action Items:</p> <p><i>Discussion of the Psychotherapy Committee's potential role in promoting ADPRT members' interest and participation in the American Psychoanalytic Association's new Psychoanalytic and Psychodynamic Teachers' Academy.</i></p>	Lee Ascherman <i>Report</i>
8:40-9:00	<p><u>Model Curriculum</u></p> <p><u>Subspecialty Caucus</u></p>	<p>Tony Rostain <i>(not attending)</i></p> <p>Catherine Woodman</p>

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<b>FRIDAY October 1 Delores &amp; Bob Hope Room</b>	<b>Report</b>	<b>Reporter</b>
8:00-8:30	Breakfast	
8:30 – 9:00	Resident Safety Taskforce Action Items: <i>Post list of references, and components of prevention and post-vention protocols on AADPRT website within the next few weeks.</i>	Isis Marrero <i>Report</i>
9:00-9:30	Professionalism & the Internet <i>Post resources on website in coming weeks.</i>	Sandra DeJong <i>Report</i>
9:30-9:45	Academic Psychiatry Governance <i>The Governance Board recommended (pending approval from each sponsoring organization) an increase of \$500 (from \$1,500 to \$2,000) annual support to the journal. These funds are used to help defray costs of sending editors to annual meetings of sponsoring organizations. The Steering Committee of AADPRT approved this increase.</i>	Bruce Levy <i>Report</i>
9:45-10	Regional Representatives	Sahana Misra
10-10:15	Fellowship Committees	Rick Summers
10:15-10:40	Clinical Skills Verification Taskforce Action Items: <i>1-What is the appropriate web platform for CSV training materials — APA LMS vs. AADPRT website? 2-Suggestions for additional questions for 2010-2011 CSV Survey (last year's survey is included in materials)</i>	Rick Summers <i>Report</i>
10:40-11:10	Remaining Committee and Task Force Reports  <u>RRC Task Force</u>  <u>Child &amp; Adolescent Psych Caucus</u> Action Items: <i>Request a specific child section on the AADPRT website to contain all of the child related program and educational</i>	Adrienne Bentman Gene Beresin( <i>not attending</i> ) <i>Report</i>  Arden Dingle <i>Report (not attending)</i>

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	<p><i>material to facilitate member use</i></p> <p><u>Assistant/Associate Training Directors Caucus</u> <i>Workshop being submitted</i></p> <p>APA</p>	<p>Melissa Arbuckle <i>Report (not attending)</i></p> <p>Sandra Sexson <i>Report (not attending)</i></p>
11:10-11:30	Coordinators Update Annual meeting & new award	Lucille Meinsler Lee Ascherman <i>Report</i>

**American Association of Directors of Psychiatric  
Residency Training, Inc.**  
**Statement of Revenues, Expenses and Change**  
**in Net Assets - Cash Basis**  
**Consolidated**

	Fiscal Year 2009-2010 Budget	Year Ended June 30, 2010	Year Ended June 30, 2009
<b>Revenues</b>			
Membership Dues	\$ 170,000	\$ 172,636	\$ 172,286
Interest	2,850	2,613	5,726
Labels	800	850	750
Miscellaneous	1,000	11,817	-
Annual Meeting	184,000	247,432	214,365
Fellowships	2,000	-	21,882
 Total Revenues	 360,650	 435,348	 415,009
<b>Expenses</b>			
General Operating	176,250	163,670	155,019
Annual Meeting	242,990	279,031	223,406
Fellowships	15,300	20,671	23,748
 Total Expenses	 434,540	 463,372	 402,173
 <b>Net Revenues Over (Under) Expenses</b>	 <u>\$ (73,890)</u>	 (28,024)	 12,836
 <b>Net Assets - Beginning</b>	 <u>462,864</u>	 450,031	
 <b>Net Assets - Ending</b>	 <u>\$ 434,840</u>	 \$ 462,867	

See Accountant's Compilation Report

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**AADPRT Committee, Task Force, Caucus Report**  
**Executive Council Meeting**  
**September 30-October 1, 2010**

Date: September 4, 2010

Committee or Liaison Group Name: PreMeeting

Chair/Representative's Name: Sid Zisook, MD  
Email: [szisook@ucsd.edu](mailto:szisook@ucsd.edu)

Brief summary of committee, taskforce, or caucus purpose or "charge"

- 1) To seek NIMH funding for continued support of these pre-meeting conferences.
- 2) To work with an advisory board to plan, implement and evaluate annual pre-meeting conferences.

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

- 1) Receive NIMH funding for the R13 competitive renewal mechanism
- 2) 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:

- 1) R13 application has been reviewed and received a competitive priority score. We have submitted a response to the reviewers' concerns and are awaiting a final decision.
- 2) A program has been developed and plenary speakers have been contacted. However, we are awaiting the final NIMH decision before finalizing the agenda.

Action Items:

- 1) Should NIMH funding be secured, we will rapidly develop the mechanism to announce the availability of resident "scholarships" and selection.
- 2) Once we know about funding (should be by mid-October), we will schedule the first teleconference of the Advisory Board to discuss pertinent issues and goals, this year's meeting, and future initiatives.

## Inspiring Residents to Make a Difference

Our job is the most important in medicine—to educate and to promote the growth and development of tomorrow's leaders in clinical care, teaching, and research. This year's theme highlights the importance of supporting and channeling the passion that our residents bring to us, to our programs and to the field. How do we bring out the best in each individual we train, recognizing their diverse interests, backgrounds, and aspirations?

### Plenary Speakers

We are thrilled to announce this year's plenary speakers, selected to help inspire us to inspire our trainees.



**Joia Mukherjee, M.D., MPH** is the Medical Director of Partners in Health, an international medical charity with clinical programs around the world. An internist/pediatrician/infectious disease specialist, Joia will inspire us with the story of her efforts to reduce health disparities by developing public sector and community-based programs with local colleagues in Haiti, Rwanda, Lesotho, Malawi, Peru, Mexico, Russia, and inner-city Boston.



**Helen S. Mayberg, M.D.**, Professor of Psychiatry and Neurology at Emory University, will inspire us to consider the impact of neuroscience on psychiatric treatment, by showing how functional imaging and a knowledge of frontal-subcortical neurocircuitry has led to her pioneering work in deep brain stimulation for mood disorders.



**David J. Kupfer, M.D.**, Thomas Detre Professor, Department of Psychiatry, University of Pittsburgh and Chair of the DSM-V Taskforce will brief us on DSM V and inspire us to begin thinking of the educational path that lies before us in the evolution of our diagnostic system.

### Pre-Meeting: Suicide Risk Assessment and Prevention

The pre-meeting Wednesday, March 2nd will be on "Evidence-based Approaches to Suicide Risk Assessment and Prevention: Insights from the Neurosciences and Behavioral Sciences for Use in Psychiatry Residency Training." Thanks to Sid Zisook,

MD and the Pre-Meeting Committee for all their work in planning for what promises to be an inspiring pre-meeting on an important topic.

## **Attention New Training Directors, Associate Directors**

You will not want to miss the New Training Directors symposium Thursday morning March 3rd. A lot of thought goes into preparing a concise program that provides both the nuts and bolts and wisdom from experienced directors.

## **CSV Workshops**

By popular demand, AADPRT will again offer workshops on the Clinical Skills Verification process for both general and child and adolescent psychiatry on Thursday morning.

## **Coordinators Meeting**

The 2011 AADPRT meeting will feature an even more extensive Coordinators Program, including a half-day Coordinators Symposium Thursday and additional workshops for coordinators throughout the meeting. Last year, over 125 coordinators attended the annual meeting. Feedback shows it has been tremendously valuable for those who have attended.

## **Plan Your Travel**

In response to input from members, the structure of our meeting will change this year, closing at 2:00 pm Saturday. A good deal of work has gone into planning how to get the most out of every meeting day. The new meeting structure will only work if ALL members remain through the end of the meeting. The 2011 meeting will close with a luncheon plenary featuring Dr. Kupfer's important presentation on DSM-V.

The new meeting structure has the added benefit of allowing members to have plenty of time to enjoy Austin's great atmosphere, music, and food by staying over until Sunday at the convention rate. Flights are also available to get you home after the meeting on Saturday. Our hotel is only 15 min from the Austin Airport.

Chris Varley, MD 2011  
AADPRT Program Chair

Sheldon Benjamin, MD  
President, AADPRT

**NEW TRAINING DIRECTORS' SYMPOSIUM**  
**Thursday, March 2**

7:30 am – 8:30 am	Continental Breakfast
8:00 am – 10:15 am	Welcome Chris Varley, MD, Program Chair Adrienne Bentman, MD and Tami Benton, MD Membership Committee Co-chairs  AADPRT: The Organization & Current Initiatives Sheldon Benjamin, , MD, AADPRT President  Plenary Speaker TBA
10:30 am – 11:45 am	The General Psychiatry CSV as an Educational Opportunity David Goldberg, MD, Michael Jibson, MD Rick Summers, MD  CSV Child & Adolescent Psychiatry Education: Implementation Models and Faculty Training Jeffrey Hunt, MD, Sandra Sexson, MD, Dorothy Stubbe, MD
11:45 am – 1:15 pm	New Training Directors Lunch and Breakout Group Meetings <i>(Designated tables for each of the breakout groups during lunch)</i>
1:30 pm – 2:15 pm	The Accreditation Process for Psychiatric Residency Programs—The RRC Essentials Chris Thomas, MD (Incoming Chair, Psychiatry Residency Review Committee, ACGME)
2:15 pm – 3:00 pm	National Resident Matching Program (NRMP) Laurie Curtin, PhD Director, National Residency Matching Program
3:00 pm – 3:15	BREAK
3:15 pm – 4:30 pm	ABPN Workshop: Overview of Credentialing Process and New Psychiatry Certification Examination Larry Faulkner, MD, Pat Janda, Dorthea Juul, PhD

# AADPRT 40<sup>TH</sup> ANNUAL MEETING

## "Inspiring Residents to Make a Difference" Hilton Austin Hotel Austin, Texas March 2-5, 2011

### MEETING AT A GLANCE

DATE/TIME	EVENT
<b>Wednesday, March 2</b>	
8:00 am - 5:00 pm PREMEETING— REGISTRATION REQUIRED	"Evidence-based Approaches to Suicide Risk Assessment and Prevention: Insights from the Neurosciences and Behavioral Sciences for use in Psychiatry Residency Training"
3:00 pm - 7:00 pm	Registration opens for Annual Meeting
4:30 pm - 6:00 pm	Steering Committee Meeting
6:00 pm - 10:00 pm	Executive Council Dinner & Meeting
<b>Thursday, March 3</b>	
7:30 am - 8:30 am	IMG Fellowship Committee
7:30 am - 8:30 am	Henderson Award Committee
7:30 am - 8:00 am	Continental Breakfast-New Training Directors
8:00 am - 10:15 am	Symposium: New Training Directors
8:00 am - 8:30 am	Continental Breakfast: Residency Coordinators
8:30 am - 10:00 am	PreMeeting Advisory Board Meeting
8:30 am - 11:45 am	Symposium: Residency Coordinators
	ABPN Session: Overview of the New Psychiatry Certification Examination
9:30 am - 10:30 am	
10:30 am - 11:45 am	The General Psychiatry CSV as an Educational Opportunity
10:30 am - 11:45 am	CSV and Child & Adolescent Psychiatry Education: Implementation Models and Faculty Training
11:45 am - 1:00 pm	Lunch available to purchase
11:45 am - 1:15 pm	Lunch: New Training Directors Breakout Group Meetings
11:45 am - 1:15 pm	Lunch: Residency Coordinators
12:00 N - 4:30 pm	Executive Council lunch and Meeting
12:00 N - 1:00 pm	Lunch: Regional Representatives
12:00 N - 1:00 pm	Triple Board Meeting
1:30 pm - 2:15 pm	RRC Workshop
2:15 pm - 3:00 pm	NRMP Workshop
	ABPN Workshop: Overview of Credentialing Process and New Psychiatry Certification Examination
3:15 pm - 4:30 pm	
3:45 pm - 4:15 pm	Orientation: Ginsberg Fellows
3:45 pm - 4:15 pm	Orientation: IMG Fellows
3:45 pm - 4:15 pm	Orientation: Henderson Awardee
	Residency Coordinators—informal meetings with representatives from ABPN, RRC, PRITE, APA
4:45 pm - 5:30 pm	<b>Caucus Meetings</b>
	Addictions
	Assistant/Associate Training Directors
	Child & Adolescent Caucus
	Combined Neuropsychiatry Programs

<b>4:45 pm – 5:45 pm</b>	<b>Caucus Meetings (continued)</b>
	Directors of Small Programs
	Forensic
	Geriatric
	IMG
	Psychosomatic Medicine
	Residents
	VA
6:00 pm - 7:30 pm	Opening Session & Presentation: Joia Mukherjee, MD, MPH
7:30 pm - 9:30 pm	Reception

### **Friday, March 4**

7:30 am - 8:30 am	Model Curriculum Task Force Meeting
8:00 am – 9:00 am	Continental Breakfast for all attendees
8:00 am - 9:30 am	Coordinators Breakfast and Best Practices Presentations
8:30 am - 10:00 am	Welcome/Input & Award session
10:00 am - 10:30 am	Break-Poster & Authors' Session
10:00 am – 11:45 am	Residency Coordinators-Workshop sessions
10:30 am - 11:45 am	Plenary Session—Helen Mayberg, MD
11:45 am - 1:00 pm	Lunch available to purchase
11:45 pm - 1:00 pm	<b>MEETINGS</b>
	C&A Caucus II
	Interview Skills Credentialing Taskforce
	Psychotherapy Taskforce
	Subspecialty Caucus Leaders
	Duty Hours Task Force
	RRC Taskforce
	Academic Psychiatry Editorial Board
1:00 pm - 2:30 pm	<b>WORKSHOPS-SESSION I</b>
2:30 pm - 3:15 pm	Refreshment Break, Poster & Authors' Session
3:15 pm - 4:45 pm	<b>WORKSHOPS SESSION II</b>
5:00 pm – 6:00 pm	<b>Regional Caucus Meetings (7)</b>
	Psychiatry Residents
	Residency Coordinators
6:00 pm - 7:00 pm	Reception-Award Recipients

### **Saturday, March 5**

7:00 am - 9:00 am	Executive Council Breakfast & Meeting with Regional Representatives
8:00 am – 8:45 am	Continental Breakfast
8:00 am – 10:00 am	Coordinators Breakfast and Presentation
9:00 am - 9:45 am	Business Meeting
9:45 am – 10:15 am	Break-Poster & Authors' Session
10:15 am – 11:45 am	<b>WORKSHOPS-SESSION III</b>
11:45 am – 2:00 pm	Plenary Session—David Kupfer, MD
2:00 pm – 3:00 pm	Steering Committee

**AADPRT DUTY HOURS TASKFORCE REPORT**  
**September 30, 2010**

- 1) The ACGME finalized the new Common Program requirements on 9/28/2010. These requirements include new and far-reaching standards, not only about duty hours, but also regarding resident (especially R1) supervision, transitions of care, monitoring of and education of faculty and trainees about fatigue and alertness, etc. In general, the requirements are very similar to the draft standards posted in late June.
- 2) Specific, major points of the new requirements are:
  - a) Implementation date remains July 1, 2011.
  - b) R1s should be supervised directly (faculty member, senior resident, or fellow physically present with the R1 and the patient) or indirectly with direct supervision immediately available (faculty member, senior resident, or fellow in house and available for direct supervision).
  - c) Duty periods for R1s cannot exceed 16 hours.
  - d) PGY-2s and above can work a maximum of 24 hours in house, plus an additional 4 hours as needed for transitions of care.
- 3) There are several areas where RRCs can/will specify the requirements further. Our RRC will discuss these issues in late October. These items, and our recommendations (to be discussed by EC) are:
  - a) VI.D.1: "In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care."
    - i) We do not see a need for the RRC to specify this further. However, to maintain maximal flexibility, the wording could be modified to read: "attending physician or licensed independent practitioner".
  - b) VI.D.5.a).(1): "In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. (Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.)"
    - i) Specific PGY-1 duties may vary, depending on the setting and patient. For example, PGY-1 duties may include admitting patients already evaluated by an emergency room psychiatrist, assessing new patients in the emergency room, managing acute behavioral disturbances, cross-cover for medical or other acute issues in psychiatric inpatients, doing emergent consultations on medical or surgical patients. It seems difficult to specify competencies for all of these settings and patients.
    - ii) In general, the competencies would need to include: 1. being observed to be able to competently carry out the specific immediate clinical responsibilities required; 2. being able and willing to ask for help when indicated; 3. being able to gather an

- adequate history, do a physical examination (as needed), and collect other pertinent data and present these data accurately to a supervisor who has not seen the patient.
- iii) We recommend that the RRC make general, rather than specific, requirements here, and require that each program have a competency-based assessment process to ensure that each PGY-1 receives the optimal level of supervision.
- c) VI.E.: “The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. (Optimal clinical workload will be further specified by each Review Committee.)”
- i) We recommend that the Psychiatry RRC not specify numbers of patients per service or shift. In the January 2009 AADPRT survey regarding the Institute of Medicine report, we asked our members: “Would you like the Psychiatry RRC to specify “caps” in the number of patients treated on any given service or the number of patients evaluated on any given shift?” 76% responded no, 13% yes, and 11% no opinion. The majority of our members thought that clinical services in psychiatry residency are so variable in terms of patient acuity, complexity, and diagnoses, and that clinical services are so variable in type and quantity of support personnel, that specifying exact numbers of patients per resident would be undesirable.
- d) VI.F.: “Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. (Each Review Committee will define the elements that must be present in each specialty.)”
- i) The members of interprofessional/multidisciplinary teams are already specified in the Psychiatry requirements in section IV.A.5.f).(13).
- e) VI.G.5.: This section allows the RRC to define “intermediate-level” residents and residents “in the final years of education” for the sake of relaxing the requirement for 8-10 hours between duty shifts.
- i) This issue does not apply to our specialty. Based upon our knowledge of the process, we believe this was crafted in response to requests from the surgical specialties. We recommend that all psychiatry residents be required to have 8-10 hours off between duty periods.
- f) VI.G.6.: “Residents must not be scheduled for more than six consecutive nights of night float. (The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.)”
- i) Since psychiatry residency programs are required to ensure that residents attend at least 70% of scheduled didactics, and since residents usually have 3-4 weeks of vacation per year, it would be difficult to see how a psychiatry program could include more than 10 weeks of night float per year.
- ii) The maximum number of consecutive weeks of night float could be higher in the interests of maximizing adaptation to nighttime duty, but lower to prevent feelings of

isolation and disconnection from other residents, faculty, didactics and other educational activities. We recommend that the RRC not specify this further.

- g) Of note, there is no requirement in these standards to specify which “senior residents” can supervise PGY-1s. Many program directors wonder whether PGY-2s could do this. We would recommend not specifying in the Psychiatry requirements which residents can supervise PGY-1s, but instead requiring that programs have a competency-based process for determining whether a resident beyond the PGY-1 level is qualified to serve as a supervising resident.
- 4) The AADPRT Duty Hours Task Force plans to solicit best practices and models of meeting the new ACGME requirements from our members and post these on the AADPRT website, and to sponsor a workshop at the annual meeting.
- 5) Question for the EC:

- a) Do the above proposed recommendations to the RRC require modification?

Respectfully submitted,

Bill Greenberg, M.D.

Deb Cowley, M.D.



# American Association of Directors of Psychiatric Residency Training

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## COMMITTEES

Arden Dingle, MD  
**Child & Adolescent Psychiatry Caucus**

Michael Jibson, MD  
Art Walaszek, MD  
**Development**

Robert Boland, MD  
**Information Management**

Adrienne Bentman, MD  
Tami Benton, MD  
**Membership**

Tony Rostain, MD  
**Model Curriculum**

Christopher Varley, MD  
**Program**

Lee Ascherman, MD  
**Psychotherapy**

Sahana Misra, MD  
**Regional Representatives**

Catherine Woodman, MD  
**Subspecialty Caucuses**

Steven Schlozman, MD  
**Workforce**

**Appointed Members**  
Gene Beresin, MD  
Sandra DeJong, MD  
Isis Marrero, MD  
Mark Servis, MD

**Immediate Past Presidents**  
David Kaye, MD  
Deborah Cowley, MD

**Administrative Director**  
Lucille F. Meinsler

August 4, 2010

Thomas J. Nasca, M.D., MACP  
Chief Executive Officer  
Accreditation Council for Graduate Medical Education  
515 North State Street  
Suite 2000  
Chicago, IL 60654

Dear Dr. Nasca:

Thanks to you and to the ACGME Duty Hours Task force for all of your efforts aimed at revising the duty hour requirements for graduate medical education programs throughout the country. We have been impressed by the rigor of your group, and by its comprehensive review of the issues involved in setting standards that insure patient safety while preserving excellent and humane training for our interns, residents, and fellows. We have been particularly appreciative of the inclusiveness of your efforts and your solicitation of input from all “shareholders” during this process. Two of us were privileged to testify at last June’s National Duty Hours Congress where we witnessed some of the diversity of opinion and multiplicity of goals of the various constituencies and developed a deeper understanding the complexity of the challenges you face. We applaud your invitation for input at this late stage of the process.

Soon after receiving the Proposed Standards in late June, we invited the membership of the American Association of Directors of Psychiatric Residency Training (AADPRT) to send us their input. Rather than asking about any specific recommendations, we asked that they send us their “responses to and assessment of” the new proposals. We received responses from more than 30 programs. Although there were a small number of concerns voiced by only one or two of our members, we were impressed by the similarity of the input that we received from most of those who responded. The responses can be briefly summarized as follows:

1. Several respondents provided positive feedback regarding the proposed new standards. Given the Institute of Medicine’s recommendations in December 2008, our members had not known what to expect and some were quite pessimistic before seeing the proposed new standards. Three respondents expressed overall support for the proposed standards, while a fourth specifically supported enhanced supervision of PGY 1 residents.
2. By far, the issue that received the most discussion was the sixteen-hour restriction on PGY 1 residents. Our members found this requirement particularly arbitrary, and could find no reason for PGY 1’s being singled out in this way. Moreover, they noted many costs which they found onerous and deleterious. Implementing a 16-hour limit for psychiatry PGY 1’s will mean that they are limited to serving overnight as night float and, as such, will spend more of their time on this kind of rotation than they otherwise would. For example, many small psychiatry programs (4 residents per year) noted that a night float system would require that their residents do 3-4 months of night float, or that they eliminate crucial training sites. Both of these solutions would have a negative impact on residents’ educational experience. Night float is seen as a less rich academic and supervisory setting than rotations in which, aside from call, residents are in the hospital during the daytime. Night float rotators provide less access to clinical and teaching conferences, grand rounds, and the larger faculty. In addition, psychiatry residencies are structured so that the most closely supervised rotations (inpatient psychiatry rotations) are done during the PGY 1 and PGY 2 years. Having PGY 1 residents do overnight call provides enhanced integration of night and daytime learning, excellent training in acute psychiatry, and greater continuity of patient care. Increasing night float rotations will likely mean increasing the number of handoffs and fragmenting the educational experience for PGY 1’s.

3. The requirement for on-site, immediate supervision for PGY 1's drew considerable attention as well. Although some of our members supported this requirement and already have it in place, many members, particularly from smaller programs, thought it was unnecessary, costly, and would bring with it unanticipated negative consequences. They pointed out that it is a "one size fits all" solution to a problem which does not exist in psychiatry. Urgent, on-site consultation by an attending or senior resident is needed for very few of our patients and, in those cases, the short time required for a supervising resident or attending to drive to the hospital will not impact the safe care of patients.
4. Many of our members expressed their concern that both the 16-hour limit and the supervision requirements for PGY 1's will necessarily require that PGY 2, 3, and 4 residents do more call than they are currently doing. This will have deleterious effects on the education of these more senior residents for a few reasons:
  - a. With fewer PGY 1s spending more time on night float, there will be fewer residents on the inpatient units and other rotations. This will increase the work load of the remaining residents.
  - b. With more PGY 2, 3, and 4 residents doing on-site call both in lieu of PGY 1's and to supervise PGY 1's, there will be more residents "post-call", leaving fewer residents available during the daytime on the wards and on other clinical settings.
  - c. With more PGY 2, 3, and 4 residents doing on-site call, more senior residents will be post-call during their outpatient months (in psychiatry, at least 12 months of residency), which will disrupt their outpatient clinical and educational experiences, including the crucial continuity of care needed for ongoing psychotherapy. Disrupting psychotherapy and outpatient treatment will also adversely affect patient care.
5. Many training directors from smaller programs felt that the new requirements would be particularly hard for their programs because the increased call and supervision requirements would be shared by fewer residents. They fear that these changes will significantly reduce the educational quality of their programs, increase costs to their institutions, decrease their ability to attract competitive applicants, and, in some cases, threaten their ability to continue as residency programs. Losing small psychiatry residency programs would be of grave concern to our field, given the national shortage of psychiatrists, especially in the underserved areas where many small programs are located.
6. Many are concerned that this will be another unfunded mandate. Given financial constraints across the nation, hospitals are not in a position to hire more residents, staff physicians, nurse practitioners, or physicians' assistants to assume the added clinical and supervisory requirements. Neither are they able to hire more administrative personnel for the significant increase in reporting requirements.

We hope you will consider these points of view and amend the current proposals as follows:

1. PGY 1 residents should have the same 24-hour limit as more senior residents.
2. Supervision requirements for PGY 1's should be decided upon by the individual RRC's and not be part of the common program requirements.
3. Because of the significant changes required in many programs in order to comply with these requirements, the costs involved, and the time required to hire additional personnel, the timeline for implementation should be altered from a deadline of July 1, 2011 to a deadline of July 1, 2012.
4. An effort should be made to diminish the reporting requirements for training directors.
5. The ACGME should advocate strongly for increases in funding for graduate medical education, to support and make feasible implementation of these new requirements.

Thank you again for all your efforts on behalf of our patients and our residents and fellows.

Sincerely yours,



William Greenberg, MD  
Chair, Task Force on Duty Hours



Deborah Cowley, MD  
Past President



Sheldon Benjamin, MD  
President

September 30, 2010

The Honorable David Michaels, PhD, MPH  
Assistant Secretary for Occupational Safety and Health  
U.S. Department of Labor  
Occupational Safety and Health Administration  
200 Constitution Avenue, N.W.  
Washington, D.C. 20210

Dear Dr. Michaels:

The American Psychiatric Association (APA), representing America's 37,000 psychiatrists, has become aware of a petition to OSHA concerning the regulation of house officer duty hours. The APA and the organizations named below strongly favor the responsibility for duty hour regulation and oversight remaining with the Accreditation Council on Graduate Medical Education (ACGME) for the following reasons:

- 1) The issue of house officer work hours is inseparable from the issues of patient care quality and education. Duty hours cannot be considered in a vacuum. A proper balance must be struck in the curriculum between teaching high quality care and providing a safe working environment for house staff. The ACGME, with oversight of the entire training curriculum, is best able to assure this balance.
- 2) The ACGME has a demonstrated track record of proactively addressing resident duty hours. In 2003, the ACGME promulgated new duty hour regulations for all accredited residency and fellowship training programs that limited night call frequency, hours of continuous duty, required a minimum number of hours off between shifts, and required a minimum number of days off per week. In response to these regulatory changes, hours worked by US house officers fell precipitously, as outlined in a recent study by Douglas O. Staiger, et al, in Journal of the American Medical Association 2010; 303(8) 747-753. These changes have already improved resident well-being, patient safety, and amount of supervision available to house staff.
- 3) The ACGME has already announced more stringent duty hour and supervision standards to take effect in the coming year based on the scientific evidence. The ACGME reviewed the issue of duty hours in detail in 2009-2010. Following review of the scientific literature bearing on house officer duty hours, input by numerous organizations and individuals involved in residency training, input by house officers and by the public, the ACGME announced revised, even more

stringent standards in June 2010. Input from the field was again requested before their final publication, expected very shortly. These proposed new regulations limit continuous duty by interns to 16 hours, require on-site supervision of interns, and contain a number of other provisions to decrease risks to patient safety related to shift length. The ACGME thus continues to review outcome data and adjust standards as dictated by the evidence. Due to residency training lengths that vary from 3 to 6 years depending on specialty, it takes several years to understand the impact of a given change. We are just beginning to see the data demonstrating improvement from the 2003 standards and the ACGME has already announced new standards. They are clearly being highly proactive in this important area.

- 4) The Institute of Medicine concurs that the ACGME is best able to regulate resident duty hours. The Institute of Medicine, which reviewed the subject of house officer duty hours and recommended further reductions in allowable work hours in its 2009 report, stated clearly that the ACGME is best able to implement work hours regulations for residents. OSHA itself concluded in its October 2002 response to Public Citizen on a similar petition that ACGME was best able to regulate work hours.
- 5) At a time of significant budget deficit it would be fiscally irresponsible to create a new regulatory agency. The tremendous cost, manpower, and expansion of government regulatory responsibility that would be required for the federal government to take over resident duty hour oversight is rendered unnecessary by the demonstrated track record of the ACGME in regulating resident duty hours.

The American Psychiatric Association and the organizations named below are committed to the highest standard of patient care and residency training. Recognizing that duty hours are inseparable from education and patient care, that the ACGME has a demonstrated track record in this area and has already proposed tighter work hours regulation, that both the IOM and OSHA have agreed that ACGME is best able to regulate resident work hours, and that it would be fiscally irresponsible for the federal government to create a new regulatory body, we feel that it is in the best interest of both patients and residents that the ACGME should be the responsible agency for oversight of all aspects of residency training, including duty hours.

Sincerely,

***Note: Agreement in principle to sign this letter has already been obtained from all the organizations below except the ACP and AACAP.***

Carol Bernstein, MD  
President, American Psychiatric Association



Sheldon Benjamin, MD  
President, American Association of Directors of Psychiatry Residency Training



Robert Boland, MD  
President, Association for Academic Psychiatry



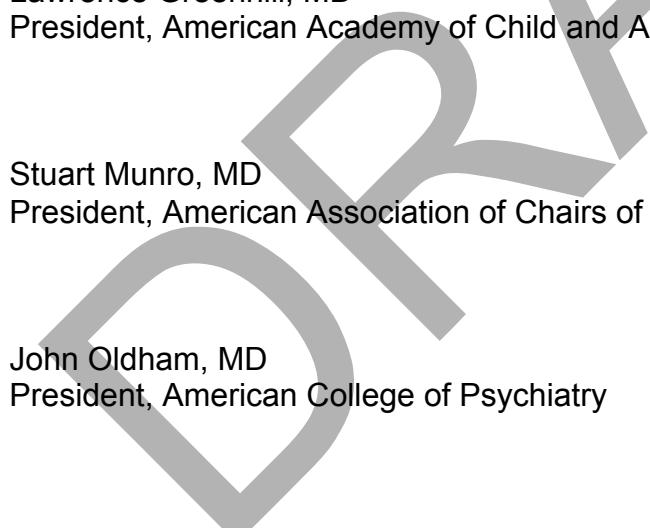
Darlene Shaw, PhD  
President, Association of Directors of Medical Student Education in Psychiatry

Lawrence Greenhill, MD  
President, American Academy of Child and Adolescent Psychiatry

Stuart Munro, MD  
President, American Association of Chairs of Departments of Psychiatry

John Oldham, MD  
President, American College of Psychiatry

Sandra Sexson, MD  
President, Society of Professors of Child and Adolescent Psychiatry



September 27, 2010

Dear Executive Committee of Council on Medical Education and Lifelong Learning,

On behalf of the council members-in-training and per our discussion at the APA Components Meeting on September 25<sup>th</sup>, 2010 in Washington DC, we would like to propose the following message as a position statement from the APA to AADPRT and ACGME as a recommendation to all residency programs.

1. Request APA to strongly recommend that program directors ensure resident involvement in the implementation of new ACGME work hour restrictions. Current residents will be the ones most directly affected by proposed changes. They are best positioned to collectively assess the immediate impact of duty hour restrictions on resident well-being and patient care. Involving residents at the inception of programmatic changes will improve investment and ultimately success in achieving duty hour restrictions that are both realistic and sustainable.
2. Request APA to encourage program directors to actively respond to the data on increased rates of depression and other mental illness during residency. It is imperative that program directors work to improve resident access to expeditious and confidential mental health services. To take preventive action, program directors are also strongly recommended to communicate with their residents about the risk of mental illness during residency, especially depression.

We appreciate the Executive Committee's support and efforts to seek board approval of this position statement.

Sincerely,

Puja Chadha, M.D.

Jason Cheng, M.D.

Juliet Glover, M.D.

Colin Stewart, M.D.

Erik Vanderlip, M.D.

**AADPRT Committee, Task Force, Caucus Report**  
**Executive Council Meeting**  
**September 30-October 1, 2010**

**Date:** September 27, 2010

**Committee or Liaison Group Name:** Development Committee

**Chair/Representative's Name:** Art Walaszek, MD

**Email:** awalaszek@wisc.edu

**Brief summary of committee, taskforce, or caucus purpose or “charge”**

The Development Committee seeks to identify funding sources to support the activities of the organization, in particular at the Annual Meeting. The Committee also develops policies to minimize the conflict of interest that may arise from such arrangements, as well as possible conflicts of interest among the leadership of the organization.

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

1. Update assessment of Exhibitor COI policy, and continue to monitor for possible COI.
2. Post results of first iteration of COI policy for AADPRT leadership.
3. Explore the possibility of donation-based funding for the Ginsberg and IMG Fellowships, as well as other philanthropic approaches.

**Report/Updates of Importance & Pertinence:**

*1. COI Policy for Exhibitors*

Following the March 2010 meeting, we collected feedback from attendees, which did not show any evidence of problems with the exhibitor space or problems with conflict of interest. However, the three assessment questions were phrased somewhat confusingly (specifically, use of negative statements). The questions have now been rewritten so that they will be clearer.

*2. COI Policy for AADPRT Leadership*

Lucille Meinsler successfully collected disclosures of possible COI from AADPRT Executive Council members and Committee Chairs. We will post these on a web page on the AADPRT website. The listing will include each person's name and a list of disclosures (or if none, "Nothing to disclose.") This list will be updated each Spring following the start of new leadership terms after each Annual Meeting.

### *3. Philanthropic Approaches to Funding Ginsberg and IMG Fellowships*

We have further explored this possibility via consultation with the University of Wisconsin Foundation, the fundraising and gift-receiving organization for the University of Wisconsin-Madison. It does not appear that we have a donor base large enough to raise funds to fully support the fellowships. Parenthetically, the Geriatric Mental Health Foundation (fundraising cousin of AAGP) has raised less money in 2010 than in 2009 for its Geriatric Scholars program.

An alternate possibility could be to raise funds via grant requests to other organizations, e.g., NAMI or Mental Health America, or foundations, e.g., John D. and Catherine T. MacArthur Foundation, Stanley Foundation, etc.

#### **Action Items:**

Determine direction for fellowship funding: fundraising from membership versus seeking new sources of grants

## **Update to Psychiatry GME Programs on Combined Training Program Accreditation/Approval**

**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.

In 2009, the ABPN announced a moratorium on the approval of NEW combined residency training programs involving psychiatry and neurology because of questions about state licensing and insurance reimbursement for graduates of residency programs that do not have independent and separate ACGME accreditation (After letters were written on their behalf by the ABPN, no graduates of combined programs have been denied licensure or insurance reimbursement to date). The ACGME does not separately accredit combined training programs, with the exception of internal medicine/pediatrics, which has its own RRC. 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.*

**Update:** The ABPN has stated that current residents and accepted applicants to combined residency training programs for 2011-12 will be able to complete their training and become board eligible in the relevant specialties, as is their current policy. The ABPN is continuing its moratorium on the approval of NEW combined residencies pending the resolution of its negotiations with the ACGME to develop an accreditation mechanism for combined training programs.

Larry Faulkner, MD  
President and CEO  
ABPN

Sheldon Benjamin, MD  
President  
AADPRT

## **AADPRT Committee, Task Force, Caucus Report**

### **Executive Council Meeting**

**September 30-October 1, 2010**

Date: 9/24/10

Committee or Liaison Group Name: Membership Committee

Co-Chair/Representative's Name: Adrienne Bentman, MD and Tami Benton, MD

Email: [abentma@harthosp.org](mailto:abentma@harthosp.org)/benton@email.chop.edu

Summary of committee "charge":

The Membership Committee is responsible for welcoming new and old members to the organization and for listening for ways in which AADPRT can better serve the needs of its members. Co-Chairs are responsible for member registration, for the timely payment of institutional and individual dues, and for tracking membership trends. Responsibility for planning the Annual Meeting New Training Director Symposium and break-out groups and for revision of the AADPRT Manual and Training Director Calendars also rests with the Committee. Lastly, oversight of the new training director Mentorship Program is a Membership Committee responsibility.

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

1. Establish a Membership Committee with members representing diversity within AADPRT membership
2. Place a Child/Adolescent Residency Annual Calendar in the Virtual Training Office
3. Review & revise the Adult Residency Annual Calendar
4. Review & revise the AADPRT Manual
5. See Action Items - ACGME-specific Competencies: collating experiences, projects leading to completion of PIF & its supporting materials

Report/Updates of Importance & Pertinence: Progress moves apace on the items above.

Action Items:

1. #5 above. Is this deemed a worthy task for AADPRT to take on? If yes, in which Committee or Task Force domain does this lie?

## AADPRT MEMBERSHIP REPORT

3/01/09

**AADPRT Committee, Task Force, Caucus Report**  
**Executive Council Meeting**  
**September 30-October 1, 2010**

Date: September 8, 2010

Committee or Liaison Group Name: Psychotherapy Committee

Chair/Representative's Name: Lee Ascherman, MD

Email: lascherman@uab.edu

Brief summary of committee, taskforce, or caucus purpose or "charge"

The Psychotherapy Committee was established in recognition of the integral importance of psychotherapy training in the development of psychiatry residents. Its purpose is to serve as a resource for AADPRT members focusing on psychotherapy competencies and their implementation through model curriculum. It is also a resource to demonstrate the relevance and applicability of psychotherapy constructs to wide areas of psychiatric practice including diagnostic interviewing, inpatient psychiatry, consultation, and medication management.

Goal(s) or tasks to be completed in 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: An initial inquiry to AADPRT members re: best practices yielded but a few responses. Those that did respond offered interesting samples of approaches to psychotherapy training focusing on the therapeutic alliance. An additional inquiry to AADPRT members will proceed before the March meeting.

Action Items: Discussion of the Psychotherapy Committee's potential role in promoting ADPRT members' interest and participation in the American Psychoanalytic Association's new Psychoanalytic and Psychodynamic Teachers' Academy.

**AADPRT Committee, Task Force, Caucus Report**  
**Executive Council Meeting**  
**September, 2010**

**AADPRT Executive Office ([aadprt@verizon.net](mailto:aadprt@verizon.net))**

Date: Fall 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—there is also concern that there is not content specific for the fellowships at the AADPRT meeting.
4. Lack of education for fellowship directors on the presence of the ABPN and the RRC at the AADPRT meeting.

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—this has not yet occurred.
3. Send out personal invitations to fellowship directors for next AADPRT annual meeting—each subspecialty caucus leader is scheduled to do this prior to December 2010.
4. Consider workshops for fellowship directors on RRC and ABPN issues.

**AADPRT Committee Chair/Liaison Representative Report**  
**Executive Council Meeting**  
**AADPRT September Meeting**  
**2010**

Date:  
September 27, 2010

First, note all the stuff from last meeting. Many of these plans are still possible, but have changed somewhat or might change with recent changes in health care policy. I have included the stuff from last report so that these can be seen in context.

Committee or Liaison Group Name: **Workforce**

Chair/Representative's Name: Steve Schlozman

Existing Members of the Workforce Committee

Aurora Bennett  
Paula Del Regno  
Geri Fox  
Mike Scharf  
Lee Ascherman  
Francis Lu  
Diana Antonacci  
Cynthia Pristach

**Charge:**

The workforce committee is charged with helping the members of AADPRT to stay abreast of developments with regard to recruitment into psychiatry. This includes a better understanding of the issues that lead medical school graduates to matriculate into psychiatry, a means by which preconceived notions of psychiatry can be combated as these misconceptions are hypothesize as central to some of the barriers towards psychiatric recruitment, and the various potential roles AADPRT can play in enhancing recruitment into psychiatry. Possible roles include lobbying efforts, policy statements about post graduate education, and ways that residency training experience impacts medical students as they rotate through psychiatry throughout medical school. Ultimately, the goal of the workforce committee is to enhance recruitment into psychiatry using the bully pulpit of psychiatric education that AADPRT occupies.

**BIGGEST ISSUE RIGHT NOW:**

- I. Shortage of Psychiatrists.
  - a. A national problem (nothing new)
  - b. A nationally recognized problem (very new)

[http://www.usatoday.com/news/health/2010-07-01-psychiatristdemand01\\_ST\\_N.htm](http://www.usatoday.com/news/health/2010-07-01-psychiatristdemand01_ST_N.htm)

<http://www.medscape.com/viewarticle/727435>

<http://www.allvoices.com/news/5680165-ind-centers-battle-shortage-of-psychiatrists>

[http://www.thecourier.com/Issues/2010/Aug/07/ar\\_news\\_080710\\_story1.asp?d=080710\\_story1,2010,Aug,07&c=n](http://www.thecourier.com/Issues/2010/Aug/07/ar_news_080710_story1.asp?d=080710_story1,2010,Aug,07&c=n)

As we can see, this issue is receiving both national and local attention, and is being covered in professional and lay publications.

A medical student last month saw the USA today article and wrote me an e-mail asking why the shortage exists.

II. I think it would behoove AADPRT to have some kind of agreed upon explanation to offer to medical students and residents about the reasons for this shortage.

III. I think that central to that message ought to be a recruiting call to all medical students to consider psychiatry as a much needed and now much more accepted area of medicine.

IV. I think we are in an ideal position to recruit towards psychiatry based on this need, as well as on the new need for world psychiatric mental health programs.  
(Look at the Plenary for AADPRT! By the way, I was in a book group for a few years with Joia, and would love to have the pleasure of saying a few words about her literary talents as well as her substantial medical acumen.)

V. I WAS ASKED BY PSYCHIATRIC TIMES WHAT “AADPRT PLANNED TO DO ABOUT THE SHORTAGE OF PSYCHIATRISTS.” ANY THOUGHTS? DO WE HAVE A SPECIFIC POLICY STATEMENT? I AM HAPPY TO TAKE A STAB AT THAT.

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#### MATERIAL FROM LAST REPORT THAT WE DID NOT COVER IN PREVIOUS EC MEETING

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.

**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 discuss 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
    1. Faculty Commitment to Resident Education:
      - a. US Seniors: 4.6
      - b. Independent: 4.5
    2. Work/Life Balance
      - a. US seniors: 3.9
      - b. Independent: 4.3
    3. Salary
      - a. US Seniors 3.0
      - b. Independent: 2.7
  - ii. Psychiatry
    1. Faculty Commitment to Resident Education
      - a. US Seniors: 4.5
      - b. Independents: 4.6

- 2. Work/Life Balance:
    - a. US seniors: 4.0
    - b. Independent: 4.0
  - 3. Salary:
    - a. US Seniors: 3.0
    - b. Independent: 3.0
- iii. Neurology
- 1. Faculty Commitment to Resident Education :
  - 2. Work/Life Balance:
  - 3. Salary
- iv. Family Medicine
- 1. Faculty Commitment to Resident Education
  - 2. Work/Life Balance
  - 3. Salary
- v. Dermatology
- 1. Faculty Commitment to Resident Education
  - 2. Work/Life Balance
  - 3. Salary
- b. Salary Comparisons from Rand McNally/LA Times Poll 2006  
[http://www.allied-physicians.com/salary\\_surveys/physician-salaries.htm](http://www.allied-physicians.com/salary_surveys/physician-salaries.htm)

i. Psychiatry Average -		
Years 1-2: \$128,000	Year 3 \$168,000	Max \$292,000
ii. Neurology		
\$180,000	\$228,000	\$345,000
iii. Family Medicine with OB		
\$182,000	\$204,000	\$241,000
iv. Family Medicine w/o OB		
\$161,000	\$135,000	\$239,000

v. Dermatology		
\$ 195,000	\$308,000	\$452,000

**Why this Matters:**

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

1. **Training in Psychiatry is Unique and Involves Lots of Mentorship**
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**  
**September 30-October 1, 2010**

**Date:** September 23, 2010

**Committee or Liaison Group Name:** Assistant/Associate Training Directors Caucus

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

**Email:** [ma2063@columbmia.edu](mailto:ma2063@columbmia.edu)

Ass

**Brief (e.g. 3 sentences) summary of committee, taskforce, or caucus purpose or "charge"**

The Assistant/Associate Training Director Caucus of the American Association of Directors of Psychiatry Residency Training was created to allow ATDs an opportunity to interact and network.

**Report/Updates of Importance & Pertinence:**

Based upon our 2009 survey, most ATDs (approximately 70%) have been in their positions for three years or less with a quarter of ATDs in their position for less than a year (manuscript in preparation). These findings strongly highlight the value of the ATD Caucus as a resource for networking and support among our members.

Many ATDs have recently graduated or are relatively junior faculty members. Topics of interest among ATDs both this year and in previous years have centered on professional development within academics.

In order to address this need, AADPRT members drawn from this caucus have held a workshop at both the 2008 and 2010 AADPRT meetings specifically focusing on topics salient to the career development interests of ATDs. The workshop in 2010 specifically focused on 1) developing a plan for scholarly activity and academic advancement 2) building time management skills and 3) obtaining mentorship.

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

These two workshops have been well received. In addition, these workshops appear to address a specific need among many AADPRT members which is not exclusive to ATDs. We propose including a workshop focusing on career development issues within academic psychiatry as part of the annual AADPRT meeting.

**Action Items:**

See goals above. A subgroup of AADPRT members drawn from this caucus will be submitting a workshop on career development for the 2011 AADPRT meeting.



## American Psychiatric Association Report to AADPRT

Date: September 2010

American Psychiatric Association, Division of Education

Deborah J. Hales, MD, Director

Sandra Sexson, MD, Chair, Council on Medical Education and Lifelong Learning

Nancy Delanoche, MS, Associate Director for Graduate and Undergraduate Education

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### **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 the first section of an online research literacy course. This Course will be available online later this year in the APA Learning Management System (LMS). It will be available free to resident APA members

**New Poster Competition at 2011 APA Annual Meeting** - a special, newly created poster session dedicated to residents, medical students, and research or clinical fellows. Submission categories are as follows: (1) Psychosocial and/or Biomedical Research Projects; (2) Patient-Oriented & Epidemiology Projects; (3) Curriculum Development and Educational Projects; and (4) Community Service Projects. All posters will undergo expert review and will receive formative feedback pertaining to the scientific quality, innovation and creativity, and presentation of the posters. An award and plaque will be given for the best poster within each category. The poster session will take place on **Saturday, May 14, 2010, at the Hawaii Convention Center**.

The Office will be conducting a survey on industry relationship and trainee education. This is a follow-up survey on the same topic done by Sheldon Benjamin and Chris Varley. The resident committee is creating a companion survey for resident data.

The **100% Club**: in 2009-2010, 24 residency programs have achieved 100% resident membership. The process is now open for the 2010-2011 classes. More information is available on <http://www.psych.org/100percentclub>.

The Office continues to support **PsychSIGN** and the student leaders. The PsychSIGN students elected a new set of officers which include a national chair and regional chairs for each of the 7 APA areas. Visit [www.psychsign.org](http://www.psychsign.org) for more information regarding the new PsychSIGN leaders and their plans for regional conferences for the year.

**Mind Games** 2010: final competition at the APA meeting in New Orleans. Brown University (Butler Hospital) won the 2010 championship. Other finalists were Boston University Medical Center and Carilion Clinic - Virginia Tech Carilion School of Medicine.

The Office is preparing the **2009-2010 Census of Residents** with demographic information on residents and fellows. The data is received from AAMC's GMETrack. Previous census reports, by academic year, are available to download from [www.psych.org/census](http://www.psych.org/census).

**APA Education eNewsletter** is sent to over 5,900 psychiatry educators and residents, each issue covers important issues and announcements for all levels of education in psychiatry.

APA now accepting nominations for the following: **Nancy CA Roeske Certificate of Recognition for Excellence in Medical Student Education and the Irma Bland Award for Excellence in Teaching Residents.**

## **Continuing Medical Education**

The APA reaccreditation self-study for the period November 2004 through November 2010 was completed and submitted to ACCME March 31, 2010.

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

Michele and Carlos Pato edited the summer issue on Genetics and Genomics; Substance Abuse, edited by Joyce Tinsley, will be the topic of the Fall issue, and will contain a Performance in Practice (PIP) on Substance Abuse Screening from the APA Division of Research.

### **APA Online CME**

- Education and Information Systems completed work on a new learning management system (LMS) which delivers CME courses online and keeps transcript records of an individual's activities and CME credits. Existing courses and individuals' previous CME recorder data was transferred to the new system.
- A grant from the Center for Substance Abuse Treatment supported the development of a state of the art online buprenorphine training course. The online course allows physicians to qualify for the waiver to prescribe buprenorphine for office-based use treating opiate dependent patients.
- 65 symposia and lectures were recorded and made available in the 2010 Annual Meeting online. Certificates and CME tests for the AM Online are recorded on the new LMS.

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

The American Board of Psychiatry and Neurology (ABPN) Performance in Practice (PIP) requirement is Part 4 of the Maintenance of Certification (MOC) program. PIP modules enable a clinician to review patient records and document compliance with recommended quality measures and guidelines. Completion of the modules as required by the ABPN will demonstrate practice improvement over the 10-year MOC cycle. Education staff are editing the two published PIP sample tools to meet standards for actual performance (PIP) modules. PIP modules on Substance Abuse Screening, Patient Evaluation and Schizophrenia are in development.

### **Subcommittee on Joint Sponsorship**

During the annual meeting, CME staff meet with representatives of participating district branches to discuss ACCME requirements for DB jointly sponsored meetings and share best practices.

### **IPS**

- The 61<sup>st</sup> Institute on Psychiatric Services: Thursday, October 14 - Sunday, October 17, 2010 at the Boston Marriott Copley Plaza

### **APA ANNUAL MEETING**

- Honolulu, HI May 14-18, 2011

**AADPRT Committee, Task Force, Caucus Report**  
**Executive Council Meeting**  
**September 30-October 1, 2010**

**Date:** September 23, 2010

**Committee or Liaison Group Name:** Assistant/Associate Training Directors Caucus

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

**Email:** [ma2063@columbmia.edu](mailto:ma2063@columbmia.edu)

Ass

**Brief (e.g. 3 sentences) summary of committee, taskforce, or caucus purpose or "charge"**

The Assistant/Associate Training Director Caucus of the American Association of Directors of Psychiatry Residency Training was created to allow ATDs an opportunity to interact and network.

**Report/Updates of Importance & Pertinence:**

Based upon our 2009 survey, most ATDs (approximately 70%) have been in their positions for three years or less with a quarter of ATDs in their position for less than a year (manuscript in preparation). These findings strongly highlight the value of the ATD Caucus as a resource for networking and support among our members.

Many ATDs have recently graduated or are relatively junior faculty members. Topics of interest among ATDs both this year and in previous years have centered on professional development within academics.

In order to address this need, AADPRT members drawn from this caucus have held a workshop at both the 2008 and 2010 AADPRT meetings specifically focusing on topics salient to the career development interests of ATDs. The workshop in 2010 specifically focused on 1) developing a plan for scholarly activity and academic advancement 2) building time management skills and 3) obtaining mentorship.

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

These two workshops have been well received. In addition, these workshops appear to address a specific need among many AADPRT members which is not exclusive to ATDs. We propose including a workshop focusing on career development issues within academic psychiatry as part of the annual AADPRT meeting.

**Action Items:**

See goals above. A subgroup of AADPRT members drawn from this caucus will be submitting a workshop on career development for the 2011 AADPRT meeting.

Update – Child Caucus

AADPRT

September 2010

Contacted: Child Caucus, ACGME Child Programs (listed by June 2010, still open, 122 programs; including Triple Board and Peds Portal Programs)

Responses: 79 programs, 77 training directors, 11 assistant training directors, 4 division chiefs, 1 Vice-Chair

**Collaboration**

Psychiatry Directors

- Developing clear, shared expectations and processes for information from psychiatry directors about child applicants:
  - resolved problems, probation, concerns, etc
  - completion of CSVs
  - completion of psychiatry requirements
- Ongoing education about what child does and on relevant issues/ concerns

AACAP

- Clarification/ delineation of mission, scope, roles, responsibilities and activities of AADPRT Child Caucus and AACAP Work Group on Education and Training so that have separate but complimentary goals with effective division of labor
- Sharing and communicating about curricula and curricular resources
- Additional modules like the Systems of Care one
- Helping with AACAP initiative on membership (retention and recruitment); anyone interested should contact David Kaye, [dlkaye@buffalo.edu](mailto:dlkaye@buffalo.edu)

APA

- Increased communication and collaboration with child and education groups
- Advocacy for triple board program

ADMSEP

- Helping with needs assessment of what medical schools might want in terms of a developed CAP curricula for medical students; anyone interested should contact Geri Fox, [foxg@uic.edu](mailto:foxg@uic.edu)

ACGME

- Timely information/ updates about proposed, potential changes to RRC requirements, accreditation process
- Maintain flexibility of current requirements, don't increase mandates

ABPN

- Timely information/ updates about proposed, potential changes to child certification exams and MOC

AADPRT

- Encourage child directors to become involved in AADPRT
- Information on how to become involved in AADPRT administration/ committees
- Facilitation of more minority representation in leadership positions
- Connection/ involvement of child residents in AADPRT

**Communication**

- Periodic updates throughout the year; summary, information of decisions, status
- More active use of child listserve
- Hear more about what other programs doing
- Developing structure with subcommittees to promote/ accomplish tasks throughout the year
- Develop more organized, collective advocacy to help child training directors obtain necessary support and resources from their departments
  - Adequate administrative support/ better infrastructure
  - Training and time for faculty development for the CSVs
  - Minimize negative impact of faculty clinical productivity requirements upon educational and training activities
  - Promotion and advancement

Update – Child Caucus

AADPRT

September 2010

- More active outreach to new training directors, follow up after orientation during meeting
- More use of technology by programs to communicate/ collaborate
- Facilitate regional caucuses to collaborate/ communication more
- Support, encouragement and facilitation of more consistent, systematic sharing between child directors about experiences, activities, issues
- Not negatively competing for applicants
- More active solicitation for input from newer, less involved members, can be difficult to contribute if not part of core group

**Annual Meeting**

Child Caucus Meetings

Preparation

- Solicit items for agenda prior to meeting
- Survey group about thoughts/ concerns before meeting, target most endorsed areas for discussion during meeting
- Distribute agenda prior to meeting

Format

- Consider smaller, breakout groups
- Work on getting involvement/ participation by more participants
- Skip introductions, though nice, too time consuming
- Distribute updates/ information that does not need to be discussed by handouts, electronically to allow time for issues that need discussion
- Discuss in detail, 1-2 specific topics that have been chosen in advance with review of possible solutions, various perspectives
- Divide into structured/ less structured segments

Content

- Brief presentations/ updates by 1-2 programs on program and assessment activities, resources
- Continued updates/ information on CSVs and how different programs managing; developing consistent standards for various types of faculty (academic, voluntary, community)
- Novel ideas/ program approaches to ensuring that residents have grasped competencies
- More discussion about how can we help each other
- Child specific issues related to MATCH, ACGME and ABPN
- Updates and continued discussion of mentoring, formal and informal: process, resources, issues
- Professional identity as CAP, unique and importance aspects of field and what means for training and trainees
- Work/ life balance and understanding/ management of different generational perspectives
- Obtaining and maintain funding for CAP training, especially for programs reliant on/ working in public systems
- Discussing possible child workshops and presenters
- Continue to use as sounding board
- Continue to use as networking opportunity, a time/ place to meet, talk with others, learn about other programs; important for developing and maintaining strong alliance between child directors
- Discuss specific items with the inclusion of identified tasks for after meeting with a plan for updates
- Continue to allow participants to share common challenges and frustrations
- Have time devoted to problem solving/ practical tips

**AADPRT Website**

- Create child section, currently more useful for adults

Update – Child Caucus

AADPRT

September 2010

- Post specific material, resources, individuals willing to share about child accreditation issues, site visits, PIF preparation
- Have more child specific curricula
- Clinical vignettes/ representative cases
- Specific examples of implementation of core competencies
- Examples of application material, sample questionnaires, evaluation forms
- Frequently asked questions (FAQ) section
- Resource list

**Resources**

- Calendar of child specific dates
- Specific material, suggestions on RRC requirements (e.g. quality control projects, supervision, caseload and productivity standards for residents)
- Help with GME Internal reviews
- Information on role and responsibilities of assistant/ associate directors
- Development of material specifically for subgroups of training directors, e.g. experienced, new, small, geographical location, etc
- Effective recruitment of child applicants, especially for small programs
- How to work with child applicants while still in the psychiatry program
- Information on how different program organize and optimize clinical and didactic experiences
- Developing material that emphasizes child uniqueness and strengths for activities/ requirements that share with others (e.g. CSVs) rather than just modify the work of others
- Monitoring the common CAP application and determine if any need for modification
- More senior child directors available for mentoring, coaching
- Senior, experienced members more available for consultation about program development, program/ applicant issues, issues related to the RRC/ site visit concerns
- More help, content, resources for smaller programs and challenges they face
- More help, resources to help child IMGs; often in smaller programs with more limited resources, issues with language, culture, writing

**Curriculum**

- Develop organized, more systemic method to develop and share curricular resources
- More active collaboration between programs to develop curriculum
- Model curricular ideas organized using the competencies/ specific child competencies
- Develop more standardized and model curricula
- Develop on-line modules, residents can do on own time
- Specific suggested topics
  - Advocacy
  - Faculty development/ training
  - Teaching methods, especially technology related
  - Psychotherapy
  - Neurosciences
  - Advances/ changes in standard of care
  - Genetics/ psychogenomics
  - Substance abuse
  - Bipolar
  - Culture

Update – Child Caucus

AADPRT

September 2010

- Spirituality/ religion

**Issues to work on/ advocate about/ collaborate with others on**

- Recruitment of medical students, psychiatric residents into CAP
- Effective recruitment strategies, especially for smaller programs
- Support and expansion of Triple Board and Peds Portal programs
- More systematic, solid financial support for training; heavy infrastructure demands with limited funds
- CSVs
  - National, general guidelines and standards for implementation, methods of conduction and evaluation criteria for CSV so uniform, similar passing rates
  - More rigorous training models for directors to use with faculty, develop good inter rater reliability
  - Developing consortiums, physically or through technology to train for/ administrate CSVs
  - Create collection of CSV training videos for faculty development and put on website – range of patients, information on how resident evaluated with data on how decisions/ ratings decided upon
- Inclusion and maintenance of psychotherapy in training
- State licensing board views of/ restrictions related to residents being in mental health/ psychiatric care
- Implementing and using ERAS
- Developing consensus and expectations about on call and work hours for child programs

**Caucus Input on Issues raised by members (13 respondents)**

Resident call and possible impact of work hour changes, coordination/ collaboration with psychiatry programs

Respondents thought

- Psychiatry programs are training general psychiatrists, should learn to manage children and adolescents
- The RRC would disapprove of child residents doing psychiatry call or supervising psychiatry residents for adults
- Child programs should not be expected to help with psychiatry call; other subspecialties do not provide help with primary program; child residents have already done call as adult residents
- Additional call will impact recruitment, morale, be career disincentive

In one program, child residents do not have call

Programs with call (child faculty back up child residents)

- Most have call from home with the residents just providing phone coverage
- Some require residents to go in if necessary, report that can be recruitment issue
- In number of programs, child residents provide phone coverage to back up psychiatry residents and faculty as needed in emergency rooms and inpatient units
- Other schedules/ systems
  - Child residents round on inpatient child units on weekends and are available by phone
  - Child residents do weekends, faculty do weekdays
- Some programs only require call for part of child residency; 6 months (phone, go in rarely), 1 week (night crisis team)
- Some programs report increased discussions of having child residents do more call, come into the hospital more for child related work

Faculty

- Child faculty are in the same call pool as the general psychiatry faculty
- Faculty provide coverage instead of residents

Other approaches

- Physician assistants and nurse practitioners to help with emergency room work
- Social workers to evaluate youth in emergency room, present to ER and child psychiatry faculty
- Moonlighters to cover call
- Attending physicians to cover emergency room at night

Update – Child Caucus

AADPRT

September 2010

Resources to transition from child assistant/ associate to child training director

Institutional Resources

- GME – potential mentors, educational activities, program meetings, accreditation support and updates
- Mentoring – psychiatry senior faculty, administrators; other departmental program directors
- Regular supervision initially from someone in department, dean's office

Resources

- Sandra BS. Overview of Training in the Twenty-First Century. *Child and Adolescent Psychiatric Clinics of North America*. 2007;16(1):1-16.
- Sandra BS. Directing Child and Adolescent Psychiatry Training for Residents. *Child and Adolescent Psychiatric Clinics of North America*. 2010;19(1):31-46.
- Beresin EB. The administration of residency training programs. *Child and Adolescent Psychiatric Clinics of North America*. 2002;11(1):67-89.
- Stubbe D & Beresin EB. Education and training in Lewis and Martin (eds), *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook*, 4th Edition (Lewis, Lewis's Child and Adolescent Psychiatry, Lippincott Williams & Wilkins; Philadelphia, PA, 2007)
- Andolsek K & Cohen S. *Insider's Guide to ACGME Survey Prep*, HCPro; 2006
- Andrews LB & William J. *Core Competencies for Psychiatric Education: Defining, Teaching, and Assessing Resident Competence*, American Psychiatric Publishing, Inc, Washington DC, 2004.

Organizations/ Websites

- Helpful to attend meetings, get actively involved, particularly AADPRT, AACAP and APA  
American Academy of Directors of Psychiatry Training, <http://www.aadprt.org>
- Mentoring Program, paired with senior training director, organized by Paul Mohl,  
[paul.mohl@utsouthwestern.edu](mailto:paul.mohl@utsouthwestern.edu)
- Communicating with colleagues meet at the meeting throughout the year
- Virtual Training Office
  - Clinical Skills Assessment
  - Competency Tools
  - Evaluation Forms
  - Model Curricula
  - Program Administrative Tools
  - Teaching Resources
- AADPRT Manual, [http://www.aadprt.org/documents/AADPRT\\_Manual.pdf](http://www.aadprt.org/documents/AADPRT_Manual.pdf)
- Member Directory, <http://www.aadprt.org/secure/members/memdir.aspx>
- AADPRT Listserve, [http://www.aadprt.org/pages.aspx?PageName=AADPRT\\_ListServs](http://www.aadprt.org/pages.aspx?PageName=AADPRT_ListServs)
- AADPRT Awards and Fellowships,  
[http://www.aadprt.org/pages.aspx?PageName=AADPRT\\_Fellowships\\_and\\_Awards](http://www.aadprt.org/pages.aspx?PageName=AADPRT_Fellowships_and_Awards)
- Committee Reports, [http://www.aadprt.org/pages.aspx?PageName=Committee\\_Reports](http://www.aadprt.org/pages.aspx?PageName=Committee_Reports)

Related Organizations/ Websites

- American Council on Graduate Medical Education, ACGME, <http://www.acgme.org>;
- American Association of Psychiatry, APA, <http://www.psych.org>; Education and Career Development Section
- American Academy of Child and Adolescent Psychiatry, AACAP, <http://www.aacap.org>
- American Association of Psychiatry, AAP, <http://www.academicpsychiatry.org>
- American Board of Psychiatry and Neurology, ABPN, <http://www.abpn.com>
- American Association of Medical Colleges, AAMC, <http://www.aamc.org>; MedEd Portal,  
<http://services.aamc.org/30/mededportal>
- Association of Directors of Medical Student Education in Psychiatry, ADMSEP,  
[www.admsep.org](http://www.admsep.org)
- Group for the Advancement of Psychiatry, GAP, <http://ourgap.org>
- National Resident Matching Program, NRMP, <http://www.nrmp.org>
- ACP American College of Psychiatry (PRITE); [www.acpsych.org](http://www.acpsych.org)

Update – Child Caucus

AADPRT

September 2010

- CMHS Center for Mental Health Services, SAMHSA Substance Abuse and Mental Health Services Administration; [www.mentalhealth.samhsa.gov/cmhs](http://www.mentalhealth.samhsa.gov/cmhs)
- American Academy of Pediatrics, <http://www.aap.org>
- American Medical Association, <http://www.ama-assn.org/ama/pub/education-careers/graduate-medical-education.shtml>

Journals

- Academic Psychiatry, <http://ap.psychiatryonline.org>
- Journal of Graduate Education, [www.jgme.org](http://www.jgme.org)

Programs

- University of Illinois College of Medicine at Chicago, Professional Certificate Program, Certificate Program for Clinical Education Program  
Directors, <http://www.medicine.uic.edu/cms/One.aspx?portalId=506244&pageId=650547>
- Harvard Macy Institute runs a program for medical educators which is not specifically for program directors, <http://www.harvardmacy.org/Programs/Overview.aspx#51>

**MATCH Update**

21 programs were not in the 2009 child MATCH (3 Military); contacted all non military programs, Responses from 9 Reasons for not participating included

- Applicants from psychiatry program, not applying elsewhere; concern will lose applicants if make go through MATCH, applicants view as hassle and extra cost; work closely with residents throughout psychiatry residency
- Identify and accept applicants early (PGY IIs mostly) even though officially start as PGY IVs; some programs looking for researchers
- Some participate in MATCH during the years that have open positions and are recruiting PGY IIIIs; participation in MATCH depends on number of internal applicants, candidate pool
- No incentives for small programs, can't compete against larger programs or will lose out to those that are not or only partially participating; have the impression that larger programs go in and out of MATCH or only put in some of their positions; RRC issues if can't fill positions, don't get enough applicants to effectively compete in MATCH
- Can't effectively compete in MATCH if geographically disadvantaged
- Recruitment better outside MATCH; many applicants interviewing ask about, prefer and take positions outside of the MATCH
- Applicants chose program based on personal reasons, not specific training offered by program so no advantages to being in MATCH

Several programs developing/ implementing either formal (going through psychiatry MATCH) or informal tracks in which applicants are accepted early in psychiatry, have lots of contact with child as psychiatry residents and start child as PGY IVs

2010-2011 Child MATCH, <http://www.nrmp.org>

Registration Opens: September 1, 2010

Ranking Option Opens: November 3, 2010

Quota Change Deadline: December 1, 2010

Ranking Option Closes: December 15, 2010

Match Day: January 5, 2011

- No current plans to offer post-MATCH program (Supplemental Offer and Acceptance Program); usually get residency MATCH programs working before extend to fellowships

**AADPRT Committee, Task Force, Caucus Report**  
**Executive Council Meeting**  
**September 30-October 1, 2010**

Date: Tuesday, September 28, 2010

Committee or Liaison Group Name: Information Committee

Chair/Representative's Name: Robert Boland, MD

Email: [Robert\\_boland\\_1@brown.edu](mailto:Robert_boland_1@brown.edu)

Brief (e.g. 3 sentences) summary of committee, taskforce, or caucus purpose or "charge"

This committee oversees the organization's communication with its members and with the public at large. This includes overseeing the organization's web site and list serve. The members of the committee are charged with both initiating and vetting proposals for the web site and directing the web master as to changes or enhancements to the site.

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

Old/ongoing items:

- Update of membership registration with forced entries. This has been completed. It includes radio buttons and a drop down list to better standardize entries.
- Prep of website for this year's meeting.
- Update of website. This is an ongoing project. Currently we have worked with Rick and Shan to update the links for the programs list, many of which were broken.
- Electronic conflict of interest form.
- Electronic Submission for Model Curricula
- Improvements to the virtual training office (ex. adding the work of several committees to the site).

New projects:

- Collection of annual meeting information. Needs to be updated, still lots of "coming soon's".
- Correcting other broken links, missing information.
- More additions (ex. old newsletters?).

Potential ideas: "Virtual tour" of website. I have been waiting until the web site has been fully updated to the new database design, but it is probably time, and should happen before annual meeting.

Report/Updates of Importance & Pertinence: as above.

Action Items: no new items.