Teaching the Physician-Manager Role to Psychiatric Residents: Development and Implementation of a Pilot Curriculum

Sanjeev Sockalingam, M.D., F.R.C.P.C.

Objective: The authors describe a pilot physician-manager curriculum designed to address the learning needs of psychiatric residents in administrative psychiatry and health systems.

Methods: The pilot curriculum includes a junior and a senior toolkit of four workshops each. The junior toolkit introduces postgraduate-year two (PGY-2) residents to the principles of teamwork, conflict resolution, quality improvement, and program planning and evaluation. The senior toolkit exposes PGY-4 residents to leadership and change management, organizational structures, mental health and addictions reform, and self and career development. Following curriculum implementation at the University of Toronto, residents rated the importance and clinical relevance of curriculum objectives and commented on the strengths and weaknesses of the workshops and areas needing improvement.

Results: The pilot curriculum was successfully introduced at the University of Toronto in 2006. Residents rated the curriculum very highly and commented that interactive learning and contextually relevant topics are essential in meeting their needs.

Conclusion: It is possible to successfully introduce a physician-manager curriculum early during psychiatric residency training, to match the specific needs of clinical rotations. Interactive techniques and clinical illustrations may be crucial in facilitating teaching and learning the physician-manager role. The authors discuss barriers, facilitators, and critical success factors in implementing such a curriculum.

In Canada, the Royal College of Physicians and Surgeons (RCPSC) has adopted a new framework of core competencies for all specialists, called the CanMEDS roles (1). The CanMEDS framework includes the roles of medical expert, professional, communicator, scholar, collaborator, advocate, and manager.

The physician-manager role has been identified as one of the most difficult to integrate into postgraduate medical education (2). The RCPSC (1) has defined this role as encompassing four key competencies:

1. To participate in activities that contribute to the effectiveness of their health care organizations and systems.
2. To manage their practice and careers effectively.
3. To allocate finite health care resources appropriately.
4. To participate in administrative and leadership roles.

Within psychiatry, the concept of “physician-manager” emerged during the past 20 years, in the context of an increasingly complex mental health care environment (3). As managers, practicing psychiatrists feel deficient in several administrative knowledge and skill areas (4–6). Similarly, surveyed psychiatric residents feel unprepared in several system-based roles, and more than one-third of residents in our program feel unprepared to fulfill 12 of the 23 CanMEDS-defined competencies, notably in the manager, scholar, and advocate roles (7).

The Canadian Psychiatric Association has acknowledged these gaps in training and endorsed the importance of the physician-manager role in a position paper, highlighting the need for specific residency training (8). To date, however, the literature suggests a generalized lack of structured residency training in administration in Canada (8, Lieff S, personal communication, 2005). In the United States, where the Accreditation Council for Graduate Medical Education (ACGME) recently launched a training framework of six competencies, including that of expertise in systems-based practice (9), there has been a
longer tradition of teaching and learning administrative psychiatry (10). Yu-Chin and Talbott (11, 12) have described administrative psychiatry curricula for senior residents, using both didactic and experiential learning. Despite these isolated efforts, because most training programs have only recently started to focus on physician-manager education and development, there is considerable work to be done to develop teaching programs that are contextually relevant to psychiatric residents’ learning needs.

This article describes the development and implementation of a pilot physician-manager curriculum at the University of Toronto to address gaps in physician-manager training at our institution. Resident feedback will be reviewed and recommendations for further development in this important area will be discussed.

Methods

Setting

The University of Toronto offers the largest psychiatric residency program in Canada, with over 700 faculty and 124 residents training in one of the seven main affiliated sites. Until 2006, there had been no formal training in the role of the physician-manager. Few among the faculty have formal management or leadership training.

Needs Assessment

Psychiatric residents’ perceived needs and teaching preferences were central to our curriculum development efforts (13). A survey of University of Toronto psychiatric residents was undertaken in 2005 to identify perceived gaps in administrative training and educational preferences. Residents identified gaps in several areas, including program evaluation, leadership and change management, physician compensation, and self and career development (13). With regard to educational preferences, 79.6% of residents favored workshops (n = 39), 73.5% small groups (n = 36), 61.2% mentorship (n = 30), and 57.1% lecture formats (n = 28), delivered at a centralized location (13).

Curriculum Development

Curriculum development was informed by the RCPSC competency framework (1), review of other curricula (Waddell C, personal communication, 2005, 11, 12, 14), and perceived needs of residents (12). A 10-member committee, consisting of our project team, one additional resident representative, administrators, and content and education experts, reviewed the needs assessment findings and guided the development of a pilot curriculum framework, including suggested learning objectives and teaching methods. The selected topic areas included teamwork, conflict resolution, quality improvement, program planning and evaluation, leadership and change management, mental health reform, organizational structures, and self and career development (Table 1). In the absence of any consensus in the literature regarding length or structure for such a curriculum (11, 12, 14), we opted for a junior and a senior toolkit, consisting of four half-day workshops each. The class sizes were a maximum of 25 participants to allow for group interaction. The choice of topics for each toolkit was based on rotation-specific needs to make learning contextual and to match residents’ stage of professional identity development. Workshop leaders were encouraged to use as much interactive teaching as possible (15–18).

Curriculum Implementation

Four junior workshops were offered to PGY-2 (n = 24) and four senior workshops to PGY-4 (n = 28) residents, as a mandatory part of training, between December 2006 and May 2007. Each workshop followed the same general format of didactic teaching and small groups or other interactive techniques. The sessions were augmented with handouts and slides. The workshop leaders provided references and reference materials to the residents for use in their daily practice. Clinical illustrations were used throughout.

Interactive techniques included buzz groups, brainstorming, think-pair-share discussions, a debate, and clinical case studies (17, 18). The educational strategies used in each workshop and a list of all readings are available upon request. The interactive components of selected workshops are further detailed below in following sections.

Case Studies. Case studies focused on clinical and educational challenges faced by residents at our institution and were developed for the workshops on quality improvement, program planning and evaluation, leadership and change management, and organizational structures in mental health.

Think-Pair-Share. In advance of the workshop on self and career development, residents were asked to prepare a framework of their autobiography as it would be written at the time of their retirement. During the workshop they engaged in storytelling and interviewing colleagues about their careers, which they then shared with the group.

Buzz Groups. The buzz groups technique (17) was utilized in three of the workshops: teamwork, conflict reso-