Subspecialization in Psychiatry: Third-Generation Programs

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Psychiatry, unlike internal medicine, was slow to develop subspecialty certification. For many years, child and adolescent psychiatry was the only major subspecialty recognized by the American Board of Psychiatry and Neurology (ABPN). The situation changed in the early 1990s with the recognition by the ABPN of additional subspecialties of psychiatry including forensic psychiatry. Using the experience of the American Board of Internal Medicine as a guide, this commentary asks what comes next? What are our options as it becomes clear that there is a deepening of knowledge in the field of forensic psychiatry? Are we ready for, or interested in, the development of so-called third-generation certification programs?

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This commentary is meant to raise a question. What happens when the knowledge base and skills of a recognized medical subspecialty evolve to the point that further subspecialization becomes reasonable? We intend to focus this discussion on the field of forensic psychiatry, but will look at what has been done in the field of internal medicine as an example of a medical field with experience in the area of subspecialization, to provide guidelines for forensic psychiatry. The American Board of Internal Medicine (ABIM) has had long experience with subspecialty certification and now has significant experience with sub-subspecialty programs (third-generation certifications).

The American Board of Internal Medicine

As a primary certifying specialty board, the ABIM has had a long-standing policy requiring training and certification first in the general field, before certification in a subspecialty. The goal has been to keep internal medicine integrated as a practice specialty and academic discipline. Having certified qualified ABIM diplomates in three subspecialties since the early 1940s, and in six more since 1972, the ABIM has been petitioned many times, usually by academicians and subspecialty societies, to issue certificates in branches of the subspecialties—a third tier of standard-setting in internal medicine. The ABIM recognizes that specialized, concentrated domains of internal medicine will continue to differentiate, both to assure optimal medical care and to advance knowledge.

Logic and fairness required a rational and uniform policy for handling requests for third-tier certifications. Guiding principles and legitimate reasons employed by the ABIM to make decisions that a sub-subspecialty has sufficiently "matured" are as follows[1,2]:

- The new discipline must have a distinct and unique body of knowledge within internal medicine.
- Certification in a new discipline should provide greater benefit to patient care than is provided by incorporating that discipline into existing subspecialty certification processes.
- The new area should be a recognized branch of medical practice.
- There should be a reasonable number of potential candidates in practice (and therefore a feasible fee for certification).
- There must be accreditation by the Accreditation Council for Graduate Medical Education (ACGME) of formal training in the sub-subspecialty, often obtained with the help of ABIM more or less concurrently with the development of the new certification process.

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- The member certifying boards of the American Board of Medical Specialties (ABMS) must be satisfied with the request and formally approve it.
- Integration of both the parent specialty and its subspecialty and the significance of their certificates should not be compromised.

To accommodate the new process, the ABIM created the term "added qualifications" to refer to competencies added to certification in the specialty or subspecialty. It insisted on at least one year of added training (i.e., no grandfathering solely on the basis of experience), and only time-limited certificates were offered. Policy requires an internist-diplomate to maintain certification in both the added qualification and the parent discipline (i.e., internal medicine or the subspecialty). Trying to avoid fragmentation, as an alternative to creating an added qualification, the board preferred to incorporate new science into the certification of existing and inevitably evolving subspecialty disciplines, even if training in the latter must be extended. The board has also added to the name of a subspecialty the desired new emphasis (e.g., the addition of diabetes to the subspecialty of endocrinology, diabetes, and metabolism).

That said, new third-tier Certificates of Added Qualifications (CAQs) are currently offered in clinical cardiac electrophysiology (after certification in cardiology), interventional cardiology (after cardiology), critical care medicine (after pulmonary disease), and transplantation hepatology (after gastroenterology). Others are under consideration by ABIM and ABMS.

The impact of this phenomenon on practice and training is closely monitored by ABIM. The board assiduously avoids endorsing the use of its certificates as required credentials for granting clinical privileges, even though hospital credentialing bodies do use certificates for this purpose.

New certificates impose new costs, both for the board and for those seeking such recognition. These costs may ultimately be borne by the patient or the public, but the public is protected by a widely recognized certification process from either wanton, self-declared competence or from credentials offered by specialty societies with their inherent conflict of interest.

The American Board of Psychiatry and Neurology: Forensic Psychiatry

The American Board of Psychiatry and Neurology (ABPN) was founded in 1934,[3] two years earlier than the ABIM, but the ABPN, unlike the ABIM, certified relatively few subspecialties until recently. Today, the ABPN certifies a wide variety of competencies including certification in the "Subspecialty of Forensic Psychiatry."[4] Its first certificates in forensic psychiatry were awarded in 1994. The subspecialty is currently supported by 42 forensic psychiatric training programs approved by the ACGME.[5]

The ABPN describes the content of its multiple-choice examination in forensic psychiatry as covering, in essence, the whole field of forensic psychiatry:

> Candidates will be assessed in legal regulation of psychiatry, civil law, criminal law, corrections and correctional health care, legal systems and basic law, children and families, special diagnostic and treatment issues, special procedures in forensic psychiatry, special consultations and investigations, and risk assessment (including violence, dangerousness, criminology, suicide, and psychiatric autopsy), and forensic psychiatry practice issues [Ref. 6, p 31].

This broad approach is as it should be. A year of added training in a subspecialty should attempt to cover the entire subspecialty. Not surprisingly, in a sample of forensic psychiatry training program Web sites, the training program statements mirror the areas outlined by the ABPN. Again, we should be clear that we have no argument with this approach. However, it is within this approach that the seed of this commentary was developed.

Third-Generation Competencies

As a subspecialty develops and as the number of academic and clinical practitioners increases, the knowledge base of a field in turn expands. As this occurs, the ability to maintain expertise in all of the areas of the subspecialty is likely to, of necessity, decrease. In a one-year training program, an individual trainee can develop the knowledge base promised by the program, and can indeed begin to function as a subspecialist. But what does the trainee do if he or she wants to become an expert in a segment of forensic psychiatry? How is this problem addressed?

Before attempting to answer this question, let us briefly illustrate the question with two examples. We provide these examples of what might be considered potential sub-subspecialty areas within forensic psychiatry that might be worthy of Certificates of Added Qualifications.

Public Psychiatry and the Law

One of us (J.D.B.) came to forensic psychiatry with an interest and having received a fellowship in community psychiatry. It became obvious, as the federal effort in community psychiatry slowed[7] and as deinstitutionalization gained momentum, that knowledge of the laws regulating the care and treatment of severely mentally ill individuals was an absolute necessity for an individual interested in this area of psychiatry. Hence, over the years the Oregon Health and Science University (OHSU) Public Psychiatry Training Program developed a subsection[8] focused on public psychiatry and the law. This program explored a range of forensic interests related to the care and treatment of severely mentally ill individuals. The program originated with a focus on public policy and the treatment of severely mentally ill individuals in hospitals and community mental health centers. As the forensic aspects of the program grew, it focused on the involvement of severely mentally ill individuals in forensic psychiatric hospitals, jails, and prisons. Along with this focus, the OHSU program developed empirical research related to those laws that influence the care and treatment of severely mentally ill individuals, including civil commitment, the right to refuse treatment, and the insanity defense.[9]

Evaluation and Treatment of Sexual Offenders

The evaluation and treatment of sex offenders is an area of great complexity and an area of forensic psychiatry that is underemphasized in most forensic programs, most likely because of the paucity of model treatment programs for this population in most areas of the country. There is an extensive body of literature in this area, and the extent of the problem has become more clear in the last two decades.[10] A training program in this sub-subspecialty could very easily be designed.

Other Examples

Other potential sub-subspecialty areas include correctional psychiatry with a subfocus on offenders with substance abuse, sexual abuse, or antisocial personality. A program could also be developed with a focus on civil law. This is an area that is greatly underemphasized in many training programs and an area that could be combined with a major focus on traumatology.

Discussion

What are the potential solutions to the problems we have defined? Is forensic psychiatry ready for third-generation programs of training and certification? It is our contention that, if we are not at that point now, then we will soon be there. Having some experience with the development of the certification process in forensic psychiatry, we know that forensic psychiatry, as a subspecialty of the ABPN, has had its opponents, both in psychiatry and among other medical specialists. The criteria defined by the ABIM earlier for its new certificates provide some of the reasons. Forensic psychiatry has had a difficult time justifying to others that it is a branch of medical practice and that it benefits patient care. Many forensic psychiatrists have had to go to great lengths to overcome these objections; but the field has overcome the objections and may be able to do so again in regard to third-tier programs. However, the greatest objection, and probably one that is quite justifiable, is that there may not be a reasonable number of potential candidates to warrant the development of a new, very costly certification process.

If this objection is substantiated, what alternatives are there for the development of third-tier training and certification programs? Three potential options come to mind.

1. Encourage diversity among existing training programs. Forensic psychiatry is a popular subspecialty. There does not seem to be too much difficulty in attracting excellent candidates into the already existing programs. There is every reason to believe that additional training programs will be developed in the near future. There is, however, probably a limit to the potential number of applicants for certification. In 2003, 916 medical students matched to psychiatry training programs, while in 2004 there were 979 matches.[11] If 100, or about 10 percent, of graduates of psychiatric residencies enter forensic fellowships, is it reasonable to expect that about 12 to 15 percent of residency program graduates will become forensic psychiatrists? Thus, with the number of forensic training programs increasing and the number of applicants perhaps also increasing modestly, training programs may want to differentiate themselves one from the other by offering general training in forensic psychiatry along with focused expertise in one or more specific areas of forensic psychiatry. Encouraging diversity among programs, which to some extent is occurring

now, would serve programs well in regard to recruitment and training individuals with third-tier expertise.

2. Extend training in certain programs to two years. The certificate awarded by the ABPN in forensic psychiatry following one year of subspecialty training was changed in 1997 from "Added Qualifications" in forensic psychiatry to "Certification in the Subspecialty of Forensic Psychiatry."[12] All newer certifications of the ABPN have this designation. At the subspecialty level, however, child and adolescent psychiatry still requires two years of subspecialty training, but awards a certificate entitled "Certification in the Subspecialty of Child and Adolescent Psychiatry." One solution to the dilemma presented in this commentary is for certain forensic training programs to develop two-year programs that offer a second year of training in one of the third-tier areas. This proposal would mean that the second year of these training programs would not meet the exact lock-step goals of the other two-year programs, but they would produce unique training experiences in the third-tier areas. This would be a highly unusual approach, but one that would embrace the best features of the two other proposals in this section. The certificates (and corresponding examinations) awarded for one- and two-year training could be differentiated. The two years of training would be accredited by the ACGME.

3. Pair unaccredited sub-subspecialty programs with accredited training programs. This third option is one that is unorthodox and may be regarded by established accrediting agencies and the ABMS as a dangerous precedent. It involves the use of an unaccredited sub-subspecialty fellowship paired with an ACGME-approved forensic psychiatry fellowship. This option would preserve the training in the subspecialty of forensic psychiatry and would, in very selected programs, add a non-ACGME accredited fellowship in some particular area of forensic psychiatry, such as those suggested earlier. Although typically non-ACGME accredited fellowships are clinically oriented, we also recommend that these programs not be mere apprenticeships and that they have a healthy component dedicated to research. In this option, such programs may be accepted by some substantial national authority (such as the chairs of academic departments of psychiatry) as selected training programs in a given sub-subspecialty of forensic psychiatry. The operative credential for graduates might be a certificate of satisfactory completion of such training in a nationally recognized institution.

Certification in forensic psychiatry as a subspecialty of psychiatry is a success story. From the early days of the specialty examination originally organized by the American Academy of Psychiatry and the Law to the success of the ABPN examination, the subspecialty has enjoyed steady positive momentum. Trying to figure out how to handle matters associated with third-generation certification is certainly not a bad problem to have. We believe that it is time to begin to focus on these questions. The trick will be to avoid the undue proliferation of recognition of third-generation competencies by other certifying boards, or specialty societies, especially recognition involving only technical skills. But the march of medical knowledge and practice demands that serious deliberation address new policy considerations governing training and standards.

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