American Association of Directors of Psychiatric Residency Training

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Dear Chris,

I write to thank you and members of the Psychiatry Residency Committee for delaying the decision to permit PG3 residents to short track in their PG4 year into fellowship training. AADPRT needs time to survey its members and provide carefully considered feedback to the RC. Though patient demographics, workforce needs, fellowship preservation, and GME financing reductions led you to consider this change, this decision is likely to have far-reaching consequences to milestone implementation, supervision and teaching, patient care, recruitment, and job satisfaction. This topic was an item for discussion at the Regional Caucuses and at the Subspecialty Caucus. This letter serves to summarize those conversations.

Regional Representative and Subspecialty Caucus Meeting Summary:
Program directors in their regional meetings suggest the following reasons that fellowships are not filling. Residents depart training with large debts. A fifth year of training and delayed entry into the post-graduate salaried workforce delays earning a larger salary. Subspecialty training does not increase their salary, unlike the majority of other fields, nor does the absence of such training preclude practice in these subspecialty fields. Forensic psychiatry represents an exception.

In support of short-tracking:
1. More fellowships may fill positions that now go empty.
2. Workforce demands for psychiatrists with expertise in addictions, geriatrics, and psychosomatic medicine will be better accommodated.
3. Institutional GME offices facing reductions in funding will be less likely to re-allocate or eliminate unfilled positions or to close fellowships which do not fill.
4. The Psychiatry RC would be managing the fate of subspecialty education in psychiatry rather than departments, institutions, or other organizations.

In opposition to short-tracking:
1. The Milestones –
This change would complicate adoption of the Milestones. This proposed change would occur nearly simultaneous with implementation of the Milestones. Tasks will include faculty development and adoption and implementation of new curricula and assessment tools, and activation of the Clinical Competency Committee for the parent general program director, the subspecialty program director, and their faculties. Subspecialty program directors and faculty are customarily dependent on the expertise of the general program directors and faculty. Both would be implementing not only new milestones but a new PG4 year and a new PG4/5 fellowship year and their respective milestones.

This change would inhibit the consolidation of knowledge and skills. It is not clear how PG4 residents would learn new knowledge and skills of the subspecialty while simultaneously consolidating their general psychiatry reasoning skills and completing their general PG4 milestones in a one year fellowship. This simultaneous acquisition may become more difficult as the impact of duty hours and supervisory requirements on the time line of the development of autonomy adequate to practice independently becomes evident.

This change would limit important experiences often reserved for the PG4 year. Though there are no official PG4 requirements, most residencies include the following opportunities to meet the developmental expectations for independent practice: a consolidation experience, teaching/supervision/administration/curriculum development experiences, QI participation, systems analysis, and research. One might imagine the possibility of accomplishing this during a psychosomatic medicine fellowship in one's own institution, but it would be more challenging in addictions and geriatrics, and likely very difficult in forensics, especially in a new institution.

Some subspecialties have raised concerns regarding how this would affect fellowship training. Though some subspecialty program directors were more sanguine about this than were the general program directors, others worry that their fellows will be completing the tasks of the PG4 year during what should be their fellowship year. Forensic program directors are not interested in this model, believing that maturation in the PG4 year is a requisite for Forensic training. In addition, Forensic directors are concerned about the need for increased supervision and about fellows' inability to testify as a consequence of their not having graduated from residency.

This change would affect the resident's role as a peer teacher. The ACGME has an expectation of learning from peers. Fast-tracking presents the risk of very small PG4 classes and limited peer learning.

Psychiatry residencies may be unique in their education requirements. Psychiatry residencies shoulder a deeper educational burden than many other fields. Neither the brain nor the mind is given their fair share of attention in pre-college, college or medical school education. This is provided in residency.

Despite best intentions, this may have unintended detrimental effects on residency training. Some are concerned that this change coupled with the milestones and reductions in GME funding will lead to the reduction of psychiatry residency to three years or, given time in primary care and neurology, just 2.5 years.

2. ACGME Supervisory, Duty Hour, On call Requirements and the Teaching Milestone –

PG4 direct and indirect supervision and teaching of junior residents would be jeopardized. Many PG4 residents supervise, teach, model for, and mentor their junior peers. PG1-3 residents would have a more limited opportunity to receive this from seniors. Many programs have managed the PG1 supervision and duty hour requirements and the PG4 progression to independence by shifting PG4s into supervisory roles on rotations and during extended duty periods. In these endeavors, PG4s are preferred over PG3's in order not to disrupt the PG3 12-month fulltime continuity outpatient experience. PG1 supervision is not customarily needed on the addictions, geriatric and consultation-liaison rotations. With fast-tracking there would be fewer PG4s to provide this supervision.

Since the advent of the ACGME supervisory, duty hours, and on call requirements; in many departments, PG4s are a staple of the on call roster. Removing them will have a deleterious effect on the morale and well-being of PG2/3s who have already shouldered this additional burden too.

3. Patient Care –
PG4 residents provide service to departments by treating complex and acutely ill patients. A decrease in their numbers will have an impact on the numbers of such patients seen. Alternatively, their care will be shifted to faculty whose time is needed to supervise and teach.

4. Finances –
Financial planning will be more difficult and unfilled lines may be at risk. It will be difficult for programs and departments to plan for educational, supervisory, and patient care needs with the fast-track model as they will not know how many FTEs they have from year to year. The unforeseeable aspect of this also limits programs from shifting unfilled slots to earlier years. Once a slot has been shifted, the institution is obliged to provide all years of training remaining, not just a single PG-year.

Unfilled lines may be at risk for elimination.

PG4 residents generate indirect collectables. These will be reduced.

5. Recruitment –
General programs that offer fellowships may have a recruitment advantage. Residents may not find moving for a one year fellowship desirable. Smaller and rural residencies will be at risk. Alternatively, departments may elect to establish new fellowships creating additional fellowship positions to fill.

6. Fellowship Selection –
Child/Adolescent Residencies will compete with fellowships for PG4 residents. Residents interested in advanced credentials will be able to choose among many subspecialties at the conclusion of their PG3 year.

7. Child/Adolescent Residencies –
Unlike fellowships, Child/Adolescent residencies are two (2) years in duration. PG3 residents can fast-track into C/A Residencies. Residents receive PG4 general psychiatry credit for the first of their two years of C/A training. The two years of training permit the resident to mature, consolidate knowledge and skills, participate in the customary advanced experiences, and learn a new field.

8. Work Transfer, Job Satisfaction and Retention –
There may be no PG4s available to be Chief Resident(s). Their administrative and "care taking" duties will fall to the program director and the coordinator. These will be in addition to duties added with the NAS.

PG4 supervision of junior residents will fall to the faculty. These will be in addition to those added by the requirements of the NAS.

Work load increases may deplete faculty morale and deprive them of research and teaching time. Both these increases to work load and the time relief PG4s "donate" to faculty research and teaching time may deplete faculty morale and department ability to recruit and retain faculty.

Summary and request:
Based on the initial feedback from Regional and Subspecialty Caucuses, members of the Executive Council felt that there were too many substantive concerns and uncertainties regarding the proposal to endorse it at this time.

The Council appreciates that, after considering the complex issues inherent in PG3 fast-tracking into fellowship, you have delayed the Psychiatry RC's deliberative process. This provides AADPRT valuable time to conduct a survey of its members and forward a summary of the results and our thoughts to you.

Sincerely,

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