A Preliminary Report on Resident Emergency Psychiatry Training From a Survey of Psychiatry Chief Residents

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Abstract

Background The Accreditation Council for Graduate Medical Education (ACGME) requirements stipulate that psychiatry residents need to be educated in the area of emergency psychiatry. Existing research investigating the current state of this training is limited, and no research to date has assessed whether the ACGME Residency Review Committee requirements for psychiatry residency training are followed by psychiatry residency training programs.

Methods We administered, to chief resident attendees of a national leadership conference, a 24-item paper survey on the types and amount of emergency psychiatry training provided by their psychiatric residency training programs. Descriptive statistics were used in the analysis.

Results Of 154 surveys distributed, 111 were returned (72% response rate). Nearly one-third of chief resident respondents indicated that more than 50% of their program's emergency psychiatry training was provided during on-call periods. A minority indicated that they were aware of the ACGME program requirements for emergency psychiatry training. While training in emergency psychiatry occurred in many programs through rotations—different from the on-call period—direct supervision was available during on-call training only about one-third of the time.

Conclusions The findings suggest that about one-third of psychiatry residency training programs do not adhere to the ACGME standards for emergency psychiatry training. Enhanced knowledge of the ACGME requirements may enhance psychiatry residents' understanding on how their programs are fulfilling the need for more emergency psychiatry training. Alternative settings to the on-call period for emergency psychiatry training are more likely to provide for direct supervision.

Introduction

The American Association for Emergency Psychiatry (AAEP) Education Committee developed and published recommendations for emergency psychiatry training.[1] The aim of these standards is to institute a standard of training across the United States that ensures adequate knowledge and exposure for clinical trainees in psychiatric emergencies. A search of the literature failed to reveal any study of the degree of adherence to these guidelines by psychiatric residency training programs. These ACGME standards emphasize the need for direct supervision, in that residents be given opportunities to "be observed interviewing patients and receive feedback on interviewing techniques and style" during emergency psychiatry training.[1]

Related educational research tends to fall into 2 categories, both of which are insufficient to address among psychiatric residency programs—how to provide adequate quality and amount of training in emergency psychiatry. First, there is a body of earlier literature that investigates training in the management of psychiatric emergencies in psychiatry residency programs.[2–5] Second, there is more recent literature that describes the training of nonpsychiatric physicians and trainees in emergency psychiatry.[6–8] Neither adequately addresses the current state of psychiatry residency training in emergency psychiatry.

The current (July 2007) Accreditation Council for Graduate Medical Education (ACGME) requirements for emergency psychiatry training state:

> … This experience must be conducted in an organized, 24-hour psychiatric emergency service, a portion of which may occur in ambulatory urgent-care settings, but not as part of the 12-month outpatient requirement. Residents must be provided experiences in evaluation, crisis evaluation and management, and triage of psychiatric patients. On-call experiences may be a part of this experience, but no more than 50%.[9]

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Interpretation of the ACGME requirements suggests that there must be training in either a directly supervised "night float" rotation or exposure during the workday, and the requirements stipulate that on-call experiences be no more than 50% of the total training. In the absence of urgent care clinics or emergency services during the day, residents may be receiving a disproportionate amount of emergency psychiatry training during on-call hours.

We surveyed how ACGME requirements were being followed by psychiatry training programs through the perspective of chief residents. We queried resident knowledge of the most recent ACGME requirements and the relative amount of resident exposure to emergency psychiatric training during on-call periods, acute or urgent care settings, general emergency department settings, and dedicated psychiatric emergency department settings. We also asked about the types of supervision provided during these emergency psychiatry training experiences. Our decision to query chief residents was based on the observation that they represent the group who will soon need to be competent in providing emergency psychiatric services and know firsthand what training is being provided. Our survey appears to be the first of its kind in the past 2 decades and provides basic information about the amount and quality of residency psychiatric emergency training.

Methods

A 24-item survey was designed to query chief residents currently in United States psychiatry training programs on the types and amounts of emergency psychiatry training experiences provided during the course of their training. The 24-item survey included evaluative, demographic, and qualitative indicators. The questionnaires were distributed to attendees at the Chief Residents' Executive Leadership Program held at the American Psychiatric Association 2010 Annual Meeting. The study received Institutional Review Board approval by the Springfield Committee for Research Involving Human Subjects.

Descriptive statistics serve as the means of analysis. PASW 18 software (IBM, Chicago, IL) was used to complete the analysis.

Results

Of 154 distributed surveys, 111 were returned (72% response rate). Of the 111 returned surveys, 4 indicated that the respondents were not from United States residency training programs and were removed from the analysis. Of the remaining surveys, 28 (26.1%) had missing responses for 1 or more items. To test for bias in nonresponse, we compared survey answers between those who completed all questions and those who did not. Only a few incomplete surveys had missing responses for many questions. The analysis indicated limited differences between those respondents who provided complete data and those with incomplete data. Fourteen respondents (13.1%) did not answer the final question regarding whether or not their program should change its clinical curriculum. We use data from all 107 respondents, as the nonresponse bias probably is random.

Of these 107 surveys, 10 (9.3%) self-identified as post-graduate year (PGY)–2, 86 (80.4%) as PGY-3, 10 (9.3%) as PGY-4, and 1 (0.9%) as PGY-5. As this chief resident leadership program took place in May, it is likely that the respondents who self-identified as PGY-2 are transitioning to PGY-3 and their new chief resident roles. When asked in which region of the United States their training program was located, 40 (37.3%) indicated the Northeast; 17 (15.8%), the Midwest; 21 (19.6%), the South; 10 (9.3%), the West; and 19 (17.8%) did not indicate any region.

TABLE 1 presents the responses to the 12 dichotomous (yes/no) questions asked of chief residents. Each question is presented, followed by the number and percentage of respondents answering "yes" or "no" to the question.

TABLE 2 presents the mean percentage of time, as indicated by chief residents, that was spent in various clinical areas including acute or urgent care ambulatory clinics, general emergency departments, dedicated psychiatric emergency departments, and on-call periods, as part of their total emergency psychiatry training. Standard deviations, ranges, and confidence intervals are also reported. In addition, 30 respondents (28.8%) indicated that they received more than 50% of their total emergency psychiatry training during on-call periods.

TABLE 3 presents the types of supervision received, by emergency psychiatry training experience. These results indicate that direct supervision occurs less frequently during on-call periods (35.4% of the time) versus other settings (66.7% to 80%).

Discussion

Most respondents (88.8%) indicated that the amount of emergency psychiatry training is sufficient in their training programs, yet more than half of chief residents (58.5%) reported they were not aware of the current ACGME RRC requirements for emergency psychiatry training. This suggests that better education of residents about the latest ACGME requirements for emergency psychiatry training might enhance trainee understanding of what constitutes sufficient training during the 4-year curriculum. For example, a minority of respondents (15.1%) indicated that there was no rotation on an explicitly dedicated full-time emergency psychiatry service, which is a potential limitation to the training that residents receive. Despite most chief residents reporting that their programs provide sufficient emergency psychiatry training, 15.1% indicated that their program curriculum should be changed to conform to current ACGME requirements. Most respondents (91.5%) reported being exposed to emergency psychiatry training during on-call periods. The minority (8.5%) reported not

TABLE 1 **Summary of Responses to Questions by Chief Residents**[a]

Question	Yes, No. (%)	No, No. (%)
Are you aware of the current ACGME RRC requirements for psychiatry for emergency psychiatry training?	44 (41.5)	62 (58.5)
Is your program's emergency psychiatry experience conducted in an organized, 24-hour psychiatric emergency service?	88 (83)	18 (17)
Are you getting experience in evaluation, crisis evaluation and management, and triage of psychiatric patients?	100 (95.2)	5 (4.8)
Does your program provide emergency psychiatry training in an acute or urgent care ambulatory clinic?	48 (45.3)	58 (54.7)
Does your program provide emergency psychiatry training in a hospital general emergency department setting?	86 (80.4)	21 (19.6)
Does your program provide emergency psychiatry training in a hospital setting with a specifically designated psychiatric emergency department?	69 (64.5)	38 (35.5)
Does your program provide emergency psychiatry training during a full-time rotation or rotations (eg, during the workday)?	90 (84.9)	16 (15.1)
Does your program provide emergency psychiatry training during a part-time rotation or rotations that occur concomitantly with other clinical experiences (during consultation-liaison service experiences, inpatient service experiences, etc)?	64 (60.4)	42 (39.6)
Does your program provide emergency psychiatry training during on-call duty periods?	97 (91.5)	9 (8.5)
Does your program provide a morning report or emergency psychiatry case conference format for the discussion or supervision of emergency psychiatry cases?	58 (54.2)	49 (45.8)
Do you feel that your program provides a sufficient amount of clinical experience and training in emergency psychiatry?	95 (88.8)	12 (11.2)
Finally, do you feel that your program needs to change its clinical curriculum to conform to the current requirements set forth by the RRC for psychiatry?	14 (15.1)	79 (84.9)

Abbreviations: ACGME, Accreditation Council for Graduate Medical Education; RRC, Residency Review Committee.

[a] Not all respondents answered all questions; hence, percentages are given as based on the total number of responses to a specific question.

TABLE 2 **Percentage of Total Emergency Psychiatry Experience Spent in Clinical Area, By Type**[b]

Question	Mean, %	SD, %	Range, %	95% CI	N
What percentage of the total emergency psychiatry experience in your program is spent in acute or urgent care ambulatory clinic(s) (not on-call)?	9.64	18.84	0–100	5.98–13.31	104
What percentage of the total emergency psychiatry experience in your program is spent in the general emergency department (not on-call)?	14.72	17.76	0–80	11.27–18.18	104
What percentage of the total emergency psychiatry experience in your program is spent in a dedicated psychiatry emergency department (not on-call)?	29.55	30.34	0–100	23.65–35.45	104
What percentage of the total emergency psychiatry experience in your program is spent in on-call periods?	44.94	28.70	0–100	39.36–50.52	104

Abbreviation: CI, confidence interval.

[b] The mean, SD, and range values were calculated numerically, directly from numerical values given by respondents.

TABLE 3 **Types of Supervision Received, by Emergency Psychiatry Experience**[c]

Emergency Psychiatry Experience	No. (%) of Respondents Receiving Telephone Backup	No. (%) of Respondents Receiving Direct Observation	No. (%) of Respondents Receiving Videomonitoring	No. (%) of Respondents Receiving Indirect Supervision
Acute or urgent care ambulatory clinic(s) (N = 42)	10 (27.8)	24 (66.7)	36 (0)	9 (25)
General emergency department (N = 64)	28 (49.1)	41 (71.9)	57 (0)	7 (12.3)
Dedicated psychiatry emergency department (N = 75)	20 (30.8)	52 (80)	65 (0)	11 (16.9)
On-call periods (N = 93)	56 (68.3)	29 (35.4)	82 (0)	15 (18.3)

[c] Response choices are not mutually exclusive; hence, some total percentages may add up to more than 100. Not all respondents indicated types of supervision received.

having this important training experience during their residencies. Moreover, 60.4% of respondents indicated that they receive emergency psychiatry training during part-time rotations involving other clinical experiences, such as consultation-liaison or inpatient service rotations. How this part-time rotation exposure better integrates and expands the breadth of training in psychiatric emergencies is of interest as programs seek to develop models of training more compatible with their clinical resources, yet in compliance with the ACGME requirements.

Other potential inadequacies in training were noted from the responses by chief residents. Nearly one-half of the residents (45.3%) reported that their training programs offered innovative services for patients, such as acute or urgent care ambulatory clinics. These clinics can provide diversion from the often busy emergency department setting and are another avenue for meeting programmatic requirements.[10,11] A significant percentage (28.8%) of respondents indicated that their programs did not provide at least 50% of emergency psychiatric training outside of experiences during the on-call periods. This suggests that resident education in a proportion of programs may not be in compliance with the ACGME requirements.

Besides assessing the scope of emergency psychiatry training in residency programs, we were interested in quantifying the types and amounts of supervision that trainees receive. Given the newly proposed Common Program Requirements by the ACGME, which emphasize the need for the immediate availability of direct supervision,[12] our findings are relevant to the current discourse regarding supervision. Respondents reported that direct supervision during on-call exposure to emergency psychiatry training is provided less often, when compared to other clinical settings in which this training occurs. Hence, programs in which most emergency psychiatry training occurs during on-call periods may have less direct supervision of their residents. None of the respondents indicated that video monitoring was a source of supervision in any emergency psychiatry training setting, and telephone backup and indirect supervision via report or conferences were common. The proposed definition of direct supervision, "The supervising physician is physically present with the resident and patient,"[12] raises the possibility that programs may need innovative strategies to achieve this standard.

This pilot study of the types of emergency psychiatry training provided to residents in psychiatric training programs has several potential limitations. First, the final survey item has the most data missing, probably owing to its placement in the survey. Additional rationales for nonresponse include the following: (1) some questions, including the final question, may be sensitive or difficult to answer and (2) respondents may have run out of time before answering the final few questions. Second, there were also some inconsistencies in the reporting of types and amount of training experienced, which are largely accounted for because of response attrition toward the end of the survey. Overall, although some surveys had missing data, those data were limited and we find no evidence of response bias.

Finally, although this survey has a generally high response rate, it may not represent the true structure of psychiatry residency training programs in the United States. A larger-scale study is necessary to fully assess the strengths and weaknesses in emergency psychiatry training. A survey of psychiatry residency program directors, as well as chief residents, would likely illuminate any deficiencies and may also identify discrepancies between reports of program directors and chief residents. By surveying the chief residents, we have obtained a preliminary view of how the programs are experienced by trainees, though it is possible that some chief residents are unaware of the extent of accommodations their programs make to comply with ACGME guidelines.

Conclusions

Overall, our findings suggest that many chief residents are unaware of ACGME requirements for emergency psychiatry training. Inclusion of educational standards, such as the AAEP guidelines for training and ACGME requirements in the curriculum for residents, would enhance resident awareness of their knowledge and praxis needs and of whether these are being met in their training programs.[1,9] Programs should review the amount of time, clinical settings, and types of supervision devoted to emergency psychiatry training, given our finding that many programs may not be in compliance. Proposed standards of supervision emphasizing direct supervision[1,12] may require significant structural and faculty deployment changes to ensure compliance.[9]

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