A national voice for psychiatry in Canada was realized in the formation of the Canadian Psychiatric Association (CPA) in 1951. The CPA was instrumental in advocating for psychiatric training to be university-based and for the development of training in general hospital psychiatric units. It follows that these training approaches would more closely reflect the emerging realities of the practice of psychiatry. The CPA has remained quite active in training issues and has provided a series of position papers relevant to psychiatric training through its Standing Committee on Education. One major CPA issue was the need to provide a forum for CPA members who had an interest in subspecialty areas. This led to the creation of three formally constituted academies of subspecialized areas of practice in psychiatry. These areas of practice are child and adolescent psychiatry, geriatric psychiatry and psychiatry and the law. They make up the Council of Academies, whose chair sits on the CPA Board of Directors. Two other organized subspecialized areas—neuropsychopharmacology and psychiatric epidemiology—have been more loosely affiliated with the CPA and with other related organizations.

In a letter dated February 25, 1999, Dr. Pierre Beauséjour, chair of the CPA Board of Directors, wrote to Dr. Richard B. Baltzan, the president of the Royal College of Physicians and Surgeons of Canada (RCPSC), and stated, “As you know psychiatry is one of the largest practice areas and yet it has no formerly recognized areas of subspecialization. We rigorously reviewed and debated the need, and the most appropriate mechanisms, to recognize subspecialties within psychiatry so as to respond to evolving scopes of practice while ensuring these remain rooted in the core specialty of psychiatry, with a view to retaining a unified specialty. As a result of this debate in 1995, the CPA firmly resolved to support the formal establishment of subspecialized practice areas through accreditation without examination. Subsequently, we set up our own process to review applications. This concluded with the CPA’s January 1996 request for recognition of child psychiatry, geriatric psychiatry and psychiatry and the law as official subspecialized areas of practice within the specialty of psychiatry.”

An exchange of letters occurred, as well as a meeting between the CPA leadership and the RCPSC Committee on Specialties. The documentation from the CPA to the RCPSC pointed out that subspecialization has been a fact of practice within psychiatry since the 1950s, with child and adolescent psychiatry leading the way, followed by forensic psychiatry and geriatric psychiatry. Those individuals seeking credentialing in these specialized areas of practice would seek certification through relevant organizations in the United States. Some psychiatry departments in Canada began to develop specialized training objectives in each of these areas, supported by the granting of a diploma or certificate by the department or by the university.

In the year 2000, the RCPSC Committee on Specialties reopened a debate on subspecialization in response to ongoing lobbying from internal medicine. As a result, the RCPSC produced a discussion paper entitled “The Medical Specialty Stream Model”(1). This document was forwarded to the Specialty Committee in Psychiatry with a request that it provide a proposal that would comply with the principles outlined in the discussion paper. This was added as a priority item on the Specialty Committee’s agenda, and a proposal was developed in November 2001 and circulated to all program directors for comments. Notably, at that time, we were still using the phrase “added competencies” to describe subspecialization.

Interestingly, the Specialty Committee was, at that time, in the process of overseeing three major developments affecting postgraduate education. These developments finalized the reciprocity agreement with the American Board of Psychiatry and Neurology, the rewriting of the training objectives in psychiatry (aligned to the CanMed’s competency roles) and the reorganization of the certification
examination. The Specialty Committee was also guiding the development of the new Final Intraining Evaluation Report (FITER), which will be introduced for the next certification examinations in 2003.

In the mid 1990s, the Specialty Committee became concerned about the increasing number of postgraduate programs in psychiatry receiving provisional approval by the RCPSC Accreditation Committee. The issue of safety in emergency departments emerged as one of the common reasons for the granting of provisional approval. The Specialty Committee met with the Chair of the Accreditation Committee, in an attempt to improve the accreditation process in psychiatry. As a result of these developments, the CPA Standing Committee on Education joined with the Specialty Committee to create a national forum on postgraduate education. Postgraduate education in psychiatry was facing significant challenges that were, in part, systemic. Their concerns therefore were communicated to the RCPSC and to all the deans of medicine. Readers requiring additional information on these developments are referred to a chapter on postgraduate education in the CPA Publication Psychiatry in Canada: 50 years (1951 to 2001) (2), as well as to Dr. John Leverette’s paper on subspecialization entitled “Another Window of Opportunity, But At What Cost?” (3). Simultaneously, an editorial in the CPA Bulletin, by Dr. George Awad, focused on the issue of subspecialization (4). In addition, Dr. Ellen Margolese, a resident in psychiatry at the University of Toronto, wrote an article on training issues entitled “The End of General Psychiatry?” (5). This article referred to the debate on specialization.

Important for purposes of the discussion that is now ongoing with respect to the Primary Specialty Model, the following three paragraphs include definitions for the terms “core training,” “specialty” and “subspecialty.”

“Core training,” as defined by the RCPSC, is the initial period of postgraduate training required to acquire the competencies underlying the basics to the practice of the specialty and is preparatory to further training in a specialty.

“Specialty” is defined as a broad-based body of knowledge that is relevant in both community and tertiary settings and is a foundation for additional competencies (subspecialties). Specialties must be able to produce a valid and reliable examination that leads to certification by the RCPSC. Training that leads to specialty certification can begin after successful completion of a medical degree. Specialty training may involve a period of core training prior to, or concurrent with, the completion of specialty training.

“Subspecialty” is defined as a body of knowledge and identifiable competencies that build upon the broad-based body of knowledge defined in a specialty. There must be evidence of societal need for the subspecialty to justify the development of and support for a RCPSC-accredited training program. Successful completion of a subspecialty requires certification by examination in one of the primary specialties and the successful completion of a subspecialty training program. Subspecialty training must be at least one year in duration, can only be entered in the final year of primary specialty training and may be evaluated with or without an RCPSC examination.

To proceed with developing a proposal for submission to the Committee on Specialties, the Specialty Committee partnered with the CPA Standing Committee on Education and invited input from a wide variety of stakeholders. The CPA generously agreed to provide staff support for this initiative.

Three teleconferences or meetings have occurred to date. First, a teleconference was held on March 20, 2002, with the chairs of the three academies at the CPA and with the chair of the CPA Board. At that meeting, members determined that a further meeting should be held with a wider group of stakeholders and noted a need to develop a stream in adult psychiatry. Second, a special SEARCH meeting, sponsored by the CPA, on the Primary Specialty Model was held on April 19, 2002, in Ottawa, Ontario.

The following lists the attendees and the constituencies they represent:

Dr. Jeff Waldeman, Coordinators of Postgraduate Education (COPE); member-in-training representative
Dr. Aidan Stokes, president, Canadian Academy of Child Psychiatry (CACP)
Dr. Emmanuel Persad, chair, RCPSC Specialty Committee in Psychiatry; co-chair, SEARCH meeting
Dr. Richard Swinson, RCPSC Specialty Committee; Association of Chairs of Psychiatry in Canada (ACPC)
Dr. Simon Davidson, past chair, CPA Council of Academies; past president, CACP
Dr. Donald Addington, chair, ACPC
Dr. Dominique Bourget, chair, CPA Council of Academies; president, Canadian Academy of Psychiatry and the Law
Dr. John Leverette, chair, CPA Standing Committee on Education and Specialty Committee; co-chair, special SEARCH meeting
Dr. Luc Morin, president-elect, CACP
Dr. Michael Myers, CPA representative, the Executive Committee; past president, CPA

Important for purposes of the discussion that is now ongoing with respect to the Primary Specialty Model, the following three paragraphs include definitions for the terms “core training,” “specialty” and “subspecialty.”

“Core training,” as defined by the RCPSC, is the initial period of postgraduate training required to acquire the competencies underlying the basics to the practice of the specialty and is preparatory to further training in a specialty.

“Specialty” is defined as a broad-based body of knowledge that is relevant in both community and tertiary settings and is a foundation for additional competencies (subspecialties). Specialties must be able to produce a valid and reliable examination that leads to certification by the RCPSC. Training that leads to specialty certification can begin after successful completion of a medical degree. Specialty training may involve a period of core training prior to, or concurrent with, the completion of specialty training.

“Subspecialty” is defined as a body of knowledge and identifiable competencies that build upon the broad-based body of knowledge defined in a specialty. There must be evidence of societal need for the subspecialty to justify the development of and support for a RCPSC-accredited training program. Successful completion of a subspecialty requires certification by examination in one of the primary specialties and the successful completion of a subspecialty training program. Subspecialty training must be at least one year in duration, can only be entered in the final year of primary specialty training and may be evaluated with or without an RCPSC examination.

To proceed with developing a proposal for submission to the Committee on Specialties, the Specialty Committee partnered with the CPA Standing Committee on Education and invited input from a wide variety of stakeholders. The CPA generously agreed to provide staff support for this initiative.

Three teleconferences or meetings have occurred to date. First, a teleconference was held on March 20, 2002, with the chairs of the three academies at the CPA and with the chair of the CPA Board. At that meeting, members determined that a further meeting should be held with a wider group of stakeholders and noted a need to develop a stream in adult psychiatry. Second, a special SEARCH meeting, sponsored by the CPA, on the Primary Specialty Model was held on April 19, 2002, in Ottawa, Ontario.

The following lists the attendees and the constituencies they represent:

Dr. Jeff Waldeman, Coordinators of Postgraduate Education (COPE); member-in-training representative
Dr. Aidan Stokes, president, Canadian Academy of Child Psychiatry (CACP)
Dr. Emmanuel Persad, chair, RCPSC Specialty Committee in Psychiatry; co-chair, SEARCH meeting
Dr. Richard Swinson, RCPSC Specialty Committee; Association of Chairs of Psychiatry in Canada (ACPC)
Dr. Simon Davidson, past chair, CPA Council of Academies; past president, CACP
Dr. Donald Addington, chair, ACPC
Dr. Dominique Bourget, chair, CPA Council of Academies; president, Canadian Academy of Psychiatry and the Law
Dr. John Leverette, chair, CPA Standing Committee on Education and Specialty Committee; co-chair, special SEARCH meeting
Dr. Luc Morin, president-elect, CACP
Dr. Michael Myers, CPA representative, the Executive Committee; past president, CPA
Dr. Marie-France Tourigny-Rivard, past president, Canadian Academy of Geriatric Psychiatry
Dr. Renee Roy, co-chair, COPE
Dr. David Conn (by teleconference), president, Canadian Academy of Geriatric Psychiatry
Ms. Francine Knoops, CPA staff

The minutes of that meeting were circulated to all relevant stakeholders.

Third, attendees discussed the matter of subspecialization at the COPE meeting, which was held on April 20, 2002. The minutes of that meeting confirmed the concerns expressed earlier with respect to the impact of moving forward with a Primary Specialty Model in psychiatry. Concerns included the format and timing of examinations, the increasing burden on residents to make premature decision about career choices, the effect of the Primary Specialty Model on flexibility and elective time and the increased challenges for smaller programs—especially in recruitment and retention of faculty.

These issues became the subject of teleconferences on June 20 and July 18, 2002, under the auspices of the newly formed CPA working group on a national strategy for postgraduate education. Represented at these teleconferences were all the organizations present at the April 19, 2002, meeting in Ottawa, with additional representation from COPE (Dr. Lawrence Martin and Dr. Candice Cattan). The minutes of those teleconferences were circulated to all program directors and to members of the Specialty Committee.

At the teleconference on July 18, 2002, participants agreed to devote attention to developing the principles for core training. Dr. John Leverette agreed to provide a document on these principles, which was the subject of a teleconference on August 20, 2002. The minutes, along with a revised document on core training, were provided to all program directors.

Following discussion about applying the Internal Medicine Primary Specialty Model to psychiatry, participants suggested that, in the ongoing discussion on subspecialization, attention should be paid to the following five points:

1. The philosophy of training in psychiatry should ensure the provision of training opportunities for the sophisticated generalist.

2. The PGY1 year should offer both flexibility and the assurance of acquiring those skills necessary to consolidate the trainee’s identity as a physician and the ability to interact with other medical specialties. Further, up to six months of the PGY1 year could be devoted to psychiatry without adverse effect on the core training.

3. It is intended that the completion of training for the core and for the Primary Specialty Model would be no longer than five years. However, additional training for the completion of the Primary Specialty Model or for subspecialization is an option.

4. A written examination on the principles of psychiatry should take place at the conclusion of the core training.

5. Residents will complete exit or credentialing examinations at the end of training in the primary specialty. The format and timing of these examinations will be developed in consultation with the Evaluation Committee at the RCPSC. Suggestion for changes in the psychiatry examinations were to be considered.

At this point, the CPA academies are prepared to provide core training objectives for the general psychiatrist with the dual purpose of consolidating general psychiatry practice across the lifespan and developing a “made-in-psychiatry model” for subspecialty recognition by the RCPSC.

The debate on subspecialization will continue; as this article is going to press, the results of the discussion on this topic during the CPA meeting in Banff are not yet in hand.

References


