

Residency Training Transformation: A View From the Frontline

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Introduction by the column editors:

This column is based on the use of an electronic mailing list (e-list) to generate a collaborative problem-solving process. For this column, Dr. Barkil-Oteo and Dr. Holoshitz asked e-list alumni of the Columbia University Public Psychiatry Fellowship to comment on the quality of leadership training they received in their residency programs. Readers are invited to submit suggestions for e-list discussions of management problems to column editor Jules Ranz, M.D. (e-mail: jmr1@columbia.edu).

The health care landscape is rapidly changing. These changes will require psychiatrists to have a wider, more expanded set of competencies, beyond what is being provided now in residency programs (1). At one time the training of residents was a fair approximation of the types of jobs available to them on graduation. The profoundly changing structure of services outside academic medical centers (AMCs) is rapidly making current models of training seem outmoded (2).

AMCs tend to be heavily focused on inpatient services, reflecting the structure of AMC health care systems. However, in other systems, more mental health services are delivered outside specialty mental health clinics, and more

medications are prescribed by non-psychiatrists (3). More services are provided in the community, integrating mental health care in primary care clinics and providing medical services in mental health centers. Both models, with few notable exceptions, are underrepresented in AMCs. In addition, fewer psychiatrists are accepting Medicaid at a time when the Medicaid system expects a massive expansion in the demand for mental health services (4). These trends portend not just a shortage in the provision of mental health services but an acute crisis, the likely outcome of which will be exponential expansion of mental health service delivery outside specialty settings. This scenario raises the question of whether there is mismatch between the skills provided in residency training programs and those needed in the workforce.

In psychiatry, as in other types of medicine, leadership skills are particularly important. Psychiatrists of the future will be called upon to lead teams of clinicians and to coordinate care with members of other specialties in increasingly complex medical care systems. Under recent changes in U.S. health care, individuals labeled “high cost–high risk” will be especially targeted, in an effort to reduce expenditures and increase quality of care (5). In this group are individuals with severe mental illness, who are more likely to have chronic medical illness and higher medical morbidity and less likely to receive appropriate medical care (6). These factors may explain the gap of ten to 25 years in life expectancy for individuals with severe mental illness (7,8). Care in our current medical system for these individuals is costly, yet

they have poorer mental health and general medical outcomes than other patients (9).

More important, the shift toward collaborative care models in accountable care organizations will require psychiatrists to understand system structures, regulations, and incentives in order to optimize these components for the benefit of their clients (10). Working collaboratively will test abilities of providers to engage in multidisciplinary teams, as opposed to the traditional psychiatric model of individual consultation and treatment. To improve clinical outcomes in the new system, good leadership skills will be more necessary than ever (11).

With the understanding that leadership skills are essential to the delivery of effective clinical services, it is clear that the development of such skills must become a focus of psychiatric training in addition to the acquisition of clinical knowledge and evidence-based medical practice. The current residency training model seldom focuses on the development of leadership skills (12). How can psychiatric residency programs aim to cultivate these skills as an important component of our profession and provide the training necessary to prepare the next generation of leaders in psychiatry? In what format should such training be presented? Program administrators fear that they do not have an infrastructure of faculty experts to formally teach administrative and leadership skills. To meet increasing demands of the Accreditation Council for Graduate Medical Education (ACGME), the current curriculum is already spread thin.

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Dialogue

Members of the Columbia University Public Psychiatry Fellowship (PPF) e-list were asked two questions: What specific skills and knowledge base can you identify as important to your current leadership role that were not stressed in general residency education, and what do you wish you would have learned? What role can mentors who specialize in clinical administration play in residency programs to help develop residents into the next generation of leaders? The study received approval by the institutional review boards at Yale University and the New York State Psychiatric Institute. The need for informed consent was waived, because e-mail respondents knew that a study was being conducted and no identifiers were collected.

Responses to the first question addressed both skill and knowledge acquisition. Many responses addressed issues related to knowledge of the overall health system, especially related to funding and regulation. List participants wanted to have learned more in residency training about the various commissions overseeing mental health systems, such as the Joint Commission and local departments of health, and about federal and state reimbursements, which would increase their awareness of the cost of services. Such an awareness has not been a focus of current residency training in psychiatry or other specialties.

Another common theme was one of learning to collaborate. One participant noted that “silos are rampant in our work.” Collaboration is a necessary component of working with other psychiatric services and programs and with members of other disciplines in team settings. A participant pointed out that “our patients need housing, case management, employment, physical health care, substance use treatment, etc. . . . I wish I had learned how to work as a team member before I was out in practice.”

In response to the question about administrative mentors, all of the e-list respondents agreed that formal mentorship from administrators in residency was absent and that its presence could be important for role modeling and teaching some essential administrative knowledge and skills. Administrative

mentors could teach how to run meetings effectively, navigate interpersonal issues between various team members, resolve conflicts, and interact with administration and other department leaders to advocate for psychiatry. Finally, such mentorship could emphasize that leadership is its own discipline with its own literature and continuing education.

Changes proposed and discussion

The first requirement for producing change is to understand the system in which one is working. Once such an analysis is made, the second step is to create a plan for change, in conjunction with others in the system. Communication and collaboration across disciplinary lines are crucial not only for developing a plan but also to ensure that everyone involved will work together to implement the plan.

ACGME has recognized the shortcomings of current training models and is moving to update resident training. The new framework will require a different view of the role of residents in the system (13). In the current system, trainees are seen as the glue that holds the system together, which often furthers a dysfunctional status quo (14). In the new system, trainees will need to better understand systems and perhaps even be encouraged to become change agents to improve the systems in which they are being trained and in which they will work after graduation. There is emerging evidence that the quality of care delivered by a training program can affect the quality of care its trainees deliver after graduation (15). This perspective will prevent future trainees from feeling powerless when confronted with repeated instances of the system failing to serve patients adequately. Instead, residents will be provided with the necessary tools to help patients cope with system difficulties and, ideally, to instigate change that will provide better support to their patients (14). Training in effective systems-based practices empowers both the doctor and the patient and may help prevent burnout common among health care professionals.

Training residents in leadership skills and how to implement systemic change requires a concerted effort. Residency programs have traditionally

focused on training for careers in direct clinical care, research, or medical education, with little formal teaching in leadership despite the strong evidence that good leadership skills lead to good clinical outcomes (16). The current generation of physician-leaders took on their roles in a fashion best described as becoming “accidental administrators” (17), where physicians are identified and promoted to leadership positions generally without specific leadership training and often without regard to their leadership potential. The health care field needs to move to “cultivated leadership,” where medical students and residents are exposed to leadership opportunities early in training (17).

Even though there is much overlap in the qualities of a good leader and a good clinician, one immediate concern arises: will such training come at the expense of other critical learning opportunities in residency? A good leader should understand group dynamics, work in collaboration with others, and communicate in clear and consistent ways. These helpful and often necessary skills are by no means strictly relegated to leadership and administration. Residency training could concertedly target and emphasize the importance of these skills in other settings, both in formal didactic sessions and in clinical feedback regarding presentations, professionalism, and work ethic.

The forthcoming ACGME milestones present an opportunity to emphasize leadership skills throughout the training period. A resident’s knowledge of community-based care, resource management, and quality improvement initiatives could be explicitly measured along with clinical knowledge, psychotherapeutic principles, and evidence-based practice (18). Teaching leadership and related skills should not be the sole responsibility of training programs. ACGME encourages leaders of teaching institutions to engage with residency programs to ensure that “care provided in the clinical environment [where residents learn and practice] is both high quality and safe” (19). Additional aspects of professional practice, such as interdisciplinary teams and conflict resolution, could be required topics.

Conclusions

It is clear that modern psychiatry must broaden its scope beyond clinical skill and research acumen, and the output of our e-list discussion thoroughly supports this view. PPF alumni frequently take on leadership roles in the community. The skills, knowledge, and personal attributes that PPF e-list participants felt were necessary to thrive in their leadership roles dovetail with many features of the ACGME milestones. Observations and experiences of psychiatrists removed from residency training and academic institutions and directly confronted by the realities of the current health care environment can help guide residency training. In training the next generation of leaders in psychiatry, academic residency programs would be well advised to embrace collaboration with community psychiatrists.

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