S28—Medical Education for Psychiatrists in the USA: A Clinician’s Perspective

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Credentials & Conflicts

• Parliamentarian, APA Assembly
• President, Southern Psychiatric Association
• Not speaking as a representative of either organization
• No conflicts to report
What Is the Problem?
Do MD’s “keep current” on their own?

• “Systematic Review: The Relationship between Experience & Quality of Health Care (Choudhry et al, Annals of Internal Medicine ’05)

• “Of 62 published studies that measured physicians’ knowledge or quality of care & described time since medical school graduation or age, more than \( \frac{1}{2} \) (32/62) suggested that physician performance declined over time for all outcomes measured.”

• Of 39,007 hospitalized pts with acute MI’s managed by 4546 cardiologists, etc, mortality increased 0.5%/yr since med school graduation.
How about Psychiatrists?

• “Practice Patterns in the Dx & Tx of Anxiety & Depression in the Medically Ill: A Survey of Psychiatrists” (Epstein, et al, “Psychosomatics” ’96)

• 38 psychiatrists compared to 10 nat’l leaders in consultation-liaison psychiatry. Best model of predicting lower agreement was years in practice, along with % spent in solo vs. group practice. “Psychiatrists who are more distant from training yrs & more isolated from the current stimulation of colleagues may be particularly appropriate targets for continuing education.”
How about Psychiatrists?, II

- Case vignette survey of 278 psychiatrists: Tendency to Dx major depression was significantly associated with being Board-certified, in practice for less time, having a greater % of pts with managed care & having a greater % of patients on psychotropic meds.” Study was based on 4 case vignettes with depression & various degrees of medical co-morbidity.
Why is There a Decline?

• “the results are somewhat paradoxical since it is generally assumed that clinical experience enhances knowledge & skill and, therefore, leads to better patient care.”

• Physicians’ “tool kits” created during training may not be updated regularly. Practice innovations involving “theoretical shifts” may be particularly hard.

• But older MD’s may be more effective at delivering the humanistic, rather than the technical, aspects of medical care, and may have better clinical judgment in complex cases.
Why Is There a Decline?, II

• “Widely adopted continuing medical education techniques, such as distribution of printed materials & lectures, are largely ineffective even in experimental conditions.”
How Do Psychiatrists Keep Up with New Information?

- Journals, e.g. from medical & psychiatric associations. Journal clubs & book clubs.
- Supervision: 1) voluntarily when one who doesn’t feel confident in managing a complicated case asks someone who is more skilled to look over how he does, or
- 2) when it is mandated, e.g. by a licensing board
- Not required to follow the supervisor’s suggestions or to have one’s competency evaluated.
Grand Rounds at Universities

- Univ of South Carolina now streams them live; attendance is recorded automatically & faculty get credit when they view the entire session
- Tend to be oriented towards needs of trainees & medical students & to be research vs. practice-oriented
- Free. Most presentations are from faculty & trainees who are already being paid & who prepare the presentations at no additional cost.
University Productions

• Harvard regional & national symposia & courses: Comprehensive Review of Psych, Psychopharm Update, Neuro Aspects of Psych Practice

• $310/yr for 6 publications of Harvard Review of Psychiatry

• Plan to have podcasts, videos, blogs, and an i-pad app
APA Efforts

• Psychiatry Online ("Lifelong Learning in Psychiatry")

FOCUS

• One-yr (4 issues) $347, 2-yr (8 issues) $624

• Clinical reviews, ethics column, pt management exercise, CME quiz. 20 hrs of CME/yr + 24 additional credits for taking 120-question multiple-choice self-assessment exam.

• Provides 4 ABPN-approved Performance in Practice modules.
The 4-Yr Plan for FOCUS

- It addresses core content in Psychiatry in 4-yr cycles.
- In ’11, Addiction Psych, Bipolar Disorder, Anxiety Disorders, Professionalism & Quality Measures
- In ’12, Women’s Mental Health, Schizophrenia, Child & Adolescent Psychiatry, Depression
- In ’13, Geriatric Psychiatry, Personality Disorders, PTSD & Traumatic Brain Injury, Integrated Care & Psychosomatic Medicine.
- In ’14, Sleep, Psychopharmacology, Psychotherapies, Eating Disorders, New Biologies & New Therapies
FOCUS, Spring ‘13

• Clinical Synthesis: Co-occurring Disorders & Tx Complexity w/i Personality Disorders
• Borderline Personality Disorder and articles about several others
• Communication Commentary: Effective Communication Under Stress: Personality Disorders & Tx Engagement
• Ask the Expert: Personality Disorders
• Plus7 “influential publications”, including “Ethics Commentary: the Psychotherapeutic Relationship”
Attendance at Meetings

• Meetings of national, regional, or local medical & psychiatric associations

• Local organizations are particularly useful in helping practitioners adapt to changes in laws, guidelines, etc

• Sub-specialty organizations like American Academy of Child & Adol Psychiatry

• Alumni organizations
For-profit Educational Entities

- Audio-Digest –a/b $500 for 24 two-hr CD’s and transcripts/yr. Open-book pre- & post-lecture exams, graded later.
- Travel-oriented tours
- CME expenditures were over $2.5B in 2007.
The History of “Maintenance of Certification”

• 1934: ABPN established; board certification as a way to “establish national outcome criteria for excellence in residency training programs” (Kempen, P., “MOC—important & to whom?”)
• 1971: American Board of Internal Medicine endorses the principle of recertification (“Continuous Professional Development”). Fewer members progressively opted to participate, in-between ’74 & ’86.
• ’94: ABPN first issued time-limited certificates. Those diplomates who were certified by then were “grandfathered in”.
• 2000: American Board of Medical Specialties mandated all of its 24 member boards to limit certification to 10 years
• 2007: first year for enrollment in MOC
• 2010: NEJM survey found that 2/3 of all MD’s rejected MOC for those with lifelong certification
• 2012: The 15 Ohio medical organizations defeat MOL. This was the first state targeted by the Federation of State Medical Boards
• 2020: ABMS projects 93% of board-certified MD’s will have MOC
The Goals of MOC

• Requires diplomates to participate in sanctioned self-assessment performance measures, identify perceived weaknesses in their knowledge, pursue learning activities tailored to areas that need to be strengthened, and develop quality improvement programs based on their clinical practice.
MOC Goals, II

• The goal is for diplomates to reflect on their personal knowledge & performance and commit to a process of improvement & re-evaluation of performance measures over a specified time frame that will ultimately lead to improved care for their patients.
The 4 MOC Components

1) Must hold an active, unrestricted license
2) Must participate in at least 2 self-assessment activities that provide feedback that can be used as a basis for lifelong learning, etc. Includes 30 specialty CME credits/yr for 10 yrs—at least 8 should involved self-assessment
3) Must pass a cognitive exam within the 10 yrs
4) Must complete 3 Performance in Practice modules; each must include a chart review & a feedback module (patient/peer 2nd-party external review)
Performance in Practice

• “clinical module” is a baseline chart review in which results are compared with best practices or practice guidelines. A 2\textsuperscript{nd} chart review will determine if intervening practice improvements have had a positive effect.

• “feedback module”: reviews of clinical performance by patients, peers, or other 2\textsuperscript{nd} parties like other practice staff or administrators. They are to be repeated to see if practice improvements have occurred.
ABPN – approved products for self-assessment & PIP (required in ’14)

• APA:
• 2013 annual meeting self-assessment in Psychiatry
• Clinical e-FOCUS
• FOCUS on MDD: 1) self-assessment in major depressive disorder & 2) Performance in Practice clinical module for the care of pts with MDD
• PIP for comprehensive assessment for suicide & suicide-related behaviors
• PIP physician assessment module for the screening of adults with substance abuse disorder
Some Other ABPN-Approved Products I

• Self-assessment:
• Audio-Digest Foundation (Mood Disorders/Bipolar Disorder, Mood Disorders/MDD)
• Mass General Hospital: General Psychiatry 1-6, ADHD, Anxiety Disorders
• American College of Psychiatrists: Psychiatrists in Practice Exam
• University of Wisconsin
Some Other ABPN-Approved Products II

- Performance in Practice Modules
- American Academy of Child & Adolescent Psychiatrists—Initial & Retrospective Chart Reviews of Pediatric Patients with OCD, ADHD, Anxiety Disorders, Bipolar Disorder, & Depression
- Duke School of Medicine
- University Of Wisconsin
The MOL Threat

- In ’04, the Federation of State Medical Boards began working on a plan, which does not include a mandatory exam & does not require MOC participation. However, it recommends that state licensing boards accept MOC as essentially meeting MOL requirements.
Medicare

• In ’12, 0.5% incentive payment to MD’s participating in MOC.
• This changes to a penalty in ‘14
The AAPS Suit
Association of American Physicians & Surgeons, founded in 1943

• Filed suit in NJ Federal Court on 4/23/13
• Alleges the ABMS is restraining trade & decreasing patient access to care due to burdensome recertification process
• Claims that the ABMS is seeking MOL because so many MD’s are refusing to voluntarily participate in MOC
2009 Comments

• Dr. Stubbe: MOC “would also help psychiatrists develop more positive habits with regard to keeping up with the literature, ensuring that they are providing the best treatments, & following best practices.”

• Dr. Winstead: “It seems that, often, the confident practitioner who feels that he or she is doing just fine is actually the one who is less up-to-date on best practices that other practitioners.”

• Dr. Faulkner: “I agree. Many individuals are simply not proficient at self-reflection & may need an external, unbiased mechanism to help them engage in & benefit from self-assessment.”
Some 7/4/13 Comments

• Is there any real evidence that psychiatrists get worse with time? If so, then jr. ones should supervise their seniors.

• Why was this done so secretively that almost none of the APA leadership—and virtually no-one in the Assembly—knew about it? If there really is a problem with psychiatrists practicing worse with time, the APA should have been working on it.

• If MOC is a good idea, why do the state licensing boards and the Federal government believe they need to threaten to impose it on MD’s, who are overwhelmingly against it? Who will replace those who decide to “opt out”, particularly in the face of dramatic shortages of MD’s (especially psychiatrists)?
Some More 7/4/13 Comments

• If the American Board of Psychiatry & Neurology has been so concerned about this, why does it never contact its diplomates? Does it have any idea of what efforts I have actually made to keep up?

• Where are practitioners going to find the time to do MOC, particularly if they have sub-specialty certificates?
Some Problems with Education

• No-one can be sure what psychiatrists will need to know even a few years post-training. The current rate of change is likely to accelerate. How can we train psychiatrists to practice 40 years from now?

• What is the value of learning facts when even now one has a computer on one’s belt? What will this access to knowledge be like 40 years from now?
Some Conclusions

• Something must be very wrong if people dedicated to their profession get worse with time. Are many psychiatrists indeed “not proficient at self-reflection”? Is this an overly costly “solution in search of a problem”?

• Is it possible that practitioners just do their work differently, rather than worse, than academics?

• Could this be the final battle in the longstanding war between “town” and “gown”?
Questions? Comments?