



## Medical Training in Psychiatric Residency: The PGY-1 Experience, 2014 Update

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*This position paper has been substantially revised by the Canadian Psychiatric Association (CPA) Education Committee and approved for republication by the CPA Board of Directors on July 24, 2014. The original position paper<sup>1</sup> was developed by the Standing Committee on Education and approved by the Board of Directors on December 6, 2000.*

### Introduction

There have been several changes to psychiatry residency training since the 2001 Canadian Psychiatric Association (CPA) Position Paper on the topic of medical training during the residency.<sup>1</sup> Specifically, the Royal College of Physicians and Surgeons of Canada (RCPSC) released a document regarding Specialty Training Requirements (STRs) first in 2007, then updated in 2009, with specific requirements for the postgraduate year one (PGY-1).<sup>2</sup> According to the STR, this training year “must be a broadly based medical experience *relevant to Psychiatry*” [italics added].<sup>2, p 1</sup> The content of PGY-1 continues to demonstrate some variability across the 17 Canadian university residency training programs, congruent with the continued flexibility in the content of the PGY-1 year within the RCPSC STR (see Table 1 for specific content).

As well, there continues to be an ongoing dialogue and debate in the literature regarding the medical competencies that should be expected of psychiatrists. As such, there is no clear consensus as to which medical

experiences should be most relevant to psychiatry, and whether a more prescriptive approach to medical training than currently exists would be beneficial. Ever since the elimination of the rotating internship year in the early 1990s, there has been considerable varied opinion regarding which medical skills and knowledge are important and essential for the training of the generalist physician skill set required of all physicians, while at the same time ensuring that psychiatry trainees are adequately prepared for doing psychiatric work.

### Medical Competencies of Psychiatrists

There is a vast body of literature outlining the various medical coexisting problems in patients with psychiatric illness. Depression has been associated with multiple medical conditions, including cardiovascular disease, gastrointestinal disorders, pain conditions, endocrine disorders, respiratory illness, cancer and several neurological conditions.<sup>3-5</sup> In patients with schizophrenia, medical conditions and known adverse health behaviours, including diabetes, cardiovascular

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Note: It is the policy of the Canadian Psychiatric Association to review each position paper, policy statement and clinical practice guideline every five years after publication or last review. Any such document that has been published more than five years ago and does not explicitly state it has been reviewed and retained as an official document of the CPA, either with revisions or as originally published, should be considered as a historical reference document only.

**Table 1 Royal College Specialty Training Requirements<sup>2</sup>**

## 1. Twelve months PGY-1 and basic clinical training

One year of basic clinical residency, under the direction of academic departments of Psychiatry, most of which must be completed before Section 2 begins. This training year must be a broadly based medical experience relevant to Psychiatry, with core elements in Medicine, Pediatrics, Family Medicine, Neurology (neuroimaging is strongly recommended), Emergency Medicine and Psychiatry. The basic clinical year (PGY-1) is integrated with the subsequent years of psychiatric training. Psychiatry rotations or electives in Psychiatry may contribute to the completion of core requirements or the acquisition of longitudinal components of training under Section 2 or 3.

The year will be composed of 13 four-week blocks and must include the following:

## 1.1. Seven to nine blocks of core training composed of the following:

- 1.1.1. Three blocks of Internal Medicine, Family Medicine, and (or) Pediatrics. The entire three blocks may be taken in Internal Medicine or Family Medicine or in any combination of the three, but only one block in Pediatrics is permitted. An Endocrinology experience is strongly recommended.
- 1.1.2. One block of Neurology and one block of neuroimaging or two blocks of Neurology (a neuroimaging experience is strongly recommended).
- 1.1.3. One block of Emergency Medicine.
- 1.1.4. One to three blocks of Psychiatry that preferably include clinical experience in emergency Psychiatry and in shared or collaborative psychiatric care. If more than one block of Psychiatry is taken, it must contribute to the core experience of general Psychiatry and must be approved by the residency program director.

## 1.2. Two to four blocks of selective training drawn from Geriatric Medicine, Pediatrics, Obstetrics and Gynecology, General Surgery, Internal Medicine, Neurology, neuroimaging, Family Medicine, Palliative Care, Psychiatry or research. No more than two blocks may be selected in any one area, except for Psychiatry, which will be limited to one block.

## 1.3. One block of elective training drawn from any medical or surgical rotation, including research

disease, smoking and obesity are overrepresented and contribute to mortality, as well as reduced quality of life.<sup>6</sup> Bipolar disorder (BD) has also been associated with many medical conditions, such as genetic disorders, neurological conditions, asthma, hypothyroidism, polycystic ovarian syndrome, renal failure, obesity and type 2 diabetes mellitus.<sup>7</sup> Some of these associations may be related to adverse effects of medications used to treat psychiatric illnesses, such as metabolic disorders related to atypical antipsychotic use. There are likely complex bidirectional relations that account for others. As well, in some cases, psychiatric disorders may be an expression of certain medical disorders, such as BD in multiple sclerosis.<sup>7</sup>

Various barriers to accessing medical care exist for many patients with psychiatric illness. These may be symptoms of illness that include paranoia or executive dysfunction.<sup>6</sup> As well, there continues to be a widely publicized shortage of family physicians, with the Canadian Medical Association citing that between four to five million Canadians do not have a family doctor.<sup>8</sup> It has also been reported that even when patients have been assessed by a primary care physician, between six and 20 per cent of patients with physical illness may be misdiagnosed as having mental disorders.<sup>9</sup>

In light of these types of issues, some have suggested that psychiatrists should provide physical as well as mental health care to patients with psychiatric illness.<sup>6,9</sup> In the United States, there have been attempts to address the above problems through the creation of combined

programs for training in integrated psychiatric and primary care.<sup>10,11</sup> Two such programs are the Psychiatry Primary Care Education initiative, created in 1996, and the Psychiatry Primary Medical Care program, created in 1998. These programs taught psychiatry residents to provide integrated primary medical care, as well as psychiatric care for patients with chronic mental illness. There are also several American combined family medicine–psychiatry residency training programs that are longer in duration than the typical psychiatry residency.<sup>12</sup>

While graduates of these types of programs report having an increased sense of preparedness to handle medical problems, this blended training did not appear to increase the rate of the psychiatrist actually performing medical screenings, or treating medical conditions.<sup>13</sup> Even those trained in both family medicine and psychiatry do not tend to practice integrated medical and psychiatric care.<sup>12</sup> There are likely many barriers to psychiatrists providing direct primary medical care to patients, some of which may include concerns of practicing outside the scope of licensure, time constraints and remuneration schedules that are not designed for integrated care.

More recently, the RCPSC has formally recognized areas of subspecialty psychiatric practice in Child and Adolescent Psychiatry, Geriatric Psychiatry and Forensic Psychiatry.<sup>14–16</sup> The certification in these areas requires additional training requirements and longer duration of psychiatry residencies, and the requisite medical skill set of the subspecialist psychiatrist may be even more

narrowly defined, potentially making integration of any general medical care even more challenging to achieve in practice.

As such, in the current psychiatric training and practice culture, it appears to be difficult to expect that psychiatrists can act as providers of integrated primary medical care and psychiatric care to patients. However, psychiatrists continue to maintain an identity as physicians. Some of the recommendations made by Kathol et al<sup>17</sup> about what kinds of medical knowledge are most relevant to psychiatry provide a more practical view of what kinds of medical competencies could be expected of psychiatrists. These include how and when to appropriately include physical assessments in psychiatric assessments; how and when to order medically appropriate laboratory and radiological tests, and their salient interpretation and application in the course of psychiatric evaluations; how to treat psychiatric problems in medical patients; and how to effectively and collaboratively interact with primary care physicians in the medical setting.<sup>17</sup>

## Medical Training Experience Relevant to Psychiatry

There is still no clear consensus on exactly which types of medical expertise are most relevant to psychiatry and should best be emphasized during residency training. Some authors have identified fundamental knowledge and skills in the domains of neurology, endocrinology, immunology, pediatrics, geriatrics, genetics, imaging techniques and pharmacology as being necessary to ensure competency as a psychiatric medical expert.<sup>18</sup> It is not clear that separate rotations in each of these areas are needed to achieve this expertise. It has been suggested that specific goals of medical training should include teaching residents to identify medical complications owing to psychiatric treatments, treat basic medical problems, know when a referral to others is needed, as well as to identify medical emergencies.<sup>19</sup> There are times when psychiatric presentations directly related to existent serious medical disorders may be missed owing to changes in mental status being only attributed to pre-existing mental illness, and training psychiatric residents to recognize these situations can be lifesaving.<sup>19</sup>

Having the skills to make differential diagnoses based on a patient's presentation is an imperative skill for physicians, and having the ability to know when physical exams, laboratory tests or imaging studies are indicated, as well as knowing how to interpret them are essential competencies that also strengthen psychiatrists' identities as physicians. In addition, psychiatrists are frequently consulted to provide care to patients with coexisting physical illness. Having an understanding of patients' medical illnesses and the treatments they receive, such as effects of interferon therapy received by patients with

hepatitis C or chemotherapy regimens in patients with cancer, can help psychiatrists to build rapport, as well as understanding psychiatric symptoms in the context of physical illness and the potential interactions of psychiatric treatments.<sup>19</sup>

Gagnon has suggested that, in addition to allocating time for mandatory, selective and elective rotations, some of which are outlined in the RCPSC STR, each residency program should also define specific objectives for psychiatry residents during these rotations.<sup>20</sup> Specific examples of clinical encounters that psychiatric residents should become familiar with on nonpsychiatric rotations are described by Gagnon.<sup>20</sup> This represents a competency, rather than a strictly time-based approach to medical training during psychiatric residency. Based on the current reports of the 17 medical schools outlining their PGY-1 requirements, the approach taken continues to be time-based (Table 2). It remains unclear whether the 17 Canadian residency programs have been able to include specific objectives for psychiatry residents during the learners' off-service rotations. As well, there are likely some practical limitations to achieving this goal for ensuring that nonpsychiatric programs will be able to provide all of these clinical encounters during the time based rotations.

There has been discussion and recommendations by some educational bodies that competency-based rather than time-based models may be the direction toward which medical education is shifting. For example, the Psychiatry Milestone Project is a joint initiative of the Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurology.<sup>21</sup> This project outlined specific competencies that should be met by U.S. psychiatry residents during their training, and organized them into different levels, as well as identifying which should be achieved by the point of graduation. In the most recent draft of this document, some objectives that are relevant to medical competencies include the following: identifying and treating common psychiatric manifestations of medical illness (for example, delirium and steroid-induced psychosis), and medical and neurological conditions in psychiatric patients; and identifying common medical conditions (for example, hypothyroidism, hyperlipidemia and diabetes) in psychiatric patients.<sup>21</sup> As well, the Future of Medical Education in Canada Postgraduate Project collaboration between the RCPSC and the College of Family Physicians of Canada) produced a report in 2012 with 10 recommendations for postgraduate medical education, with the key goal of better and smoother transitions between undergraduate and postgraduate training and subsequent practice.<sup>22,23</sup> This project also emphasizes competency-based curricula, rather than the traditional time-based blocks of training, similar to the American Milestone Project. To achieve this kind of medical education, medical educators will need to

**Table 2 Individual universities' psychiatry PGY-1 requirements<sup>a</sup>**

<b>Dalhousie</b>	
4 weeks	Emergency and (or) Consultation–Liaison Psychiatry
4 weeks	Community Psychiatry
8 weeks	General Medicine
8 weeks	Neurology
8 weeks	Emergency Medicine
4 weeks	Family Medicine
12 weeks	Selectives
<b>Laval</b>	
1 month	Emergency Medicine Medicine
3 months	Family Medicine or combination of 2 periods Internal Medicine and 1 period Pediatrics
2 months	Neurology
1 month	Neurosciences and Research
2 months	Emergency Psychiatry
1 month	Consultation-Liaison Psychiatry
1 month	Initiation in cross-cutting competencies
1 month	Medicine Selective (Geriatrics, Pediatrics, Palliative Care or Addictions)
<b>McGill</b>	
16 weeks	Psychiatry Selectives
Remainder	Medical Selectives (for example, Family Medicine, Emergency Department Medicine, Internal Medicine, Pediatrics, Neurology and Endocrinology)
<b>McMaster</b>	
8 to 16 weeks	Selectives (Geriatric Medicine, Pediatrics, Obstetrics and Gynecology, General Surgery, Internal Medicine, Neurology, Neuroimaging, Family Medicine, Palliative Care, Psychiatry or Research)
4 weeks	Elective (any medical or surgical rotation, including Research)
Core (unspecified time)	Internal Medicine, Family Medicine, Pediatrics, Neurology, Neuroradiology, Emergency Medicine, Psychiatry
<b>Memorial</b>	
8 weeks	Neurology (4 weeks neuroimaging)
8 weeks	Internal Medicine
4 weeks	Pediatric Emergency
4 weeks	Adult Emergency
4 weeks	Obstetrics
4 weeks	Elective
12 weeks	Psychiatry (Emergency and [or] Short Stay Unit)
4 weeks	Inpatient Psychiatry
4 weeks	Elective
<b>Northern Ontario School of Medicine</b>	
4 weeks	Family Medicine
8 weeks	Psychiatry
16 weeks	Medicine
4 weeks	Emergency Psychiatry
4 weeks	Pediatrics
8 weeks	Neurology and Neuroradiology
4 weeks	Emergency Medicine
4 weeks	Elective
<b>Queen's University</b>	
4 blocks	Psychiatry
1 block	Internal Medicine
1 block	Neurology
1 block	Emergency Medicine
1 block	Family Medicine
1 block	Pediatrics
1 block	Geriatric Medicine
1 block	Rehabilitation Medicine
1 block	Elective

*continued*

**Table 2 Continued**
**Université de Montréal**

13 periods Including Internal Medicine, Family Medicine, Pediatrics, Neurology and Neuroradiology

**Université de Sherbrooke<sup>25</sup>**

3 periods Family Medicine

3 periods Internal Medicine

2 periods Neurology

Unspecified Possibilities of rotations in, for example, Geriatrics, Pediatrics and Gastroenterology

4 periods General Psychiatry (Emergency, Rapid Assessment Unit and Intensive Care Unit)

1 period Research

1 period General Emergency

**University of Alberta**

12 weeks Psychiatry (Addictions, Crisis Services, Emergency Department and Psychiatry)

8 weeks Internal Medicine

4 weeks Cardiology

4 weeks Emergency Medicine

4 weeks Family Medicine

4 weeks Inpatient Neurology

4 weeks Outpatient Neurology and Brain Injury Rehabilitation

8 weeks Selectives (Endocrinology, Geriatrics, Palliative Care, Family Medicine, Pediatrics, Research, Neuropsychology and Psychiatry subspecialties—maximum one block)

4 weeks Vacation

**University of British Columbia**

3 blocks Internal Medicine, Family Medicine or combination

1 block Pediatrics

1 block Neurology

1 block Neuroimaging

1 block Emergency Medicine

1 block Emergency Psychiatry

2 blocks Psychiatry

3 blocks Electives or Selectives

**University of Calgary**

4 weeks Family Medicine

8 weeks Psychiatry

16 weeks Medicine

4 weeks Emergency Psychiatry

4 weeks Pediatrics

8 weeks Neurology

4 weeks Emergency Medicine

4 weeks Elective

**University of Manitoba**

4 weeks Addictions

4 weeks Emergency Medicine

4 weeks Family Medicine

4 weeks Internal Medicine

4 weeks Neurology

4 weeks Neuroradiology (or 4 more weeks of Neurology)

8 weeks Pediatrics

4 weeks Psychiatry

4 weeks Vacation

4 to 12 weeks Selectives (maximum 2 blocks per selective, including: General Surgery, Geriatric Medicine, Internal Medicine, Neurology, Movement Disorders Clinic, Neuroradiology, Obstetrics and Gynecology, Palliative Care, Developmental Pediatrics, Pediatrics and Research)

Up to 4 weeks Electives (any medical or surgical specialty, or Psychiatry)

*continued*

**Table 2 Continued****University of Ottawa**

4 weeks	Inpatient Psychiatry
4 weeks	Emergency Psychiatry
4 weeks	Addictions
4 weeks	Underserved Psychiatry
4 weeks	Internal Medicine Clinical Teaching Unit
4 weeks	Neurology
4 weeks	Geriatrics
4 weeks	Endocrinology
4 weeks	Neuroradiology and (or) Developmental Disorders
4 weeks	Family Medicine
4 weeks	Adult Emergency Medicine
4 weeks	Pediatric Emergency Medicine
4 weeks	Palliative Care

**University of Saskatchewan**

12 weeks	Internal Medicine
4 weeks	Geriatrics
4 weeks	Psychiatry
4 weeks	Pediatrics
4 weeks	Neuroimaging
4 weeks	Elective
4 weeks	Family Medicine
4 weeks	Neurology
4 weeks	Emergency
8 weeks	Selectives (minimum 4 weeks each, from Obstetrics and Gynecology, Surgery, Palliative Care, Family Medicine, Rehabilitation Medicine and Pediatrics)
4 weeks	Vacation

**University of Toronto**

2 months	Internal Medicine
1 month	Family Medicine or Pediatrics
1 month	Neurology
1 month	Emergency Medicine
1 week	Neuroimaging
1 month	Behavioural Neurology
1 month	Palliative Care
1 month	Emergency Psychiatry
1 month	Consultation–Liaison Psychiatry
1 month	Addiction Psychiatry
1 month	Selective (Pediatrics, Obstetrics and Gynecology, Surgery, Family Medicine, Neurology and Geriatrics)
1 month	Elective

**The University of Western Ontario**

1 block	Extended Orientation
1 block	General Adult Psychiatry
1 block	Child and Adolescent Psychiatry
1 block	Emergency Psychiatry
1 block	Internal Medicine (Clinical Teaching Unit, Ambulatory or Endocrinology)
1 block	Adult Emergency Medicine
1 block	Pediatric Emergency Medicine
1 block	Neurology Clinical Teaching Unit
1 block	Neuroradiology or Neurology outpatient clinic
1 block	Family Medicine
2 blocks	Selectives (nonpsychiatry)
1 block	Elective (any specialty)

<sup>a</sup> As listed on individual universities' websites or direct communication with each program's Postgraduate Medical Education office unless otherwise referenced.

work to ensure that adequate evaluation systems for assessment of medical competencies are in place, as well as requiring greater flexibility in training.<sup>23</sup> While competency-based training appears to be the wave of the future in medical education, residency programs are not presently organized to achieve this kind of training, as the PGY-1 year continues to be organized in time-based rotations in all 17 universities (Table 2). As well, the current RCPSC continues to describe time-based rotations in its Specialty Training Requirements.<sup>2</sup>

The upcoming CanMEDS 2015 Framework of the RCPSC will maintain the same seven core CanMEDS roles but will add a focus a competency-based model of training. This next iteration of the CanMEDS framework will develop competency milestones within each CanMEDS role that can be applied throughout a physician's career including residency and continuing professional development in the long term.<sup>24</sup>

While the 17 universities continue to demonstrate some variation in the rotation requirements during the PGY-1 year, the STRs endorsed by the RCPSC appears to have resulted in more standardization than in 2001 when last reported.<sup>1</sup> There are core rotation requirements of exposure to general medicine in areas of Internal Medicine, Family Medicine and (or) Pediatrics, as well as mandatory rotations in Neurology and Emergency Medicine. Based on the training programs' website descriptions (accessed 2013), most of the residency programs report including these elements in their PGY-1 year training experience. Increased standardization in training is important for ensuring portability across the country, and more uniformity with respect to licensure. Concurrently, PGY-1 residents having some flexibility and choice in the clinical rotations they undertake is important in their consolidating their identities as physicians and in pursuing areas of interest.

## Conclusion

In light of these observations, the following recommendations are made:

1. Medical training experiences are an integral part of the development of a competent psychiatrist. These should include experiences in various medical settings so that sufficient exposure to different clinical presentations can be achieved. Residency programs should ensure that various clinical settings are available for residency training, including inpatient, outpatient and community settings.
2. During the PGY-1 experience, the psychiatry resident should have the opportunity to become competent in recognizing medical emergencies, identifying psychiatric presentations of organic illness, managing common primary care presentations on psychiatric inpatient units, monitoring side effects of psychotropic medications, managing psychiatric illness in patients with coexisting medical illness, including assessing

drug interactions, and knowing when to include physical exams, laboratory investigations and imaging in psychiatric assessment.

3. The RCPSC Specialty Committee in Psychiatry should continue to ensure that the STRs reflect the specialty's goals and objectives to train competent psychiatrists, as well as to make certain that the requirements provide trainees with adequate preparation for the Medical Council of Canada Qualifying Examination Part II (MCCQE II). Completing the MCCQE II is another way of consolidating the psychiatrist's identity and competency as a physician.
4. Training requirements should continue to reflect medical competencies that are relevant to psychiatric practice, rather than trying to address the shortage of primary care physicians by having psychiatrists provide primary care to psychiatric patients.
5. With the current trends in medical education heading toward competency-based curricula, the RCPSC Specialty Committee in Psychiatry and its educational partners at CPA, Coordinators Of Psychiatric Education (commonly referred to as COPE), and representatives of the psychiatric subspecialties should work together to identify specific measurable competencies, especially regarding medical competencies, that are imperative for psychiatrists to acquire. This may involve a joint task force to ensure that all bodies are represented in ensuring that these core biomedical competencies are rigorously elucidated and met at a national level.

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