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Perspective

Optimizing Fit: Targeting a Residency Psychiatry Consultation-Liaison Rotation to Various Levels of Training

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Background: *Determining the optimal timing and structure for a core residency rotation in consultation-liaison psychiatry (CLP) remains a key challenge for program directors and rotation leaders. Previous surveys have been conducted regarding these questions, and guidelines from national organizations have been issued, but practices remain varied among institutions.* **Methods:** *We conducted a narrative review of the literature related to the timing of CLP rotations and generated consensus recommendations based on our experience as program directors, rotation leaders, and residents.* **Results:** *Explicit goals of CLP training in residency include identifying and treating psychiatric manifestation of medical illness and communicating effectively with primary teams. Implicit goals of training may includeconflict management, limit setting, and "thinking dirty."* **Discussion:** *Although CLP rotations earlier in residency often create a better fit within the overarching curriculum and allow for generating early interest in the field, significant amounts of supervision are required, and consultees may look to attendings as the primary consultant. Conversely, while later rotations are sometimes challenging to structure with other outpatient responsibilities, they allow for greater autonomy and may map better onto the informal curriculum. A hybrid model, with training spread across multiple years, is another approach that may mitigate some of the disadvantages of confining consultation-liaison training to a single year. Compelling arguments can be made for placing the core CLP rotation in postgraduate year 2 or 3 or using a hybrid model. Regardless of placement, program directors and rotation leaders should be mindful of tailoring the rotation to the trainees' developmental stage.*

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Key words: consultation-liaison, residency, training, hidden curriculum.

INTRODUCTION

When and how to expose residents to consultation-liaison (C-L) psychiatry experiences remains a key issue in residency training. Training programs continue to grapple with questions regarding the optimal year of training for C-L rotations, the duration, the types of patients seen, the setting, and the integration of C-L with other training requirements. Some guidance in this domain does exist from national and international organizations. The Academy of Psychosomatic Medicine (now the Academy of Consultation-Liaison Psychiatry [ACLP]) issued

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recommendations for residency training in C-L psychiatry in 1996[1] and again in 2014,[2] and the European Association of Consultation-Liaison Psychiatry and Psychosomatics published guidelines in 2007.[3] All concluded that C-L training was ideally placed in the second half of residency and recommended 3–6 months of full-time equivalent training in C-L, with a focus on inpatient work.

Despite these guidelines, national practices remain highly variable. A 2013 national survey of residencies found that 54% of programs had residents spending 3–6 months on C-L rotations, whereas 42% of programs had less than 3 months and only 4% of programs had more than 6 months.[4] Furthermore, 54% of programs included C-L rotations training in multiple years, while 34% had C-L exclusively in postgraduate year 2 (PGY-2) and 11% exclusively in PGY3. When residents were on service, 42% of programs had them performing C-L-related duties less than full time. At the time, 30% of programs included an ambulatory component to the C-L experience.

The varied training experiences throughout the country likely speak to the challenges of structuring a rotation in the context of the competing demands of the overall residency experience. Accordingly, we aimed to outline recommendations for approaches to structuring a C-L experience in various years based on the literature and our collective experience training in psychiatry, supervising residents on rotations, directing C-L services, and running residency programs. We reviewed the small literature base, discussed as a group, and also used feedback and discussion generated by our presentation of a workshop on this topic at the ACLP 2019 Annual Meeting. In doing this, we focused on better understanding the explicit and implicit goals of C-L training in residency. We also hoped to provide an analysis of the relative advantages and disadvantages to certain approaches, in an effort to help program directors determine which strategy might best fit in their own curriculum. While we used the 2014 ACLP training recommendations and other prior surveys as a point of departure, our efforts are focused primarily on providing more granular, practical advice for structuring rotations than is present in those articles.

WHAT ARE THE EXPLICIT GOALS OF C-L TRAINING IN RESIDENCY?

The specific content of the C-L rotation curriculum is left broad in the Accreditation Council for Graduate Medical Education (ACGME) program requirements. The requirements are listed under Section IV.a: Patient Care and Procedural Skills and Section IV.A.5.d: Interpersonal and Communication Skills. The ACGME requires that residents must demonstrate competence in providing consultation to a variety of medical and surgical settings. Also, they are expected to "act in a consultative role" to other physicians and health professionals and to communicate effectively with those and other professionals. The ACGME is currently going through a process of focused revisions of the common program requirements, with a plan for the adoption of the new requirements this year. Although some substantial changes will affect psychiatric training, the curriculum for the C-L training remains largely unchanged in the current draft of the new requirements.

In addition to program requirements, the ACGME also defines "milestones," which are intended to be used as part of the semiannual evaluation of resident progress through training.[5] The intention is to move from a binary process of evaluation to a developmental approach in which residents progress at different rates throughout their years of training. The ACGME milestones for residency training in psychiatry include several competencies specific to C-L psychiatry. Residents are expected to demonstrate "sufficient knowledge to identify and treat common psychiatric manifestations of medical illness (KM2 3.3/C)" and should aspire to identify and treat "uncommon psychiatric conditions in medical illness (MK2 5.2/C)".[6] In the realm of systems-based practice, residents should be able to clarify the consult question (SBP4 2.3/C) and manage complicated and challenging consultation requests (SBP4 4.2/C). They also should understand models of consultation and integrative care. Residents should also demonstrate basic interpersonal communication skills with consultees, such as sustaining working relationships in the face of conflict (ICS1 3.2/B) and developing approaches to managing difficult communications (ICS1 5.2/A, B). In the revised version of the milestones (Milestones 2.0) which are being planned for use in 2021, the milestones for providing consultation range from the task of respectfully receiving a consult and clearly and concisely responding to more complex tasks such as helping the consulting team identify unrecognized clinical issues and managing challenging requests.[7] At the highest level, the resident leads a team, although it is understood that not all residents may obtain this level of expertise.

The 1996 ACLP recommendations suggest that the core goal of a resident rotation in C-L psychiatry should be to develop competence in working with patients who have a psychiatric presentation in a medical setting.[1] Specific skills for residents to master include engaging effectively in consultation and liaison processes, performing appropriate psychiatric evaluations of medically ill patients, and developing suitable therapeutic interventions. In the 2014 update of this recommendation, the ACLP reorganized the goals according to the ACGME core competencies.[2] The goals are greatly broadened and include patient care issues such as performing an appropriate assessment in the medical hospital setting and monitoring their course throughout hospitalization. The medical knowledge goals have been broadened as well and include understanding both general psychiatric illness in the medical setting (e.g., depression and anxiety), psychiatric illnesses that manifest primarily in medical settings (e.g., somatic symptom disorder), and psychiatric manifestations of medical or surgical disorders (e.g., delirium).

Finally, rotation goals for a C-L experience often focus on practical skills that residents may learn during that experience. Residents are expected to develop examination skills that allow them to interview patients in medical settings, develop an alliance with patients relatively quickly, and evaluate medically ill patients for psychiatric symptoms and cognitive ability. Communication skills, such as learning to determine the consultee's question and communicating effectively with primary teams, are often highlighted. Documentation is another commonly emphasized area, as residents are expected to learn how to create a consultation note that is comprehensive enough to delineate the patient's medical and psychiatric histories but concise and clear enough to be useful to the consultee in terms of conveying diagnostic impressions and treatment recommendations. Residents are also often expected to develop important leadership skills by helping to direct the hospital course of patients under their care.

WHAT IS THE HIDDEN CURRICULUM FOR RESIDENTS ON C-L?

Psychiatrist Ed Hundert and medical sociologist Frederic Hafferty were some of the early authors to apply the terms "hidden curriculum" and "informal curriculum" to medical education. In contrast to the formal curriculum, which refers to the stated curriculum which is formally offered and endorsed at an institution, the term informal curriculum has been used to describe the ad hoc learning that happens outside of the classroom, during interpersonal interactions between faculty and students. The broader term, hidden curriculum, has been used to describe the attitudes and values conveyed implicitly via an institution's culture, practices, and structure.[8–11] While Hundert and Hafferty were primarily interested in using these terms pertaining to bioethics education and the moral and professional development of medical students, they can easily be applied to other aspects of training.

We use the term hidden curriculum here to refer to skills and attitudes acquired by residents during a rotation that are not explicitly stated as goals or objectives of the experience but often end up being more formative and important to one's identity as a physician than do the more traditional goals outlined previously. On the C-L psychiatry service, these values and attitudes are often inferred from the behavior of individual faculty or senior trainee role models as well as from observing group processes during team rounds or consultant/consultee interactions, chart notes (inclusions vs. omissions, tone), how and which expectations are set by supervisors at the start of the rotation, and the degree of adherence to consultant recommendations. The argument can be made that the hidden curriculum strongly influences professional identity development of trainees and thus has a more powerful influence than the formal curriculum.

One of the most important skills developed by residents on the C-L psychiatry service is conflict management. Many residents learn quickly that people are not always happy with the psychiatric consultant. Patients may be upset because psychiatry is involved in the first place or may feel that the consultant is setting unfair boundaries and limits. Primary teams may be frustrated that the consultant cannot cure the patient or that the patient remains on their service despite the involvement of the consultant. Other teams may feel as though the consultant is stepping on their toes or disputing their recommendations. To be successful consultants, residents on C-L rotations must learn to tolerate conflict and to move beyond their own countertransference toward patients and potential negative affect toward others involved in the care. They must monitor their own affect while also validating the emotional response of the consultee. They learn to set

expectations proactively with primary teams at the time of the consult so that recommendations do not ultimately feel anticlimactic. For example, in the case of the patient with functional neurologic symptoms, the resident learns to prime the consultee to not expect a bedside cure and therefore mitigates a negative reaction when the ultimate recommendation is to pursue outpatient psychotherapy. Learning to manage conflicts and set expectations are useful skills residents can use in future work with patients in various settings.

Related to conflict management are the important skills of limit setting and negotiation of ownership. Issues of ownership are a frequent source of conflict on the service, such as the case of the patient with active psychiatric illness whose medical needs cannot be managed on the inpatient psychiatric service or the delirious patient with behavioral dysregulation. Trainees learn to share responsibility for the care of such complex patients while at the same time setting limits to channel ownership back to the consultee. The C-L psychiatry trainee also learns quickly the importance of flexibly defining one's limits and usefulness for each unique case, either expanding one's role to ensure quality care when asked an overly narrow question or restricting one's focus or activities if a consultee's expectations are excessive or unreasonable.[12] This process could involve compromise and creative thinking but should not involve acquiescence to inappropriate treatment or requests.[13] One of the major challenges for many residents on the consult service around defining limits is learning when and how to sign off on patients. Such situations are often highly laden with affect, and residents must ensure that the decision to sign off is not driven by anger at the patient or consultee. At the same time, residents must be taught to maintain awareness of situations where continuing to remain involved may be detrimental to the patient's care.

Through observation of faculty as they interview patients and attentiveness to group discussion during rounds, residents learn to "think dirty,"—that is, to recognize hidden motivations for symptoms or behaviors and to better regulate their own emotional responses to patients who engage in such behaviors.[14] Attendings often model curiosity for an individual patient's motives for deception and a skillful interview style which includes strategies for confrontation of the patient if appropriate. C-L psychiatry trainees learn that shame and fear are powerful nonpathologic reasons why a patient might deceive the provider and that finding empathy for the patient and seeking truth without embarrassing the patient are important clinical goals. If a therapeutic discharge of the deceptive patient is needed, the resident may be able to observe the attending facilitate this discharge or may have the opportunity to take the lead under direct attending supervision.

Outside of conflict management and negotiation skills, the C-L psychiatry service can provide trainees with the opportunity to learn important and timely lessons about resource allocation, health care disparities, cultural competency, and unconscious bias. Trainees may be called upon to assess psychosocial clearance for transplant or bariatric surgery or to comment upon candidacy for cardiac valve replacement surgery in a patient with psychosocial risk factors, such as active substance use or prior psychiatric treatment. C-L psychiatrists may also be part of discussions about allocation of hospital resources such as intensive care unit beds or ventilators, as occurred in some hospitals during the coronavirus disease 2019 (COVID-19) pandemic. In such cases of limited resources and concern for poor outcomes, trainees will learn to weigh the ethical principle of social justice with the need to treat all patients equitably, while at the same time avoiding imposing personal or consultee moral values. In the process, trainees may observe overt or unconscious biases against vulnerable patients with chronic psychiatric and substance use disorders or suboptimal socioeconomic situations. Such biases risk contributing to health care disparities in the provision of care for such individuals, such as lack of access to routine cancer screening, misattribution of symptoms to mental illness, inadequate pain control, and delays to surgical interventions such as cardiac stenting and bypass grafting.[15,16] The psychiatric consultant can serve important advocacy and educational roles, learning to challenge lowered expectations and promoting integrated care models to facilitate access to standard of care.

C-L psychiatrists are also unique witnesses to the impact of cultural factors on clinician bias as well as on an individual patient's presentation in the medical-surgical setting. The need to train physicians to provide culturally respectful and antiracist health care for a diverse patient population has become an issue of increasing importance, including for C-L psychiatrists who are often called upon to assess patients with poor treatment adherence, difficult behaviors, and negative health outcomes. Trinh et al. (2020)[17] suggested training the "culturally-humble C-L psychiatrist" to use

TABLE 1. Opportunities and Challenges for C-L Training in Each Year

Year of residency	Opportunities	Challenges
PGY-1	Logistically, fits well with block schedule	Residents lack necessary psychiatric knowledge, including psychotherapy skill and understanding of what can be managed as an outpatient
	Emphasizes interrelationship between psychiatry and the rest of medicine	Knowledge of medical aspects of cases may be limited
	Preparation for on-call emergency consults	Not ready for consultant role; consultees may ignore recommendations
	May generate early interest in the subspecialty	
PGY-2	Consistent with PGY-2 focus on acute psychiatry	Residents still require significant amount of supervision and teaching (group dynamics, psychodynamic principles)
	Fewer difficulties scheduling C-L as a full-time rotation	Consultees (and the resident) may still look to the supervising psychiatrist as the primary consultant
	More likely to view C-L as a core psychiatry rotation	
	Residents have usually mastered sufficient psychiatric clinical skills and knowledge to be capable of increased autonomy, consultant role	
	Required rotations in medicine and neurology completed	
	Sufficient knowledge and skills to supervise third year medical students	
	Still early enough to promote career interest	
PGY-3	Allows residents to function more autonomously	Logistical challenges balancing with outpatient continuity clinic; issues of ownership
	Solid foundation of psychiatric, neurologic, and medical knowledge, as well as experience with addictions, psychodynamic psychotherapy, cognitive behavioral therapy, and group therapy.	Competing demands for residents
		Fewer opportunities to explore electives
		May be too late to change career trajectory
	C-L rotation as a capstone experience	
	Residents may serve as team leaders and develop autonomy in navigating complex team dynamics.	
	More opportunity and time for scholarly pursuits within C-L	
	Services that rely heavily on outpatient work may be particularly tailored to the PGY-3 y	
PGY-4	Opportunity for chief or elective experiences	May limit ability to pursue C-L fellowships
	Promotes transition to attendinghood	May reduce the number of residents viewing C-L psychiatry as a viable career option
	Recommendations made based on experience	
	Promotes the subspecialty as being a core component of the identity of a psychiatrist	Burdensome to have required rotation in PGY-4 y
		May reduce electives and interfere with other duties
	Allows trainees to begin to develop a specific area of expertise	
	More opportunity and time for scholarly pursuits within C-L	
	Consolidate learning and reinforce principles	

These recommendations assume a typical residency curriculum structure, including the longitudinal outpatient year in PGY-3.
C-L = consultation-liaison; PGY = postgraduate year.

an open-ended, empathic approach to explore the interplay of various dimensions of a patient's cultural identity to better understand the patient's illness experience. This process should also include examination of the impact of one's own cultural identity on the provider-patient relationship as well as the identification of the role of social context and other structural factors in shaping access to care and health outcomes. The C-L psychiatry trainee can learn to use his or her privileged position as a respected consultant to model for other health care providers a cultural humble stance that incorporates an understanding of individual and systemic cultural factors into the clinical formulation.

TIMING OF C-L DURING RESIDENCY

Considering the explicit and implicit goals of C-L training in residency, there are obvious advantages and disadvantages to placing the C-L rotation in each PGY. Each year of training presents different challenges in scheduling the C-L rotation and managing competing demands from other clinical rotations. In addition, the developmental tasks for residents change as they progress through residency training. Beginning residents are transitioning from the role of medical student to resident, are capable of limited autonomy, and need a significant amount of supervision. As they move

through training, residents are capable of increasing levels of autonomy and less direct supervision. This balance between autonomy and supervision may define their role and experience on the C-L service. It should be noted that certain developmental stages and tasks are not necessarily limited to specific training years and different residents progress at different paces, cautioning against a rigid interpretation of the recommendations. A summary of opportunities and challenges of C-L training in each year can be found in Table 1.

PGY-1

Although a minority of programs include some C-L training in the intern year, doing so can have several advantages. Most notably, it prepares residents well for later rotations, can have a profound impact on how they approach their work with patients, and can also lead to early interest in the subspecialty, potentially increasing the number of residents who choose to pursue a fellowship or career in C-L psychiatry.[18] On the other hand, PGY-1 residents are at the beginning of their learning curve. Interns typically lack the psychiatric knowledge required to independently evaluate complicated patients, develop a sophisticated formulation, or impart meaningful recommendations. Teaching needs to be focused on the basics of C-L psychiatry. Developmentally, residents may see themselves as assisting the C-L attending rather feeling ready to take on the role of consultant. This may result in consultees not feeling comfortable accepting advice from interns and possibly ignoring their recommendations. The attending psychiatrist needs to provide a significant amount of teaching, supervision, and direct patient care, usually serving as the *de facto* primary consultant.

PGY-2

PGY-2 is the most common year for residents to complete their C-L rotation (Heinrich, 2013).[4] By placing C-L psychiatry early in training alongside rotations in inpatient psychiatry and other subspecialty areas such as emergency psychiatry, addictions, geriatrics, and child and adolescent psychiatry, residents are more likely to view C-L psychiatry as a core psychiatry rotation, equating it with other subspecialties. Furthermore, the PGY-2 year is still early enough in training to have a profound effect on the residents' appreciation for working at the interface of psychiatry and medicine, to develop formative mentorship relationships, become involved in academic projects or cases that can be presented at national meetings, and promote interest C-L psychiatry as a career choice. Despite these advantages and despite being able to appreciate more detailed knowledge than interns, PGY-2 residents still require a significant amount of supervision and teaching. For example, PGY-2 residents have typically not yet developed an understanding of psychodynamic and group therapy principles which can be vital to formulating assessments and managing complex team dynamics as a consultant. Supervisors need to incorporate this teaching into the C-L rotation curriculum in addition to other topics. Consultees (and the resident) may still look to the supervising psychiatrist as the primary consultant, especially in complicated cases, but PGY-2 residents are developmentally ready to successfully take on this role with the support of their supervisor.

PGY-3

PGY-3 was previously a common time for C-L rotations, although there has been a trend toward earlier experiences in the last 2 decades.[4] C-L psychiatry in PGY-3 allows residents to serve as ambassadors for psychiatry in the hospital. The C-L rotation can serve as a capstone experience, pulling together various skills acquired during training. Because PGY3 is often primarily an outpatient year, however, logistical challenges can arise in trying to balance a clinically intense C-L rotation with an ongoing outpatient continuity clinic. Although a longitudinal C-L rotation could fit well into the structure of PGY-3, this makes it difficult to maintain continuity of care on an inpatient C-L service and issues of ownership arise. Adding a block C-L psychiatry experience creates competing demands for residents, even when efforts are made to protect certain days for outpatient work or for didactics. While such a structure may very well teach residents important time management skills and help them learn to effectively juggle multiple roles, specific issues may arise surrounding the scheduling of psychotherapy patients and outpatient supervision. Residents wanting to present at conferences or interviewing to fast-track into child fellowship may also have less flexibility given the clinical demands. Finally, residents who complete C-L rotations late in the PGY-3 year may have already committed to a different career trajectory, and the additional requirement may be perceived as burdensome.

TABLE 2. Recommendations for a C-L Rotation in Each Year of Training

Year of training for C-L rotation	Educational goals	Tips for rotation structure	Tips for teaching and supervision
PGY-1	Basics of psychiatric interview and diagnostic assessment Principles of ego-supportive psychotherapy Selection of appropriate psychotropic agent for the diagnosis Management of psychiatric emergencies: suicidality and agitation	If all C-L psychiatry happens in the intern year, may be helpful to have 1-month blocks, separated by some medicine, neurology and other psychiatry experience (e.g., 1 month in the first half of the year and 1 month in the second half) Rotations should be set up for high degree of supervision and modeling by the attending or fellow Consider team-based model which pairs the PGY-1 with a more senior resident or fellow	Attending should act as the primary consultant Interns may not be able to adequately supervise medical students on the rotation Interns may need assistance triaging consult requests Attending or senior resident/fellow may need to incorporate teaching core concepts of general psychiatry into the rotation before teaching more complex specialty material
PGY-2	Introduction of psychodynamic and group therapy principles Basics of liaison work Use of psychopharmacology in the medically ill	Contiguous blocks may be preferred over separated blocks to allow for growth and consolidation of skills Early PGY-2's may have significantly less psychiatry knowledge than late PGY-2's and therefore need more supervision Consider return to C-L psychiatry later in training (hybrid model) Consider team-based model which pairs PGY-2 with PGY-4 or C-L fellow PGY-2s will likely be off-service on post-call or didactic days and may need to leave early on call days	Residents should be encouraged to assume autonomy, although consultees may view attending as the primary consultant PGY-2s should have sufficient clinical and teaching skills to supervise clerkship medical students on rotations May need to incorporate teaching core concepts of general psychiatry, especially if early PGY-2s
PGY-3	Focus on the hidden curriculum, including team dynamics, "thinking dirty" and issues of ownership Incorporate psychodynamic and group psychotherapy principles Managing practice across settings (e.g., balancing outpatient and C-L responsibilities) Use an outpatient C-L experience to introduce concepts of psychotherapy in the medically ill, new models of collaborative and integrated care, and strategies for chronic disease management	Block rotation may be superior for education and training Block rotation likely requires "protected day" for resident to focus on outpatient work; this requires block rotation to be longer than 2 months (not 1.0 full-time equivalent) Shorter block rotations spaced throughout the year may help with balance of outpatient work but make education more challenging Longitudinal structure requires thoughtfulness about ownership and continuity of care on the service Outpatient C-L experiences may be optimal for longitudinal experience	Residents should function with greater autonomy, with attendings more in a back-up role Residents will need supervision on juggling multiple different clinical responsibilities and on providing an appropriate hand-off/sign-out on protected outpatient days An outpatient C-L experience provides opportunity for supervision on topics such as boundary setting, triaging new referrals, psychotherapy in the medically ill, working with multidisciplinary outpatient treatment team, collaborative and integrative models of care, and managing chronic medical and psychiatric conditions Consider scholarly opportunities, such as conference presentations or case reports
PGY-4	Opportunity for leadership of team Learning to supervise Increasing knowledge of C-L subspecialty areas	A longitudinal model may be a better fit for the elective schedule of most PGY-4's A PGY-4 rotation provides the opportunity for a C-L chief or subspecialty elective experience (e.g., transplant psychiatry, reproductive psychiatry)	Consider opportunities to expose residents to C-L scholarly work and national/regional meetings Seek out faculty who can provide C-L subspecialty area supervision Assist residents with fellowship planning Guide resident in teaching and supervising medical students or junior trainees Supervision should allow for graded independence

TABLE 2. (*Continued*)

Year of training for C-L rotation	Educational goals	Tips for rotation structure	Tips for teaching and supervision
Hybrid model	Consolidation of psychiatry learning across training years Learning to fill different roles: clinician, supervisor, administrator Applying common principles of C-L psychiatry across care settings: inpatient vs. outpatient, liaison vs. consultant, and so forth.	Consider opportunities for later-stage trainees to explore subspecialties within C-L and/or an outpatient C-L experience A C-L chiefship allows for development of leadership skills for residents planning to pursue fellowship	Trainees' responsibilities and roles should evolve over their experiences Senior residents with prior C-L experience may be particularly well prepared for supervisory or administrative roles If program resources are available, hybrid models may benefit from allowing returning residents to customize experiences to their interest (e.g., designing a customized liaison rotation to a service of interest)

These recommendations assume a typical residency curriculum structure, including the longitudinal outpatient year in PGY-3.
C-L = consultation-liaison; PGY = postgraduate year.

PGY-4

Many programs offer C-L experiences in the PGY-4 year, and there are several different models for this approach. Some programs offer a chief residency in C-L psychiatry, a role that tends to be largely focused on teaching and administration, in which the chief helps to oversee the rotation for junior residents and may take an active role in running rounds or staffing cases with backup attending supervision. Other programs may offer elective experiences, which could be inpatient, as in the case of a liaison rotation to a specific service, or outpatient, with collaborative care or colocated models. A very small number of programs have C-L psychiatry as a core experience in PGY-4, either analogous to the PGY-3 rotation or as an addition to an earlier rotation, in which all residents return to the service for a shorter period of time as PGY-4s.

Hybrid Approach

Another model is a hybrid approach spanning multiple years which spreads out C-L experiences. National survey data from psychiatry residency programs suggest that a slight majority (54%) of programs actually divide C-L training over several training years in some form.[4] While the years in which residents complete their C-L training vary, the most frequent multiyear configuration is a 2-year PGY-2/PGY-4 split, occurring in 33% of programs.[4] It should be noted, however, that it is not clear from the data how many of these programs include only nominal C-L experiences, such as occasional weekend call, in the PGY-4 year. Programs with formal didactic curricula in C-L psychiatry similarly tend to split these up over years of training.

The authors are aware of a number of models used to divide C-L training across residency years. A classic model is the "junior/senior" model, in which senior residents provide teaching and administrative support to junior residents on the service. While this is a familiar model in medical training across specialties, its success is contingent on having a number of residents assigned to C-L services concurrently. Survey data suggest that very few residencies have more than 2 residents assigned to the C-L service simultaneously, however. An alternative "inpatient/outpatient" model consists of having discrete inpatient and outpatient experiences across different training years, for example, completing inpatient C-L psychiatry during the PGY-2 year and outpatient collaborative care during the PGY-3 year. A sizable minority of programs have an outpatient component to residency training in C-L psychiatry, and these rotations tend to occur later in residency. Finally, the "general/subspecialty" model consists of junior residents completing training in general C-L psychiatry before later rotating in subspecialty C-L experiences, such as solid organ transplant or HIV psychiatry as senior residents.

There are a number of benefits to splitting C-L training across training years. Split training allows trainees to develop foundational skills earlier in training and consolidate them toward the end of training. Split training also mitigates many of the negative aspects of

condensing all training either early or late in residency; for example, it allows trainees to explore careers in C-L psychiatry early on but also allows them to integrate C-L experiences into their professional identity later in training. Furthermore, it creates opportunities for practicing C-L across roles and settings: inpatient vs. outpatient, embedded liaison vs. consultant, supervisor vs. front line clinician, and so forth. However, there are costs to splitting C-L training across years. Successful C-L training in multiple years likely requires more overall time than do single-year training paradigms. Split training models may also afford trainees less time to acclimate to the rotation and their roles in any of its iterations. Faculty need to be more thoughtful about adjusting their teaching points to multiple levels of learners. Finally, having residents from multiple years on service may lead to an increase in the overall number of learners on the service. While it can be advantageous to have senior residents available to help teach junior residents, it also leads to a smaller faculty to resident ratio. Regardless of model, the ACLP recommends adhering to a minimum ratio of 1 attending per 2 residents.[2]

HOW SHOULD THE EXPERIENCE BE STRUCTURED?

Debate also remains regarding the total length and scheduling of the C-L rotation. Historically, many C-L rotations were 6 months or longer. The ACGME currently requires a minimum 2-month experience.[19] Residents must also have exposure to emergency psychiatry according to the ACGME, although this is considered separate from C-L psychiatry. The 2014 ACLP guidelines recommend a minimum of 3 months, with residents spending at least 50% of their time and at least 30 hours per week on service during that time.[2] Residents are encouraged to see at least 50 consultations during their C-L experience. Notably, however, there are no data showing that a longer time on service leads to increased knowledge base or an increase in the number of residents who pursue C-L psychiatry as a specialty.

In terms of the structure of the rotation, as alluded to previously, most programs use a block model, either contiguously or in 1-month blocks. Some programs alternatively use a longitudinal model, whereby residents are on-service for 1 or 2 days a week for an entire year. A 2015 study from Dartmouth found that when the program moved from a longitudinal model to a block model, the block model was associated with better education, improved clinical care, and higher satisfaction from consultees.[20] In line with these findings, the ACLP recommends a contiguous block model.

RECOMMENDATIONS FOR TRAINING PROGRAMS

Although prior guidelines have recommended placement of the core C-L experience in PGY-3, it appears that most programs have moved toward having C-L psychiatry in PGY-2. Based on the factors outlined previously, there does not appear to be a clear, compelling argument to prioritize placement in PGY-3 over PGY-2 from an educational perspective. We therefore recommend that if possible, programs place C-L psychiatry in PGY-2 or PGY-3, with attention paid to the relative advantages and disadvantages of each approach. We also recognize that there may be individual circumstances that lead a program to place the rotation elsewhere during residency training. Programs are also strongly encouraged to consider a hybrid model, which may allow for better consolidation of knowledge and skills over time.

Placing the sole C-L experience in the PGY-1 year may not allow residents to function autonomously on the team, and interns are likely unable to grasp much of the hidden curriculum. “Thinking dirty,” for example, requires experience; the roles of conflict manager, advocate, and teacher are generally advanced skills; and consolidation of these skills occurs best over a longer time period with higher engagement in the work. Conversely, having the sole C-L experience in PGY-4 impinges on what otherwise may be a largely elective year and is unlikely to stimulate early interest in the field, leading to pursuit of fellowship. Nonetheless, program directors may not have the ability to shift historical timing of the rotation, as such major changes to curriculum often require enormous upheaval of other rotations and significant adjustments to the culture of the program. For that reason, and recognizing the challenges faced by program directors and rotation leaders in trying to optimally tailor a C-L rotation to fit a particular year of training, we have created a set of recommendations for each year of training. These can be found in Table 2.

CONCLUSION

Although some guidance is available from professional subspecialty organizations and ACGME regarding the timing and structure of C-L experiences, residency program directors and rotation leaders are often tasked with tailoring a rotation to a specific year of training based on external factors such as preexisting curriculum structure, other program requirements, and the culture of the program. While placing a C-L rotation into any year of training has advantages and disadvantages, the most compelling arguments can be made for placement in PGY-2 or -3, or use of a hybrid model. Furthermore, there are steps that can be taken to optimize the educational experience for trainees and to maximize consultee and patient satisfaction, regardless of rotation placement.

Conflicts of Interest: The authors declare that they have no conflict of interest.

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