

AMERICAN
PSYCHIATRIC
ASSOCIATION



Building A Career In PSYCHIATRY

Part 1: Medical School and Residency

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Introduction

A psychiatrist is a physician who specializes in the diagnosis, treatment, and prevention of mental, addictive and emotional disorders such as schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, substance-related disorders, sexual and gender identity disorders, and adjustment disorders. Because of extensive medical training, the psychiatrist understands the body's functions and the complex relationship between emotional illness and other medical illness. The psychiatrist is thus the physician best qualified to distinguish between physical and psychological causes of both mental and physical distress.

Mental illnesses, including addictions, are common. Like other medical illnesses, mental illnesses range from severe and life-threatening disorders to relatively mild and self-limiting conditions.

Psychiatry is one of the oldest medical specialties, but is also one of the most exciting frontiers of medicine. Recent advances in the neurosciences have led to new technologies in the diagnosis and treatment of many of these illnesses. For example, the *DSM-5* diagnostic manual, brain imaging, and new pharmaceuticals have significantly improved diagnosis and treatment for these illnesses.

Most psychiatrists spend 60% of their time with patients. Two-thirds of these patients are seen as outpatients, with the rest being seen in a hospital setting or, increasingly, in partial hospitalization, day programs, and community residential programs. Psychiatric hospitalization is now more intense, more focused, and much shorter in duration than in previous years. Additional professional activities include administration, teaching, consultation, and research.

Psychiatrists work in group or solo private practice. They also practice in the public sector, such as the Veterans Administration, state hospitals and community mental health centers. Medical schools, HMOs, and hospitals are also settings for psychiatric practice.

Today's psychiatrist provides a wide range of biological, psychotherapeutic and psychosocial treatments which are tailored to the specific needs of the patient. The psychiatrist also serves as the medical expert for the mind/brain/body interface. Unfortunately, prejudice and discrimination against the mentally ill still exists. Sometimes, this stigma is also directed against those who care for the mentally ill.

HOW DOES ONE BECOME A PSYCHIATRIST?

Medical students follow a standard curriculum. In addition to chemistry, biochemistry, and physiology, students take courses in psychiatry, behavioral science and neuroscience in the first two years of medical school. In the last two years, students are assigned to medical specialty "clerkships," where they study and work with physicians in at least five different medical specialties. Medical students in a psychiatry clerkship take care of patients with mental illnesses in the hospital and in outpatient settings. They also have an opportunity to work with medical and surgical patients who may have psychiatric problems or who have difficulty coping with their illness. Because modern psychiatry places special emphasis on the relationship between mind and body, students pay special attention to issues of stress and physical illness, prevention, and behavior change, in addition to learning to care for severely mentally ill patients. Newly graduated physicians take written examinations for a state license to practice medicine. After graduation, doctors spend the first year of residency training in a hospital taking care of patients with a wide range of medical illnesses. The psychiatrist-in-training then spends at least three additional years in psychiatry residency learning the diagnosis and treatment of mental illnesses, gaining valuable skills in various forms of psychotherapy, and in the use of psychiatric medications and other treatments.

CV, COVER LETTER AND INTERVIEW PREPARATION

A curriculum vitae (CV) is a type of résumé used by professionals in the fields of academia, medicine, teaching and research. A CV is an overview of your life's accomplishments, most specifically those that are relevant to the academic realm. It is a living document that should be updated frequently to reflect the development of your career. This chapter provides an overview of strategies for writing an effective CV.

Differences between a résumé and a CV

There are several notable differences between a résumé and a CV, including the following:

- Education is always listed first on a CV. Most candidates who use a CV have an educational background directly related to the positions they seek.
- CVs almost never list an objective and seldom have a long narrative profile. If you want to make a more elaborate argument for your application, do it in a cover letter.
- CVs should be understated. Self-congratulation can make you appear overconfident, so keep your CV descriptive yet simple.
- Name-dropping is more common in CVs than in résumés. For example, if you performed research under a certain professor, you would probably include his or her name and title. Science and academia are small worlds, and it is likely that a prospective employer will have heard of a given specialist in his or her own field.
- Unlike résumés, which typically should be limited to one or two pages, CVs often run for three or more pages. However, length is not the determinant of a successful CV. You should try to present all the relevant information that you possibly can, but also try to present it in as concise a manner as possible.

- CVs often contain more categories of information than résumés and should be neatly organized with clear headings and distinct conceptual divisions. Experience may be divided between headings for “Teaching” and “Research”; education may be divided between “Degrees” and “Continuing Education” or “Advanced Training.” How you organize this material determines its impact on the reader.

IS THERE A STANDARD CV FORMAT?

One of the most important things to remember when working on your CV is that there is not one standard format. A good CV is one that emphasizes the points that are considered to be most important in your discipline and conforms to standard conventions within your discipline. So how can you find out what these conventions are? A good place to start is to find as many examples as possible of CVs by people in your discipline who have recently been in the job market. You can find these by asking a mentor or colleague or by doing an Internet search.

WHAT SHOULD I INCLUDE?

Your CV should include your name and contact information, an overview of your education, your academic and related employment (especially teaching, editorial or administrative experience), your research projects (including conference papers and publications), and your departmental and community service. You should also include a reference list, either as part of your CV or on a separate page.

What comes first on your CV depends both on your background and on the job for which you are applying. Typically, the first item on a CV for a job candidate directly out of residency is education. The remaining items depend on the requirements of the jobs you are interested in and where your strengths

lie. When determining what comes after your educational credentials, remember that the earlier in your document a particular block of information appears the more emphasis you will be placing on that block of information. Thus, the most important information should come first.

HOW DO I CONSTRUCT MY WORK DESCRIPTION ENTRIES?

Two common strategies that apply to CVs as well as résumés are gapping and parallelism.

Gapping is the use of incomplete sentences in order to present your information as clearly and concisely as possible. For example, instead of writing “I taught composition for four years, during which time I planned classes and activities, graded papers, and constructed exams. I also met with students regularly for conferences,” you might write, “Composition Instructor (2010–2014). Planned course activities. Graded all assignments. Held regular conferences with students.” By using incomplete sentences here, you cut out unnecessary words and allow your reader to see quickly what you have been doing.

Parallelism is also important to a strong CV. Generally, you will want to keep the structure of your phrases and/ or sentences consistent throughout your document. For example, if you use verb phrases in one portion of your CV to describe your duties, try to use them throughout your CV. Verb phrases are a strong way to describe job responsibilities. To write them, pretend you are telling someone about your job, beginning each sentence with “I ...” For example, “I supervise 10 residents. I organize the call schedule.” On your CV, simply omit the “I” and use only the remaining verb phrases to describe the work you do. Use the present tense for jobs you currently hold and past tense for former jobs. If you have difficulty finding the right verbs to describe your work, choose from the following list.

VERBS FOR YOUR CV

accomplished	completed	diversified	improved	oversaw	revised
achieved	composed	drafted	increased	participated	revitalized
acquired	conceptualized	edited	influenced	performed	saved
acted	conceived	educated	informed	planned	scheduled
adapted	concluded	eliminated	initiated	prepared	screened
addressed	conducted	enabled	innovated	presented	set
adjusted	consolidated	encouraged	inspected	presided	shaped
administered	contained	engineered	instructed	prioritized	screened
advanced	contracted	enlisted	interpreted	processed	selected
advised	contributed	established	interviewed	produced	simplified
allocated	controlled	ensured	introduced	programmed	solidified
analyzed	coordinated	estimated	invented	projected	streamlined
applied	corrected	evaluated	investigated	promoted	strengthened
appraised	corresponded	examined	kept	provided	summarized
approved	counseled	executed	launched	published	supervised
arranged	created	expanded	lectured	recommended	surveyed
assembled	critiqued	expedited	led	reconciled	systemized
assigned	decreased	extracted	managed	recorded	tabulated
assisted	delegated	facilitated	manufactured	reduced	taught
attained	decided	familiarized	marketed	referred	tested
authored	defined	finalized	mediated	regulated	trained
automated	delivered	focused	moderated	rehabilitated	translated
balanced	demonstrated	forecast	modified	related	traveled
brought	determined	formulated	monitored	remodeled	updated
budgeted	designed	founded	motivated	repaired	upgraded
cataloged	developed	generated	negotiated	reported	validated
chaired	devised	guided	observed	represented	worked
changed	diagnosed	handled	operated	researched	wrote
clarified	directed	headed up	ordered	restored	
communicated	dispatched	identified	organized	restructured	
compared	distinguished	illustrated	originated	reversed	
compiled	distributed	implemented	overhauled	reviewed	

Particularly within entries, make sure that the structure of your phrases is parallel so your reader can easily understand what you are communicating.

One distinction between the work description sections of résumés and CVs is that bullets are very commonly used in résumés but tend to appear somewhat less frequently in CVs. Whether you use bullets to separate lines in your CV should depend on how the bullets will affect the appearance of your CV. If you have a number of descriptive statements about your work that each runs to about a line in length, bullets can be a good way of separating them. If, however, you have a lot of very short phrases, breaking them up into bulleted lists can leave a lot of white space that could be used more efficiently. Remember that the principles guiding any decision you make should be conciseness and ease of readability.

ASSEMBLING YOUR CV

When putting together your CV, consider the following:

- **Name**—list your full legal name. This is particularly important if you were single when you received your MD degree and have since married or changed your name for other reasons. This allows prospective employers to verify that the information you provided is accurate.
- **Address**—provide home and office/hospital addresses. If you do not want to receive correspondence at your work address, do not list it. Make sure that the addresses are current.
- **Phone, fax, pager numbers**—make it easy for a potential employer to contact you by providing home and office/hospital telephone, fax and/or pager numbers. Do not provide numbers where you do not want to be reached.
- **Education**—list in descending order, with most recent first. Note the name of the institution, degree received and dates.
- **Certification and licensure**—list applicable board certification(s), national board examination and licensure data (including year and state). Give dates of completion for each. If you are in the so-called board certification pipeline but have not yet taken the final boards, you may want to state just where in the process you are—e.g., written boards, oral boards, awaiting results, board-eligible (only if your specialty board recognizes this designation).
- **Postgraduate training**—cite all training, such as internship, residency and fellowship, with name of institution and dates. List the most recent training experience first.
- **Practice experience**—again, begin with the most recent experience and work backward. This makes the CV much more practicably usable.
- **Professional or teaching appointments**—include academic and professional appointments, fellowships and other unique training experiences.
Also mention special expertise in a certain medical procedure, administrative experience and fluency in foreign language.
- **Honors, awards and recognition**—list all scholastic, career and public service awards and scholarships you have received.
- **Research and publications**—cite presentations and publications. If this listing is long, you may want to tailor this section to the position you're seeking.
- **Accomplishments**—if you have a track record for getting results, you may want to add this category to your CV. Here you can provide concise results from committees on which you served, projects and task forces you directed or managed, or highlight your clinical and nonclinical administrative or managerial skills. If appropriate, a bullet format may help your accomplishments stand out and make them easier to read. It also will help you prepare brief

statements. When listing your accomplishments, do not go into great detail, as this tends to clutter and lengthen the CV unnecessarily.

- **Professional society memberships**—list the societies to which you belong, as well as those societies in which you hold leadership positions. Indicate the name of the committee, the position held and the time period in which it occurred.
- **Personal and professional references**—include physicians who can comment on the quality of your clinical skills and on your personality within the past several years. You may also consider asking hospital administrators, residency training directors, nurses and referring physicians to be references. Be sure to inform those whom you would like to list as references that you are seeking a new practice opportunity and would like to include their names on your reference list.

State on your CV that references will be furnished on request. This protects your references from being inconvenienced by many unsolicited telephone calls and allows you to evaluate a potential practice opportunity before you release your references.

WHAT NOT TO INCLUDE

Never include the following types of information on your CV: race, religion, anticipated compensation, reasons for leaving previous positions, personal health problems or disabilities, examination scores,

and license and DEA numbers. It is also permissible to omit references to your age, place of birth, citizenship and marital status.

PRINTING YOUR CV

Remember, the CV you send out gives an impression of you. Make sure it is a professional product so that it reflects favorably on you.

Your CV should be printed with black ink on high-quality 8½" x 11" bond paper. While paper in subdued shades of beige, blue or gray is acceptable, white or off-white paper is preferable.

RESOURCES

The following topics will link you to samples and more information about preparing a CV and cover letter, obtaining references and recommendations, and preparing for the interview. (These links will take you off the APA website. The APA is not responsible for the content of other websites.)

[How to create a CV, plus samples of CVs and cover letters](#)

[Interviewing tips](#)

JOB OPPORTUNITIES

To search job opportunities in psychiatry, visit [APA's Job Central](#).



How GME Funding Works

Much of the funding for residency programs comes from federal and state government health programs (mainly Medicare, Medicaid, and the VA), funding which is accompanied by very specific rules.

Though payments are made to institutions, and not directly to residents themselves, the amount of funding received is based on a “hospital specific per resident amount” which is determined by the Center for Medicare and Medicaid Services (CMS) for each teaching hospital. The amount that each hospital receives from Medicare for the direct costs of graduate medical education (DGME) is based on the number of residents it is allowed to count,

the hospital specific per resident amount, and the percentage of its inpatient population that is comprised of Medicare beneficiaries.

Hospitals are entitled to receive payment for those residents participating in “approved educational activities.” When Medicare counts the number of residents for determining a hospital’s DGME payment, each full-time resident is counted as a 1.0 full time equivalent (FTE) during their initial residency period (IRP). After their IRP, a resident is counted only as .5 FTE, thus the institution would receive only 50% of the funding it does from a resident counted as a 1.0 FTE. The IRP is the

minimum number of years required for a resident to become board-eligible in the specialty in which the resident first begins training, a span determined by the ACGME. For example, the IRP for psychiatry is four years.

Importantly, **every resident has just one IRP, and it does not change**, even if the resident later changes specialties.

So, for example, a resident begins an internal medicine residency on July 1, 2013, which has an IRP of three years. The resident realizes that she'd rather do a psychiatry residency, which has a four year IRP. If the resident begins the psychiatry program on July 1, 2013, the IRP remains three years, of which one year of training has been spent in internal medicine). She would be counted as 1.0 FTE during her first and second years of psychiatry residency, but only as 0.5 FTE during the third and fourth years. Therefore, the hospital will be paid less for the last two years of training than it would have been paid for a resident who began training in psychiatry right out of medical school and had an IRP of four years.

If your first residency is a transitional year, or your specialty requires a broad-based clinical year and you match simultaneously into both the broad-based year and the specialty program, then your IRP is determined by the residency program you enter in your second year of training. And, even if part of your training time is completed in a program not receiving Medicare funding, those years still count against your IRP.

Clearly, these rules can be tricky. The AAMC provides a more [detailed FAQ guide](#) (PDF) to help residents navigate Medicare GME funding rules.

Your funding eligibility can also be significantly impacted if you are required to repeat a year or are terminated by your program. Every institution is required by the ACGME to maintain a due process policy which residents can exercise if they are terminated or held back. Even though most residents complete training without delay, you should always be aware of your institution's policy and how to exercise your rights under it.



Navigating the Transition to Residency

ABOUT THE USMLE

The United States Medical Licensing Exam (USMLE) is the exam administered by the National Board of Medical Examiners (NBME). The Comprehensive Osteopathic Medical Licensing Exam (COMLEX) is the licensing exam administered by the National Board of Osteopathic Medical Examiners for graduates of osteopathic medical schools. Although the USMLE is the required exam for licensure of all allopathic physicians, it may also be taken in place of the COMLEX by osteopathic physicians. Although its primary purpose is for licensure, the USMLE has many secondary uses by both medical schools

and residency programs including promotion and graduation decisions for medical students as well as ranking of residency applicants.

The USMLE currently consists of three separate exams, known as “steps.” Step 1 assesses the basic sciences taught during years one and two of medical school. Most medical schools require students to have taken and/or to have passed Step 1 before or shortly after starting clinical rotations. Step 2 currently has two separately administered components, Clinical Knowledge (Step CK) and Clinical Skills (Step 2-CS). Step 2-CK tests knowledge

and application of the basic clinical sciences taught during the core clinical rotations, and Step 2-CS tests a student's basic clinical skills, including physical examination skills, clinical decision-making, note-writing ability, and interaction and communication abilities with standardized patients.

Most medical schools and residency programs require the passage of both components in order to graduate and begin the first year of residency. Some schools also offer or require their own clinical skills exam, which can prove useful in preparing for Step 2-CS. Step 3 represents a more advanced assessment of clinical knowledge and decision-making that is usually taken toward the end of the first year of residency.

All states require passage of all three steps in order to obtain a license to practice medicine. The structure of the entire USMLE is currently undergoing comprehensive review and evaluation, which may result in changes to the format of these exams. For the latest information, stay in contact with your school's administration and to visit the [USMLE](#) and [NBME](#) websites.

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Usmle Test Format and Scheduling

Most students will take USMLE Step 1 during the summer between their second and third years of medical school. [To register, complete the online form](#) using your individual USMLE identification number and password. During online registration you will request a testing-eligibility period on a form that will be mailed back to the USMLE. Within a few weeks you should receive a scheduling permit and can schedule your test date within the requested block of dates. You are allowed to reschedule up to a certain point without penalties—see your registration permit or the USMLE Website for specific details. When scheduling Step 1, allow sufficient time to adequately prepare, considering how much studying can realistically be accomplished while you are also taking regular medical school courses, and how much preparation should wait until you have finished your coursework so you can dedicate 100 percent of your time to studying for Step 1. Keep in mind that it is also

important to schedule the exam early enough to ensure sufficient time for retest in the event you do not pass. Once you take the test, it can take from four to eight weeks to receive your results.

Most students will take the two-part USMLE Step 2 exam toward the end of third year or the beginning of fourth year. Since both exams test the knowledge and skills acquired during rotations in the core disciplines, it is helpful to have those rotations completed before taking the exam. As many residency programs use these exam scores as part of the evaluation of their applicants, it is recommended the test be taken early enough to ensure scores are available for programs that require them. Early scheduling is also crucial for students trying to improve the strength of their residency application with respect to their Step 1 scores, or students involved in the early match or military selection board, which are discussed below. The scheduling process and score reporting for Step 2-CK is similar to Step 1, but Step 2-CS can prove more difficult to schedule so consider registering for the exam early. Further, in the event of failure, early scheduling will allow you to retake the exam prior to critical events such as graduation or residency application.

USMLE Step 3 is a more comprehensive exam, and tests more in-depth biomedical and clinical knowledge and decision-making. Because Step 3 covers all of the core disciplines, it is recommended that you take this exam before your knowledge erodes; this is especially true for those in more specialized residencies. Additionally, for those seeking to obtain their medical license in order to moonlight during residency, or for military residents preparing for an operational tour, Step 3 can be taken as early as the beginning of internship year. [Registration and application for Step 3 is completed online](#) through the Federation of State Medical Boards (FSMB) and the state through which you are requesting a license. Remember, it is important to be familiar with the [specific requirements of the state](#) you will be practicing in. (These links will take you off the APA website. The APA is not responsible for the content of other websites.)

Test Preparation

When deciding how to study for all steps in the USMLE, keep in mind your best learning techniques. Preparation materials for Step 1, Step 2-CK and Step 3 include comprehensive review books, subject-specific review materials, formal review courses, and written and electronic question banks. Most students need a combination of both review materials and questions to optimize their content knowledge and familiarity with question format. Some of the most popular review books include First Aid for the USMLE, High Yield Comprehensive USMLE Review, Crush the Boards, and Kaplan Medical USMLE Q Bank series. Step 1 consists of approximately 350 multiple-choice questions divided into seven one-hour blocks given over an eight-hour period. Step 2-CK consists of approximately 370 multiple-choice questions divided into eight one-hour blocks given over nine hours. Step 3 consists of approximately 480 multiple choice questions divided into six blocks of 35–50 questions with each block running 45–60 minutes, and nine 25-minute computer-based clinical simulations. Step 3 is given over two days with one eight-hour block per day. Important elements to incorporate into your study routine is answering questions in blocks similar to the actual exam structure, and taking full-length practice exams to familiarize yourself with the time limits required for each block and to build up stamina for test day. The [USMLE website](#) also has multiple exam preparation resources for students, including information on test format, practice questions and review materials. Additionally, most medical schools will offer practice exams for students to measure where they are in their preparation. (This link will take you off the APA website. The APA is not responsible for the content of other websites.)

Special Testing Accommodations

The NBME provides testing accommodations for students with documented disabilities. After registering for an exam, a student can submit a written request for testing accommodations to the NBME. This request must include a request form, a personal statement written by the applicant, and all relevant and required documentation. The [USMLE website](#) offers all relevant forms, in addition to information and instructions on compiling complete

and comprehensive documentation. Register early to allow enough time for the approval process, which typically takes from six to eight weeks from the time a request is received. Remember, the most common reason for delay is incomplete supporting documentation. So be prepared to work with your school's administration as well as the NBME staff to ensure clear and timely communication. A separate request form and information can also be found on the NBME Website for women who need breastfeeding accommodations during the exam.

ABOUT THE COMLEX

Administered by the National Board of Osteopathic Medical Examiners (NBOME), the Comprehensive Osteopathic Medical Licensing Exam (COMLEX) is the licensing exam that can be taken by osteopathic medical students in place of the USMLE. The test is designed to assess the osteopathic medical knowledge and clinical skills considered essential for osteopathic generalist physicians to practice medicine without supervision. The exam is a three-level sequence that tests knowledge and skills in two dimensions: Dimension I addresses the clinical presentation, while Dimension II addresses the physician task. Many allopathic residency programs will accept COMLEX scores in lieu of USMLE scores, but you will need to inform the program which exam you are taking so they know which scores to expect.

COMLEX Level 1 is designed to test basic science knowledge relevant to medical problems, and emphasizes the scientific concepts and principles necessary for understanding the mechanisms of health, medical problems and disease processes. The exam is typically taken at the end of the second year of medical school and is a one-day test consisting of two four-hour sessions.

COMLEX Level 2 has two parts. Level 2-CE covers the medical concepts and principles necessary for making appropriate medical diagnoses through patient history and physical exam findings. It is a one-day problem- and symptom-based assessment exam covering all of the major medical specialties. Level 2-PE is a clinical skills assessment exam involving standardized patient encounters. It is a one-day, seven-hour exam that covers 12

standardized patient encounters. Both exams are typically taken at some point during the fourth year.

COMLEX Level 3 is a problem- and symptom-based assessment that integrates all of the major specialties, and assesses the knowledge of clinical concepts and principles necessary for solving medical problems as an independently practicing osteopathic physician. The exam is taken during the first year of residency and consists of two four-hour test sessions. COMLEX scores are reported numerically for Level 1, Level 2-CE and Level 3; Level 2-PE is scored as pass/fail. Score reporting typically takes eight to 10 weeks but can take up to 14 weeks during the initial three to four months of computerized testing.

More information on the COMLEX, including registration, testing schedules, practice materials and answers to frequently asked questions can be found on the [NBOME website](#).

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SCHEDULING CLINICAL CLERKSHIPS

After your second year of medical school, you will spend the remaining two years doing clinical clerkships in multiple medical specialties. Whereas the first half of medical school training, which consists of nearly 100 percent objective examinations, the second half is a combination of objective and subjective examinations. Keep an open mind about all the specialties you rotate through as you may discover you enjoy a field that you previously had not considered. The procedure for scheduling clinical clerkships, also known as rotations, will differ between medical schools, with some schools offering greater flexibility than others. Your grades during your third year of medical school will be an important part of your residency application, so doing well in your third-year clerkships is important. Be mindful that the people you interact with during clerkships may eventually be those who will write letters of recommendation for you or be advisors in your fourth year.

When deciding how to schedule clinical rotations, there are several things to keep in mind. If you have

an interest in a specific field, for example, it may be beneficial to schedule a rotation in that specialty early in your third year. This will provide you an opportunity to have hands-on experience in that field and enable you to make a more educated decision on whether to choose that specialty. On the other hand, gaining general clinical experience prior to starting specialized rotations may be necessary to equip you with the knowledge, skills and abilities to succeed in more specialized rotations. If you have identified particular programs you are interested in, doing elective rotations at those institutions can provide you with an opportunity to work directly with attending and resident physicians in those programs. This experience can help you decide whether you fit with a particular program and give you the opportunity to make a good impression on the attending physicians and residents who will make recommendations on applicants.

Health Professions Scholarship students can optimize face time at the residency programs they are interested in by doing one rotation early in their fourth year and the other just before the selection board meets in November. These rotations are generally four weeks in length and can include not only clinical rotations but also opportunities with the different operational medicine specialties.

CHOOSING A RESIDENCY PROGRAM

Many of the same considerations that go into choosing a specialty are also applicable when deciding where to apply to residency and how to rank programs. There are many things to take into account when looking seriously at a residency program, such as:

- Academic vs. community setting
- Multiple hospital system
- Large or small program
- Ancillary staff/facilities
- Teaching hours
- Autonomy
- Areas of concentration
- Rank status
- Quality of life of residents

Also consider the number and type of other programs located within the same institution. While each specialty tends to have its own personality, different programs within a specialty can vary considerably; therefore, it is important to get a sense of how you will fit into this environment. Geographic location can also be a key factor, especially if a spouse's or a partner's employment or preferences must be considered. If a spouse or significant other is also applying for residency, then the couples match program must be utilized in order to match in the same city. Finally, keep in mind, especially when considering transitional internships or primary care residencies, the number and type of other programs located within the same institution. Opposed programs, or programs collocated with other residency programs, provide some advantages such as an increased number of available specialists and a wider variety of cases seen. Unopposed, or solo programs, offer the undivided attention of attending faculty and the lack of competition for cases and procedures with residents from other specialty programs. These pros and cons should be weighed before making a decision.

LOCATION, FAMILY AND HOUSING CONSIDERATIONS

Although your primary considerations are the advantages and disadvantages of the residency programs themselves, there are other factors for you to consider as well. Do you enjoy a big city, the quiet life of a rural town or something in-between? Are you single, married, and/or have children? If single, how do you like to spend your limited free time? If you are married or have a significant other, is he/she planning to work and what employment opportunities are available in the geographic locations that are being considered? What is the cost of living in these areas? How are the schools and neighborhoods? Will you find an apartment or buy a house?

The following are important resources to help you during the residency program selection process and after you have made your selection.

(The following links will take you off the APA website. The APA is not responsible for the content of other websites.)

- Read about home *buying vs. renting*.
- [Homefair.com](#) and [Move.com](#)
 - ◇ Salaries—see salaries in different locations (*also see Cost of living comparisons between locations*).
 - ◇ City reports—obtain information on cost of living, climate, demographics and more by location.
 - ◇ School reports—get in-depth reports on local schools and child care centers.
 - ◇ Crime statistics—get crime indexes for thousands of U.S. cities and Canada.
 - ◇ *Check home prices*—find out home prices in particular areas.
 - ◇ *Rentals*—obtain contact information for rental placement services.
 - ◇ *Moving calculator*—check out this tool and other resources, including information on neighborhood merchants.
- [U.S. Census Bureau](#) and [ZipSkinny.com](#) View demographics of the patient population in the areas where you are considering practicing medicine.
- [Bankrate.com](#) View state information about income and sales taxes levied in each state.
- [Weather.com](#) Get detailed information about local weather conditions, including average temperatures, rainfall and sunrise and sunset times.
- [Kaiser Family Foundation](#) Resources on the latest state-level data on demographics, health and health policy, including health coverage, access, financing and state legislation.

THE RESIDENCY APPLICATION PROCESS

Preparing Your Application

Now that you have decided which residency track to pursue, it is time to prepare and send your application to programs. In 1992, the AAMC developed an electronic system for the transmission of students' applications, personal statements, Medical Student Performance Evaluations (MSPE), medical school transcripts, USMLE transcripts, COMLEX transcripts, and other supporting credentials from applicants and their Designated Dean's Office to residency program directors. Known as the Electronic Residency Application Service (ERAS), it is used by most residency programs ([a full listing can be obtained here](#) or through your Dean's office).

Prior to submitting an application, you are responsible for determining if a program of interest uses ERAS, the deadline for submitting an application and the eligibility requirements. As a general rule, review the eligibility requirements and employment policies for the residency programs for which you plan to apply. You want to avoid wasting time and money by applying to a program that is not accepting PGY1 applications. Also, if a residency program requires an official United States Medical Licensing Examination (USMLE) transcript, please make sure it is included.

ERAS is available to all US medical students through their respective Dean's office. For students and graduates of foreign medical school, it is available through the Educational Commission for Foreign Medical Graduates (ECFMG) which acts as the designated Dean's office. Once you have contacted your Dean's office, the rest of the application process can be done online at the AAMC ERAS website. There is a fee that covers registration and application for up to 10 programs in each discipline. Additional costs are incurred once the initial 10 programs have been exceeded. When choosing the number of programs, use a systematic approach. Apply to different programs, such as top tier to middle tier, while considering location, if that is a factor in your decision. For foreign medical graduates, an additional application fee is added. The fee is calculated automatically and charged

directly to the applicant. Remember that once the total fee has been paid, it is not refundable. Therefore, double check the list of programs that you have selected. Once the completed application has been sent, the waiting begins. Generally, within four to six weeks, you should start hearing about interviews. If you don't, contact ERAS (via the USMLE/ ECFMG identification number assigned to you) and inquire about the status of the application.

Composing A Personal Statement

When writing your personal statement, build in ample time for several people to review the statement and provide feedback. The individuals you select to review the statement should be from various backgrounds, both medical and non-medical professionals. Your reviewers should be skilled not only in writing, but also in providing objective, high quality and detailed feedback. Your statement should flow smoothly while conveying your reasons for choosing a career in psychiatry. Your passion, work ethic, personality and desire to make a positive contribution to the field should be apparent to the reader. Strive to underscore your interest by including things such as relevant life experiences, clinical work and research that make your statement stand out and convey your unique qualities.

Requesting Letters Of Recommendation

Depending on the specialty and sometimes the programs to which you are applying, the request for letters of recommendation can vary slightly; consequently, it's prudent to determine if any unique requirements exist before you request that letters be written on your behalf. Generally speaking, letters from attending physicians are stronger than letters from senior residents (note: some programs or specialties will not accept recommendation letters from residents). You should choose individuals who know you well enough to write a strong letter on your behalf, discussing specific qualities and experiences rather than writing in generalities. It may be useful to provide them with examples of your accomplishments and skills that they can use as supporting material for your letter. It is also recommended that you provide all letter writers with a copy of your most current CV and personal statement.

Although the required number of letters can vary by program, obtaining four to six letters is a good starting point. You should try to obtain at least one letter from a faculty member on an advanced rotation in psychiatry.

Students with pertinent experience outside of the clinical arena—i.e., research, professional society participation or special clinical experiences such as volunteer or international work— should also consider professionals from those areas as potential recommendation letter writers. Through *ERAS*, you can control which letters go to which programs.

When requesting a letter, be sure to allow adequate time for the individual to produce a quality document; keep in mind that these individuals have busy schedules and may have requests from multiple students. As a professional courtesy, a timely, handwritten thank you note to your letter writers is always appropriate.

THE NATIONAL RESIDENT MATCHING PROGRAM PROCESS

The National Resident Matching Program (NRMP or “the match”) is used by most residency programs to fill their programs with incoming residents. Applicants can register for the match starting in August of their fourth year of medical school. It is important to remember that this is a separate registration than the *ERAS* registration. Interviews take place typically between September and February with rank-list certification due to the NRMP at the end of February. Matched and unmatched results are released in March on a designated “Match Day”; this day also opens the period when unmatched applicants are allowed to start contacting programs with vacancies. For detailed information on the results of the match and the Supplemental Offer and Acceptance Program (SOAP), visit the [NRMP website for more information](#).

(This link will take you off the APA website. The APA is not responsible for the content of other websites.)

Couples match

Each partner of a couple (married or unmarried) enrolls INDIVIDUALLY in the match and indicates in

the NRMP R3 System that they want to participate in the match as a couple. You will need your partner’s NRMP ID to link your Match applications and pay the online non-refundable couple fee. The NRMP allows couples to form pairs of choices on their primary rank-order lists, which then are considered in rank order in the match. The couple will match to the most preferred pair of programs on the rank-order lists where each partner is offered a position. Couples can be matched into a combination of programs suited to their personal needs. In creating pairs of programs, couples can mix specialties, program types (preliminary or transitional, categorical and advanced), and geographic locations. The partners can be matched into positions in the same institution or in different institutions. Applicants are advised to include on their rank-order lists only those programs that represent their true preferences.

Each partner must have the same number of ranks. Each program ranked must be paired with an active program or by an indication of “No match” by the other partner, which means that one partner is willing to go unmatched if the other matches to a position in the program designated at that rank.

If one partner wishes to withdraw from the match, BOTH partners must “uncouple” in the NRMP system before either can withdraw. The remaining partner should adjust his or her rank-order list accordingly, and they must recertify their list before it can be used again in the match. Remember, partners listed as a couple are treated by the matching algorithm solely as a couple. If they do not obtain a match as a couple, the system will not run their lists separately to find a possible match for each individual.

NRMP’s summary of guidelines for the couples match rank-order lists:

- Programs should be ranked in sequence, according to the applicant’s true preferences.
- Factors to consider in determining the number of programs to rank include: the competitiveness of the specialty, the competition for the specific programs being ranked, and the applicant’s qualifications. In most instances, the issue is not

the actual number of programs being ranked but rather whether to add one or more additional programs to the list in order to reduce the likelihood of being unmatched.

- Each partner of a couple may rank up to 30 different programs on their primary rank order lists, and up to 30 different programs on all supplemental rank order lists combined before incurring an additional fee per program.
- Supplemental lists will be considered individually and NOT paired with the partner's corresponding supplemental list.
- Applicants are advised to rank all programs deemed acceptable, i.e., programs where they would be happy to undertake residency training. Conversely, if an applicant finds certain programs unacceptable and is not interested in accepting offers from those programs, the program(s) should not be included on the applicant's rank order list.
- It is highly unlikely that either applicants or programs can influence the outcome of the match in their favor by submitting a list that differs from their true preferences.

POST-MATCH "SCRAMBLE"

If an applicant did not Match, there is a short period to find unfilled positions through the Supplemental Offer and Acceptance Program (SOAP). On Monday of Match week, the NRMP will notify applicants if they Matched or not. Un-Matched applicants can then access the list of unfilled programs for those positions which they are eligible. Applicants can only apply to unfilled programs participating in SOAP and can only use ERAS to submit applications. These positions fill very quickly (usually in one day) and applicants typically send their applications to as many programs as possible through ERAS. Residency programs participating in the Match but not in the SOAP can only extend offers after SOAP concludes.

RESIDENCY PROGRAM INTERVIEWS

The interview process begins as soon as you make contact with the program. Everyone from the receptionist you speak with on the phone to the program coordinator who greets you in the lobby potentially affect your acceptance to the residency program. Accordingly, treat everyone you encounter during this time with patience and respect.

You should also thoroughly research the program before your interview. Learn as much as possible can about the institution, residency program, faculty and staff who will be interviewing you. This will help you ask targeted questions and identify topics or issues to explore further during the interview. Your research should include the specialty for which you are applying. Are there any emerging trends or specific qualities the specialty is looking for in its young physicians (like, for example, leadership or research)? Knowing this information can help you emphasize your experiences that meet their criteria.

A residency interview is a job interview and first impressions are critical. Business attire is appropriate and women should avoid heavy make-up and low neck lines.

Remember, smile and maintain eye contact with your interviewer.

It's natural to be nervous during an interview so take deep breaths to calm your nerves. Being prepared can also detract from nervous jitters. Be very familiar with your application packet, as you're likely to get questions about your background. Practice answering common residency interview questions. Sometimes the simplest questions can be the hardest to answer. Spend some time reflecting on questions like "Why do I want to be a doctor?" "Tell me about yourself." "What are your hopes for your career?" and "Why are you interested in this specialty?" Another common question with which interviewees often struggle is "What's a personal weakness?" Consider using this as an opportunity to discuss a shortcoming that could actually be, or become, a strength. For example, you might describe how you're learning to better coalesce your perfectionist tendencies with your time management skills.

The interviewers are also likely to ask if you have questions, which is a perfect opportunity to seek information about the program. Questions you might consider include:

Questions for Attendings:

- What are the strengths/weaknesses of this program?
- Is the emphasis of the program more biological or psychotherapy based?
- Do you foresee any changes in the near future? (Especially changes in program leadership.)
- How active are faculty members in teaching?
- Does the faculty publish?
- Are there any research opportunities for residents? Is research required?
- How do the residents seem to get along?
- What are you looking for in an applicant/resident?
- Do you have specialty clinics (e.g., mood disorders, anxiety disorders, eating disorders, med/psych clinics)?
- How are the residents' PRITE/board scores?
- What do your residents do when they graduate? Fellowships? Private practice? Academics?
- How well does faculty get along with each other? With residents? With other departments?
- How are residents evaluated?
- How does psychotherapy supervision work here? Do residents get to choose their supervisors? How many hours of supervision do they have per week?
- How diverse is your patient population? What is the socioeconomic mix of the patients?
- Do you have a journal club? Are faculty members involved?
- How many hospitals do residents work out of, and how far away are they? Which hospital do residents base their outpatient clinics out of? (It's nice if you can work in a variety of settings, such as a private hospital, psychiatric hospital, VA.)

- How well do residents do on their internal medicine and neurology rotations?
- What is the average length of stay for patients?
- Can I see a copy of your psychotherapy curriculum? Do residents gain experience in short- and long-term psychotherapy, CBT, group/family therapy, etc.?
- How much ECT experience do residents receive?

The interview is your best opportunity to learn about the program but exercise tact when asking your questions. Instead of "How many hours will I have to work?" consider "What's expected of a first year resident?" or "What's the resident lifestyle like here?"

The residents in the program may be additional sources of information. Plan to spend some time interacting with the residents to obtain other perspectives on the program and to have an opportunity to ask questions you may not want to ask faculty. They are your best window into the quality of life among residents in the program. Ask questions like whether they socialize as a group, how complaints are handled and what happens if a resident is sick. They can also provide insight on the program location.

Questions for Residents:

- How much supervision do you have?
- Why did you choose this program? What other programs did you look at?
- What are the strengths/weaknesses of the program?
- Any regrets about your decision to come here?
- Has anyone left the program? (a very revealing question—always ask why)
- Are you happy here? Are others happy here?
- How's call? Is there a night float system?
- How's PGY-1 morale? PGY-4 morale?
- How well do residents get along? Do you get along with faculty?
- Do you feel well-respected among other departments?
- How much teaching do you get? Conferences? Core teaching programs?

- Are didactics protected?
- How diverse is your patient population?
- How much psychotherapy exposure do you get?
- How much influence do you have on your curriculum?
- What books do you use?
- Do you have time/opportunities for research?
- How's parking/transportation?
- What's the cost of living? Where do most residents live?
- Are residents allowed to moonlight by the program? What are the rules?
- How are the facilities? Call rooms? Resident lounge? Computer system? Cafeteria?
- What benefits do you have—insurance, vacation, sick leave, educational leave, maternity/paternity leave, educational money?
- How many residents have babies during residency? How accepted is this?
- Food allowance? Laundry? Lab coats?
- Climate? Recreation? Work out facilities?
- Do you have any free time?
- Is there low fee psychotherapy for residents?
- What are your community psychiatry experiences like?
- Would you come here if you had to choose again? Types of required rotations and amount and type of elective rotations
- Participation in education conferences and organized medicine. Topics of particular interest to you (e.g., opportunity to participate in outside activities such as professional societies, volunteer work, and international opportunities)

Maintaining an Appropriate Social Media Presence During the Interview Process

As the popularity of social media continues to grow, you can be sure that more interviewers will be using these sites to learn more about their potential residents. That makes it more important than ever to maintain an appropriate social media presence. All sites on which you have a presence should be set on private or, better yet, you should censor posts to only include information you wouldn't mind a potential employer viewing.

This is good advice during the interview process and throughout your career. Medical boards are increasingly monitoring physician activity online – and launching investigations when posts go awry. Particularly inappropriate posts can be considered unprofessional conduct by some boards. Suspect behavior includes posting pictures or identifying information about patients, citing misleading information about clinical outcomes, misrepresenting credentials, and inappropriately contacting patients. The Federation of State Medical Boards offers [*Model Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice*](#) (PDF).

Unacceptable interview questions and topics
Although you are free to share this information, interviewers are not supposed to ask about your rank- list priorities. It is important to convey your interest to a program you most want to match with so that they know you are a serious. You can accomplish this without specifically revealing your rank list; however, if you choose to share your list, be consistent from program to program. Do not tell multiple programs they are your number one choice because inconsistencies in rank-list priorities can be problematic, especially if programs compare information.



FREIDA Online

FREIDA Online, the AMA's Fellowship and Residency Electronic Interactive Database Access, is a free Internet database of approximately 8,600 graduate medical education (GME) programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), as well as combined specialty programs approved by member boards of the American Board of Medical Specialties.

Users of FREIDA Online can search the database by specialty/subspecialty or state/region, among other criteria. In addition, the SearchPlus feature allows users to compare programs by features of importance, such as program size, type of

program and program setting. FREIDA Online also displays aggregate statistics for each specialty and subspecialty, providing averages and percentages on, for example, the average number of faculty per program in a specialty or the average number of hours on-duty. Aggregated information on the career plans of graduates of programs is also available, organized by specialty/subspecialty.

AMA medical student and resident members can save their search results in an electronic folder, as well as print their own mailing labels to contact the programs of their choice.

Basic and Expanded Listings

GME programs update data for FREIDA Online

via the National GME Census, an annual survey conducted by the AMA and Association of American Medical Colleges. The information from the survey is listed in either basic or expanded detail depending on the preference of each program.

FREIDA Online Listings: Basic

All programs listed in FREIDA Online include the following information.

- Program name
- Program identifier (e.g., 120-36-21-000)
- Specialty/subspecialty (e.g., family medicine)
- Program director (name, mailing address, phone, fax, e-mail, Web address)
- Person to contact for more information about the program (name, mailing address, phone, fax, e-mail)
- Accredited length; required length
- Accepting applications
- Program start date
- Participates in Electronic Residency Application Service (ERAS)
- Affiliated with U.S. government
- Institution list (sponsor and participant[s])

FREIDA Online listings: Expanded

Programs that select the “Expanded Detailed Listing” option (as the majority of programs do) provide the following information to students and residents:

General Information

- Comments (used to highlight special qualities about the program, such as unique features or a description of hospital setting)
- Total program size (by year)
- Primary teaching site (e.g., city university hospital)
- Emergency medical records at primary teaching site
- Program best described (e.g., community-based hospital)
- Previous GME required

- Preliminary positions offered
- USMLE Step 2-CS passage required
- Participation in National Resident Matching Program (NRMP); NRMP code(s)
- Participation in San Francisco Match
- Participation in other matching program
- Number of interviews conducted previous year for first-year positions
- Required letters of recommendation
- Earliest date for applications; latest date for applications; interview period

Program Faculty

- Number of faculty (physician and non-physician)
- Full and part-time physicians and non-physicians
- Percentage of full-time paid female physician faculty
- Ratio of full-time equivalent paid faculty to positions

Work Schedule

- Average hours/week on duty during first year (excluding beeper call)
- Maximum consecutive hours on duty during first year (excluding beeper call)
- Average number of 24-hour off-duty periods per week during first year
- Moonlighting allowed within institution
- Night float system (residents do/do not participate during first year)
- Call schedule (by year)
- Most taxing schedule and frequency per year
- Beeper or home call (weeks/year) Educational setting and environment
- Average hours/week of regularly scheduled lectures/conferences
- Training at hospital outpatient clinics
- Training in ambulatory non-hospital community-based settings, e.g., physician offices, community clinics

Educational Features and Benefits

- Curriculum on management of tobacco dependence

- Assessment/enhancement of medical professionalism
- Debt management/financial counseling
- Formal program to develop teaching skills
- Formal program on interdisciplinary teamwork
- Formal mentoring program
- Continuous quality improvement training
- International experience
- Resident/fellow retreats
- Off-campus electives
- Hospice/home care experience
- Cultural competence awareness
- Instruction in medical Spanish or other non-English language
- Alternative/complementary medicine curriculum
- Training in identifying and reporting of domestic violence/abuse
- MPH/MBA training or PhD training
- Research rotation

Additional Features

- Offers additional training or educational experience beyond accredited length
- Offers a primary care track, rural track, women's health track, hospitalist track, research track/non-accredited fellowship and/or another special track

Resident Evaluation

- Yearly specialty in-service examination required (advancement based/not based on exam results)
- Patient surveys
- Portfolio system
- 360-degree evaluations
- Objective Structured Clinical Examinations (OSCEs) Program evaluation

- Program graduation rates
- Board certification rates
- In-training examinations
- Performance-based assessments Employment policies and benefits
- Part-time/shared positions
- PDAs available
- On-site child care; subsidized child care
- Allowance/stipend for professional expenses
- Leave for educational meetings/conferences
- Moving allowance
- Housing stipend
- On-call meal allowance
- Free parking
- Job placement assistance
- Cross coverage in case of illness/disability

Compensation and Leave (By Year)

- Salary compensation
- Vacation weeks
- Sick days
- Paid/unpaid days for family/medical leave

Major Medical Benefits

- Major medical insurance for residents and dependents
- Outpatient/inpatient mental health insurance
- Group life insurance
- Dental insurance
- Disability insurance
- Disability insurance for occupationally acquired HIV
- Onset of medical insurance coverage

Access FREIDA Online.



Psychiatry Residency

Residency program in psychiatry is designed to ensure that its graduates are able to render effective professional care to psychiatric patients. Graduates should possess sound clinical judgment, requisite skills, and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders, together with other common medical and neurological disorders that relate to the practice of psychiatry.

General or adult psychiatry training is four years long. Physicians may enter psychiatry programs at either the first-year or second-year postgraduate

level. Physicians entering at the second-year must document successful completion of a clinical internship in an ACGME-accredited program (such as internal medicine, family medicine, pediatrics or transitional year.) Additionally, physicians who have completed prior GME training in any specialty may enter psychiatry residency as a PGY-2.

Residency training provides clinical experiences, supervision and formal didactics in all aspects of psychiatric medicine. Residents are given responsibility for a wide variety of patients in outpatient and inpatient settings. Programs also

provide the training necessary to understand the psychiatric literature, to evaluate the validity of scientific studies, and to incorporate new knowledge into the practice of medicine.

There are two patterns in psychiatry residency training. The most common is the four-year residency or 48 months which includes four months in internal medicine, family medicine and/or pediatrics (internship). The other is a three-year residency plus 1 or 2 years of subspecialty fellowship training.

Although not necessary to practice in a specific area, some psychiatrists continue training beyond general/adult psychiatry. Specific fellowships provide advanced training in child and adolescent psychiatry, geriatric psychiatry, forensic psychiatry, addictions psychiatry, psychosomatic medicine (consultation/ liaison psychiatry), pain medicine, neurodevelopmental disabilities, and psychiatric research. Additionally, advanced training is available in administrative psychiatry, emergency psychiatry, community psychiatry and public health, health policy, military psychiatry, neuropsychiatry, research, and specific psychotherapies.

COMPETENCIES IN PSYCHIATRY

The ACGME requires that each resident meet specific knowledge and skills to complete training. For psychiatry, the required competencies are:

Patient Care and Procedural Skills

Demonstrate ability to examine culturally diverse patients, develop differential diagnosis and treatment of patients, including using various means such as pharmacological regimens and various therapies.

Medical Knowledge

Knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

Practice-Based Learning And Improvement

Ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Interpersonal And Communication Skills

Demonstrate skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Professionalism

Demonstrate commitment to carrying out professional responsibilities and an adherence to ethical principles.

Systems-based practice

Demonstrate awareness of and responsiveness to the larger context and system of healthcare, as well as the ability to call effectively on other resources in the system to provide optimal health care.

COMBINED PROGRAMS

In addition to general psychiatry training, some institutions offer combined training in psychiatry and an additional field. Combined programs include: Psychiatry/Internal Medicine (5 years), Psychiatry/Family Practice (5 years), Psychiatry/Neurology (6 years) and Psychiatry/Child Psychiatry/Pediatrics or “triple board” (5 years).

RESIDENCY TRAINING

Post-Graduate Year One (PGY-I)

The first post graduate year includes four months in a primary care clinical setting that provides comprehensive and continuous patient care such as internal medicine, family medicine, surgery, pediatrics, or OB/GYN. The remaining 8 months varies with the specific training program and may consist of time on neurology and psychiatry services (no more than 8 months) such as Emergency Psychiatry, Substance Abuse, Geriatrics, etc. or additional experiences on medical and surgical units.

Post-Graduate Year Two (PGY-II) & Post-Graduate Year Three (PGY-III)

All psychiatry residents spend at least two years in the basic general residency (“double-Board” programs, for example leading to Board eligibility in general psychiatry and internal medicine may be exceptions). This time includes rotations on an inpatient service (6-16 months), with full and partial hospitalization, emergency room and/or

walk-in or crisis clinic coverage, and ambulatory services. These experiences are complemented by didactic and participatory seminars, as well as case supervision. Clinical experiences in neurology (2 months), outpatient (12 months), child psychiatry (2 months), addiction psychiatry (1 month), consultation/liaison psychiatry (2 months), forensic psychiatry, emergency psychiatry, community psychiatry, forensic psychiatry, geriatric psychiatry, and are also usually included in PGY-II and III.

Post-Graduate Year Four (PGY-IV)

The final year of psychiatry residency training (PGY-IV) generally offers opportunities for electives. Electives should enrich the educational experience of residents based on their interest and professional goals. Some residents serve as the chief residents while others may choose to focus on special clinical and/or research experiences.

SUBSPECIALTIES AND RESEARCH TRAINING

A number of subspecialties are offered within the field of psychiatry. Except for child and adolescent psychiatry which requires two years of training, most require a one-year fellowship that follows the standard four years of general psychiatry residency. When completed, one is eligible to take the ABPN board certification in general psychiatry and subspecialties.

Child and Adolescent Psychiatry

Child and Adolescent Psychiatry training emphasizes developmental considerations. Biological, sociocultural, psychodynamic, behavioral, and familial aspects of childhood and adolescence and their problems are covered in both clinical and didactic experiences. Consultation with ambulatory and hospital pediatric services is an essential part of child and adolescent training. In addition, residents consult with schools, courts and social welfare agencies.

Geriatric Psychiatry

Geriatric Psychiatry emphasizes the biological and psychological aspects of normal aging, the psychiatric impact of acute and chronic physical

illness, and the biological and psychosocial aspects of the pathology of primary psychiatric disturbances of older age.

Addiction Psychiatry

Addiction Psychiatry subspecialty training is concerned with the diagnosis and treatment of addictive disorders as well as the treatment of persons with complicated, comorbid psychiatric and substance use disorders.

Forensic Psychiatry

Forensic Psychiatry provides the psychiatrist with special skills necessary to deal with the legal system, including both civil and criminal aspects. The training includes work in evaluation competency, the insanity defense, and providing court testimony. Additionally, trainees have clinical experiences with patients in jails and prisons.

Psychosomatic Medicine

Psychiatric morbidity has serious consequences in the setting of medical illness causing increased functional disability, increased economic burden, and increased medical and psychiatric morbidity. One and two-year fellowships are available for graduates of approved psychiatric residency programs.

Research

A wide variety of research is being conducted in psychiatry and many residency programs offer funded fellowships for additional training opportunities in research after graduation. Research guides innovations in the organization and structure of mental and addictive health service delivery systems. To a greater extent than ever before, research informs public and private sector policies that affect persons with mental health and their families, as well as mental health care providers, insurers, and agencies at all levels of government. The APA online [*Directory of Research Fellowship Opportunities in Psychiatry*](#) lists research fellowships at over 60 leading institutions. In addition, each program listed in this Directory identifies funded research opportunities at their site.



Fellowship and Award Opportunities

During your residency, the APA offers leadership development opportunities, fellowships and awards to demonstrate accomplishment, and professional development activities.

[Fellowships, award and competitions](#)

[Leadership opportunities](#)

Duty Hours and Resources

As outlined by the *Accreditation Council for Graduate Medical Education* (ACGME), “duty hours are defined as all clinical and academic activities related to the program.” The resources below will give you more information on this topic. (These links will take you off the APA website. The APA is not responsible for the content of other websites.)

[Duty hour language](#) (PDF)

[FAQs about the ACGME common duty hour standards](#) (PDF)

[How to file duty hour violation complaint with the ACGME](#) (PDF)



State Medical Licensure

A medical license granted by a U.S. state or jurisdiction is required of any physician who wishes to practice medicine in one or more state(s)/jurisdiction(s). Complex licensing boards and licensing statutes vary widely from one state to the next, depending on each jurisdiction's resources and regulations (specified in its Medical Practice Act), as well as on legislative, media and public expectations. All medical boards have continued to improve licensure processes, and a growing trend toward uniformity of requirements among licensing boards should enhance both the initial licensure process and licensure portability.

However, because automatic reciprocity between state medical boards has largely been discontinued, the licensure process requires that physicians complete individual applications for each state in which they seek to practice medicine (including telemedicine). Direct, primary-source verification of education, graduate training, hospital privileges, exam scores, references, current and past licenses, and additional queries, profiles and reviews will be expected. Keep in mind that although each state's licensing processes may be different, the applications and requested information are usually similar; consequently, retaining copies of completed

materials can reduce your time spent reproducing the same information. See a [list of state medical board websites](#).

(This link will take you off the APA website. The APA is not responsible for the content of other websites.)

Many states have expanded what is considered to be the practice of medicine in order to address new trends in the medical field that require medical board regulation. For example, a number of states have passed legislation in recent years that empower medical boards to have jurisdiction over the practice of medicine across state boundaries (including telemedicine) or treatment decisions made by medical directors of managed care organizations.

Within this context, a physician seeking initial licensure or subsequently applying for a license in other states should anticipate the possibility of delays due to the necessary investigation of credentials and past practices, as well as the need to comply with necessary licensing standards. The following ground rules and suggestions should assist in the licensure process:

1. When contacting a licensing board for the first time, ask for a copy of its current licensing requirements and the average time it takes to process applications. This will provide you with a solid idea of when to consider closing an existing practice and/or plan a move, as well as information about the potential problem areas in completing an application.
2. In addition, it helps to stay informed about the practice environment in the given state and any legislative actions or public policy initiatives that may affect licensure. For example, the passage of a medical malpractice cap in Texas led to significant delays in processing of licensure applications, due to an increase in the number of physicians seeking to practice in the state. Keep abreast of current developments by monitoring state media sources; other physicians and physician recruiters can be valuable sources of information as well.
3. Although initial licensure requirements for U.S. and international medical graduates

differ somewhat among states, all states will require proof of prior education and training and proof of the completion of a licensure examination approved by the board. Specifically, all physicians must submit proof of successful completion of all three steps of the [United States Medical Licensing Examination](#) (USMLE). However, because some medical students and physicians completed portions of the National Board of Medical Examiners and Federation Licensing Examination (FLEX) sequences before the implementation of the USMLE in 1994, certain combinations of examinations may be considered by medical licensing authorities as comparable to the USMLE. The USMLE program recommends that such combinations be accepted for medical licensure only if completed prior to the year 2000. For information on the USMLE, contact the [USMLE](#) Office of the Secretariat at:

3750 Market St.
Philadelphia, PA 19104-3910
(215) 590-9700; Fax: (215) 590-9470

4. At the initial contact, the physician should provide the licensing board with a résumé or curriculum vitae. This will allow the licensing board to evaluate potential problem areas early in the process. In short, the initial contact should be used to develop a set of reasonable expectations about the duration and complexity of the licensing process in a state to avoid frustration about the time required to obtain licensure. Unreasonable expectations can result in financial jeopardy due to the premature closing of a practice or failure to meet a starting date with an employer in a new state.
5. A physician should never try to hide derogatory information from a licensing board. It is much better to come forward with the information, assist the board in obtaining records and other necessary data, and provide information about mitigating circumstances that would prevent license denial. Full and frank disclosure of all information requested is by far the best approach to successful licensure. A physician should remember that in most states, making a

false statement on an application for licensure is grounds for denial or future restriction.

A physician who is actively involved in the licensing process can often shorten the length of time it takes to obtain a license. Personally contacting and following up with the medical schools, training programs and appropriate hospitals will motivate these institutions to verify credentials more expeditiously. Following up with the licensing boards in other states where the physician holds or has held a license also may assist in shortening the time for licensure. It is important to note the difference between follow-up and excessive use of phone contact, which often delays the processing of requested verification materials, since the physician's application or request may need to be pulled from the "stack" to answer an inquiry. A short note to the organization processing the request for information 30 days after the initial letter or form was mailed may be a better course to follow than frequent phone contact.

6. Another option for physicians applying for licensure is the Federation Credentials Verification Service (FCVS). The FCVS was created in 1996 by the Federation of State Medical Boards to provide a centralized, uniform process for state medical boards—as well as private, governmental and commercial entities—to obtain a verified, primary source record of a physician's core credentials. The FCVS repository of information allows a physician to establish a confidential, lifetime professional portfolio that can be forwarded, at the physician's request, to any entity that has established an agreement with the FCVS.

The FCVS offers a new service to USMLE candidates who complete their Step 3 application online. As a convenience to examinees, information entered on their Step 3 online application can be used to begin a personalized FCVS physician information profile that contains their primary- source verified credentials. As a USMLE Step 3 applicant, you will benefit from enrolling in FCVS by having your credentials verified and accessible when you are ready to apply for your first full and

unrestricted license to practice medicine.

Currently, the majority of licensing authorities accept FCVS- verified documents for licensure. Get more information on [FCVS either online](#) or by calling (888) 275-3287. (This link will take you off the APA website. The APA is not responsible for the content of other websites.)

7. Exercise patience and courtesy in the licensing process. State licensing boards and their staff, in most cases, do the best job possible to protect the public with the resources provided them. This requires taking the necessary time to fairly evaluate each application for licensure. In that same context, all actively practicing physicians should be cognizant of state laws; they may be providing care or performing acts that might not, until recently, have required them to hold a license.

Even for physicians with uncomplicated histories who submit complete and accurate applications, delays in obtaining a medical license may be encountered. Physicians should plan for at least a 60-day period from the time they submit a completed application for license and the actual date licensure is granted. Physicians who are graduates of a medical school outside the United States should anticipate a slightly longer period. All physicians should be aware that April through September is generally the peak period for volume of licensure applications. Finally, remember that hospital credentialing and qualification for medical malpractice insurance are based on possession of full and unrestricted licensure. This too may mean additional time before a physician can actually begin practicing.

Physicians informed about the process and working cooperatively with the licensing board need not find licensing an unpleasant experience. Members of the medical profession should always remember that the business of medical licensing boards is to protect the public from unqualified and unfit physicians. However, licensing boards also strive to ensure a process that protects the legal rights and privileges of physicians. While maintaining this balance often appears bureaucratic and cumbersome, the end result is improved health care.



Board Certification Process and Requirements

After completing their residency training, most psychiatrists take a voluntary examination given by the American Board of Psychiatry and Neurology, to become a “board certified” psychiatrist. An ABPN board-certified psychiatrist has been certified as having special skills and knowledge to diagnose and treat mental disorders, emotional disorders, psychotic disorders, mood disorders, anxiety disorders, substance-related disorders, sexual and gender identity disorders and adjustment disorders. Biologic, psychological, and social components of illnesses are explored and understood in treatment of the whole person. Tools used may include

diagnostic laboratory tests, prescribed medications, evaluation and treatment of psychological and interpersonal problems with individuals and families, and intervention for coping with stress, crises, and other problems.

Subspecialties in psychiatry include; addiction psychiatry, child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, hospice and palliative medicine, pain medicine, psychosomatic medicine, and sleep medicine.

For applicants who entered psychiatry residency after 2008, the Board certification process has been changed. Some of the clinical skills evaluations are now done within the residency program. Residents will need to submit to the ABPN documentation of satisfactory performance in the evaluation of clinical skills. These residents will then need to pass the computer-delivered Psychiatry Certification Examination to become Board certified in psychiatry. The old (former) Part II Oral Examination is being phased out.

COMBINED TRAINING REQUIREMENTS

- **Psychiatry/Neurology**—PGY1 that meets neurology requirements and 5 years of residency in combined psychiatry/neurology program.
- **Triple Board**—24 months in pediatrics, 18 months of psychiatry and 18 months of CAP
- **Psychiatry/Family Medicine**—36 months of residency training beyond PGY1, of which, 30 months should be in psychiatry.
- **Psychiatry/Internal Medicine**—36 months of residency training beyond PGY1, of which, 30 months should be in psychiatry.
- **Post Pediatrics Portal Programs (PPPP)**—pediatricians who wish to obtain Board certification in psychiatry and child psychiatry may complete training in specially-approved PPP residency programs. The training consists of 18 months of psychiatry and 18 months of child and adolescent psychiatry.

Visit the [American Board of Psychiatry and Neurology \(ABPN\)](#) website to learn more about the certification process. To prepare for the board exams, the APA and the American Psychiatric Publishing have products that could help prepare you for your upcoming Boards - such as *FOCUS Patient Management Exercises in Psychiatry*, *FOCUS Psychiatry Review*, etc. The annual Psychiatry Review Course at the [APA Annual Meeting](#) is also another way to help you prepare for the Boards.



Overview of the American Health Care System

OVERVIEW

The health care system is quickly evolving and very complex. However, to better care for your patients and have a financially viable practice, it is critical that you begin to incrementally improve your understanding now so that you are prepared when you transition to practice.

WHAT IS MANAGED CARE

What is managed care, and how does it affect the practice of medicine? To help prepare you for the challenges of managed care so you can succeed in today's practice environment, this section takes

you first through basic terminology and definitions and then through more complex topics. Today the term managed care organization (MCO) is often used to refer to any entity offering health insurance coverage. Prior to the late 1980s, however, the term was more commonly associated with business entities that offered one product: the health maintenance organization (HMO). The health insurance industry rapidly evolved in the 1990s to offer alternative products to the HMO such as point of service (POS) plans and preferred provider organization (PPO). These products are discussed in more detail in subsequent sections. Although the

MCO was historically identified with the more strictly “managed care” HMO product line, this document will use MCO to more generally refer to the alphabet soup of products seen in today’s market.

If you were to ask five health care professionals to define **managed care**, you would probably get five different definitions. However, managed care can be understood by using the following concepts.

Price Discounting

The most prevalent—almost universal—form of managed care is discounted pricing. In many production-based industries, a seller of a service or good will provide a discount to a buyer in exchange for a higher volume of business from that buyer. Although most payers such as MCOs are interested in achieving discounted pricing, few are willing to discuss a specific volume commitment of patients. The reality has become that payers expect a discount without committing to a specific volume, and also retain the right to sell access to their negotiated discount with a physician to another MCO.

Utilization Management

The most technically correct use of the term managed care describes efforts by an MCO to perform utilization management procedures. Such procedures are designed to reduce health care costs by decreasing “unnecessary” procedures and services. Practically all MCOs have at least some utilization management components. Utilization management strategies have been around for more than four decades. The earliest strategies were policies that required a second opinion before surgery. More recent strategies include disease management protocols that establish the treatment path, location, provider and benefits for covered members with certain high-cost diseases.

Another form of cost control through utilization management is the use of payment policies that reduce the rate at which providers are paid for covered services. A good example is the payment

limitation for second surgical procedures. These policies do not have a direct impact on the frequency of services, but they do reduce the net payment consistent with a theoretical decrease in purchased value.

Both types of utilization management procedures—disease management protocols and payment policies—are primarily driven by the contractual arrangements between the MCO and the policyholder (also referred to as an enrollee or member). The policy or employee’s benefit booklet typically defines the benefit limits and utilization management procedures the MCO will use. A few utilization management procedures, such as referral preauthorization, target the behavior of policyholders, while most are aimed at providers.

The agreement between the physician and the MCO is often limited in its details about the utilization management procedures that will be used. Some agreements are so brief as to say only that the physician will abide by the utilization management and payment policy provisions specified in the agreement between the plan and its policyholders. Under such an agreement, the physician would accept that contract terms may be changed from time to time by the MCO either with or without notice. In many cases, MCO’s specific management and payment policies are not made available to the physician until after a contract is signed. Although it seems illogical to sign a contract without understanding or having all of the provisions declared, this seems to be the current norm. Such contracting behavior is not typical of any other industry, and the APA encourages physicians to know what they will be paid before they sign a contract. Your practice viability may depend on it.

The economic effect of utilization management can be significant. The effect can be as much as a 20 percent reduction from the contracted payment rate. Most physicians are familiar with the increased staff cost associated with preauthorization approvals.

Risk Contracting

The term risk contract refers to a payer agreement in which the final compensation is contingent on the total health care cost of a defined group of patients. The intention is to make physicians financially win or lose as a result of their treatment decisions. The essential element is that final compensation is not tied to the services provided but rather to the ultimate cost outcome. Many types of risk contracts meet this definition, and the following are some common types:

- **Primary care physician (PCP) capitation agreements**—a primary care physician is paid a flat per-member, per-month fee by an MCO for each policyholder assigned to the physician as a patient, regardless of the services provided. For example, if a physician is assigned 100 policyholders by the MCO and paid \$25 per member per month, that physician will receive a monthly payment of \$2,500 regardless of whether numerous services or no services were provided to those 100 patients/policyholders of the MCO in that month.
- **Specialty capitation**—specialist physicians are paid a flat fee each month to provide a defined list of services for a defined population of patients. This is the same concept as the example given above; however, specialists contract with MCOs to provide a narrower list of services than is typical for primary care physicians.
- **Fee-for-service with a withhold**—the fee-for-service payments are contracted at one rate, but actual claims are paid at a reduced rate. The balance is held until year-end, when, if total health care cost for the population is at or below target, the withhold is paid out. If costs are above target, then the withheld dollars are used to pay the extra costs. For example, if the patient population that a physician cares for has similar or lower costs when compared to other physicians treating a patient population with similar demographics, a higher compensation will be paid to this physician by the MCO. However, if this physician is an outlier due to

higher comparative costs, then he or she will typically receive lower total compensation.

- **Global capitation**—an entity, usually a health care system, is paid a fixed monthly rate by the MCO for each policyholder covered. The entity will then contract with physicians, possibly using various payment models, to obtain care for that population.

Multiple types of risk contracts can be in place simultaneously. Risk contracts can—and often do—coexist with other forms of managed care provisions. The degree of risk in a risk contract is best understood by measuring how much compensation is at risk.

Purpose and Function of MCOs

From a patient's perspective, the basic purpose of an MCO is to provide protection, in exchange for a monthly premium, from large out-of-pocket health care expenses that can accumulate during an acute or chronic illness. A premium is financial payment to the MCO in return for this financial protection. Although simple in appearance, the monthly premium amount, maximum lifetime benefit and whether a person receives coverage from an MCO is dependent on several factors, such as whether a person is obtaining the policy through an employer or individually; whether the person has had, or will have, interrupted health insurance coverage; whether the individual has pre-existing medical conditions; and what those conditions are and when they were identified.

The most common way for a person to obtain health insurance, and finance the premiums, is through an employer-sponsored benefit package. Most employers in the United States currently offer employees some type of health insurance benefits. The employer negotiates the premium with the MCO, which is based on the demographics of that employer's work force. The employer will usually pay a percentage of the monthly premium due, and the employee will pay the balance. In return for the paid premium, the MCO assumes the risk of health-related costs for that insured group, which is that employer's work force in this example.

Other, typically very large, employers are self-insured. These employers set aside funds to pay employee health costs directly and usually hire an MCO or claims management entity to provide the administrative aspects of processing and paying claims on the employer's behalf. Regardless of whether an employer is fully insured or self-insured and using an MCO for claims administration, a physician will typically face the same obstacles, which will be discussed in more detail later.

The **Patient Protection and Accountable Care Act** (PPACA), which was passed in March 2010, is attempting to give individuals seeking insurance with the same leverage as those in employer-sponsored coverage by creating exchanges. In the past, individuals seeking coverage with pre-existing conditions were more prevalently denied coverage by MCOs than those who were healthy. To learn more about the role of psychiatry in health care reform and integrated care, go to this [APA website](#), which includes both a video and report. The [Kaiser Family Foundation](#) also offers a good summary of PPACA.

MCO Products and Health Plans

This section discusses commercial health insurance products in which most of your patients will be enrolled if you choose to accept insurance.

Before explaining and comparing these products, two terms should be defined: **deductible** and **copayment**. A deductible is typically a fixed dollar amount that a policyholder is responsible for paying before insurance benefits are paid. For example, a policyholder may be responsible for paying an annual deductible of \$500. If the policyholder has an accident and requires surgery costing \$900, then the policyholder is responsible for paying the first \$500, and the insurance company pays the \$400 balance. If the annual deductible is satisfied, the policyholder is not responsible for any additional deductibles in that year.

However, the policyholder may be responsible for a copayment. A copayment, or copay, is a capped contribution defined in the policy and paid by a policyholder each time a medical service is used. The amount is not typically quantified but is expressed as a percentage. For example, if a policyholder has

a 20 percent copayment and requires a surgery that costs \$1,000, then the policyholder pays \$200, and the insurance company \$800.

- **Traditional fee-for-service insurance, or indemnity plan**—most indemnity policies allow enrollees, also referred to as policyholders or members, to choose any doctor and hospital that they wish when seeking health care services. The hallmark of traditional fee-for-service insurance is choice. Policyholders are given the choice of what hospital or physician (including specialists) to visit when seeking covered medical services with few, if any, geographical limitations. When purchasing an indemnity policy, individuals often have a deductible. If an enrollee's health care charges are covered, or are eligible for payment under the policy, any applicable deductible will apply. Once the deductible has been satisfied, the remaining charges are typically paid by the health insurance carrier at a specified percentage according to the policy contract. The balance remaining after the percentage of eligible charges are paid by the health insurance carrier, and the copayment is usually the enrollee's responsibility. The policy or employee's benefit booklet (if through an individual's employer) typically spells out the terms and conditions of what is covered and what is not covered.

- **Health maintenance organization (HMO)**—enrollees in an HMO are generally limited to doctors and hospitals that are designated by that HMO. It is common practice in HMOs for the policyholder to choose a primary care physician who treats and directs health care decisions and who coordinates referrals to specialties within the HMO's network. The doctors and hospital personnel can be employees of the HMO or be contracted providers. HMOs are typically divided into four categories:
 - ◆ **Staff model**—an HMO that owns and operates its own facilities and directly employs its doctors. Doctors are typically salaried and considered independent consultants or employees of the HMO. Staff

doctors are only allowed to treat enrollees. An example of this model is the Kaiser Permanente hospital system.

- ◆ **Group model**—an HMO that contracts with an outside physician group practice to provide services to all of the HMO’s enrollees. Typically, the physician group signs an exclusive contract to provide services only to HMO enrollees (i.e., closed panel) and is paid based on a negotiated per capita (i.e., capitated) rate.
- ◆ **Network model**—an HMO that, similar to the group model, contracts with physician groups. However, unlike a group model HMO, a network model contracts with two or more doctor groups. Typically, the doctor groups do not maintain exclusive contracts with the HMO and retain the right to treat non-HMO patients. It may be open or closed panel.
- ◆ **IPA model**—an HMO that contracts with one or more independent practice associations (IPAs) to provide health care services to the IPAs’ enrollees. Physicians are members of the IPA and are reimbursed for services rendered through a fee schedule or capitated basis as established by the IPA.
- **Point of service (POS)**—enrollees in a POS plan still designate a primary care physician to coordinate and direct their care like in an HMO. However, enrollees have an option to go out of network if they pay a much higher cost-sharing percentage and/or deductible. Also, this increased cost sharing applies if enrollees see an in-network specialist without a referral from their designated primary care physician.
- **Preferred provider organization (PPO)**—a mixed health plan model that combines HMO managed care and traditional insurance. However, PPO enrollees are not required to have a primary care physician coordinate their care and are not required to have a primary care referral to see a specialist. If enrollees use the PPO plan’s network of providers, they will likely pay

lower cost-sharing amounts like an HMO, but if they are willing to pay higher out-of-pocket costs (e.g., deductibles and coinsurance), they can use any provider they want, similar to traditional insurance. PPOs are organized to enable employer health benefit plans and health insurance carriers to purchase health care services for covered beneficiaries from selected groups of participating physicians, hospitals and other health care providers. Typically, participating physicians in the PPO agree to abide by utilization management and other procedures implemented by the PPO and agree to accept the PPO’s reimbursement structure and fee schedule. In return for providing the employer health benefit plan and/or insurance company with a discounted fee schedule, the plan or insurer steers its plan beneficiaries or enrollees to its network of providers by providing published lists of such network providers.

Although the words health insurance product and health insurance plan are often used interchangeably, there is a notable difference. Multiple individual and group health plans can be designed using one of the product models mentioned above. For example, a health insurer may offer two health plans to an employer group called Option PPO and Preferred PPO. Although both health plans are based on the PPO product model explained above, the two plans may have slightly varying benefits, provider networks, copays and deductibles.

MEDICAID

Medicaid is the means-tested health care program for low-income Americans, administered by Centers for Medicare & Medicaid Services (CMS) and in partnership with the states. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients. Over the years, Congress incrementally expanded Medicaid well beyond the traditional population of the low-income elderly, the blind and the disabled. Today, however, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including low-income families and persons with developmental disabilities requiring long-term care.

The CMS provides matching payments to states and Washington, D.C., to cover the Medicaid program and related administrative costs. State medical assistance payments are matched according to a formula relating each state's per capita income to the national average. In fiscal year 2013, the federal matching rate for Medicaid program costs among the states according to the formula was no less 50 and no more than 83 percent. Medicaid payments are funded by federal general revenues provided to CMS through the annual Labor/HHS/Education Appropriations Act.

The disproportionate share program adjusts payments to hospitals that treat a high percentage of low-income patients. Under Medicaid, states increase payment to these hospitals. Under Medicare, inpatient hospital payments are increased to hospitals that care for a disproportionately large number of Medicare recipients. States set eligibility, coverage and payment standards within broad statutory and regulatory guidelines that include: (1) providing coverage to persons receiving Supplemental Security Income (the disabled, blind and elderly populations), low-income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries and certain other groups and (2) covering at least 10 services mandated by law, including hospital and physician services, laboratory tests, family planning services, nursing facility services, and comprehensive health services for individuals under age 21. State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual circumstances and priorities. Accordingly, there is a wide variation in the services offered by each state (CMS Actuarial Report, 2010).

Population Characteristics

The Medicaid population consists of the following, which also includes **dual eligibles** (i.e., people who are covered by both Medicare and Medicaid).

The Medicaid program is responsible for spending about 5 cents of every health care dollar per year, which amounts to about \$44.3 billion annually. While the elderly and disabled represent only 28 percent of total Medicaid enrollees, they constitute about 63 percent of the program's total

expenditures. Children consume about 19 percent and adults 12 percent of the remaining yearly expenditures. For total health care expenditures, see the [CMS Financial Report](#) (PDF).

MEDICARE

Medicare is a health insurance program for people age 65 or older. Certain people younger than age 65 can qualify for Medicare, too, including those who have disabilities and those who have permanent kidney failure or amyotrophic lateral sclerosis (i.e., Lou Gehrig's disease). The program helps with the cost of health care, but it does not cover all medical expenses or the cost of most long-term care. Medicare is financed by a portion of the payroll taxes paid by workers and their employers. It also is financed, in part, by monthly premiums deducted from Social Security checks.

Medicare has four parts:

- Hospital insurance (Part A) helps pay for inpatient care in a hospital or skilled nursing facility (following a hospital stay), some home health care and hospice care.
- Medical insurance (Part B) helps pay for doctors' services and many other medical services and supplies that are not covered by hospital insurance.
- Medicare Advantage (Part C) plans are available in many areas. Under Part C, people with Medicare parts A and B can choose to receive all of their health care services through a nongovernmental provider organization such as a MCO.
- Prescription drug coverage (Part D) helps pay for medications doctors prescribe for treatment.

Resident and Fellow Resources

The Centers for Medicaid & Medicare Services (CMS) offers excellent resources that are free of charge. Most of the following are downloadable files that can be accessed by clicking on the titles.

(The following links will take you off the APA website. The APA is not responsible for the content of other websites.)

- [A Resource for Residents, Practicing Physicians, and the Other Health Care Professionals](#) (PDF)

This guide offers general information about the Medicare program, becoming a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management (E/M) documentation, protecting the Medicare Trust Fund, inquiries, overpayments, and appeals (July 2010).

- [Evaluation and Management Services Guide \(PDF\)](#)

This guide offers E/M services information about medical record documentation, International Classification of Diseases and Current Procedural Terminology (CPT®) codes, and key elements of service (2010).

Medicare Advantage Plans

In Medicare Advantage plans, physician networks are managed and paid by MCOs, in contrast to regular Medicare in which Medicare beneficiaries can virtually choose any physician, who is then paid directly by the federal government. To help physicians understand their options, the AMA has developed the following Medicare Advantage resources (The following links will take you off the APA website. The APA is not responsible for the content of other websites):

- [Know your options: Medicare participation guide for physicians \(PDF\)](#)
- [PAR/non-PAR decision worksheet for physicians \(PDF\)](#)

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is federal law that extends an individual's current employer-provided group health insurance when that person is experiencing a qualifying event such as termination of employment or reduction of hours to part-time status. The extension period is 18 months, though some people with special qualifying events may be eligible for a longer extension. To be eligible for COBRA, the group policy must be in force with 20 or more employees covered on more than 50 percent of its typical business days in the previous calendar year.

Indemnity policies, PPOs, HMOs and self-insured plans are all eligible for COBRA extension; however, federal government employee plans and church plans are exempt from COBRA. Individual health insurance is also exempt from COBRA extension, which may be another reason to pursue participation in group health plans if possible.

COBRA is regulated by the Department of Labor and the Employee Benefits Security Administration. These agencies can provide further information on the time frames employers and insurance companies and health plans must follow to offer COBRA extension coverage for eligible employees and their dependents. These agencies also can furnish information on the actions and responsibilities required by employees to participate and elect continuation of benefits under COBRA.

HIPAA

In 1996 the federal government passed into law the Health Insurance Portability and Accountability Act (HIPAA). HIPAA law provides eligible individuals who have recently lost their employer-sponsored group health plan the opportunity to purchase health insurance coverage even if they have a pre-existing health condition. If a person is eligible, all health insurance companies who sell individual plans must offer that person health insurance regardless of his or her medical history. This requirement to issue insurance is called guaranteed issue. A qualifying person may not be declined coverage based on medical reasons. In order to qualify, the following conditions must be met:

- The person's last health care coverage must have been under an employer-sponsored group health plan, which includes COBRA continuation coverage, for at least 18 months. This prior 18-month coverage is referred to as creditable coverage.
- All available COBRA continuation coverage has been elected and exhausted. If a person qualifies for COBRA, he or she is required to accept the coverage and continue the coverage for the maximum time period allowed. (When an employer terminates its existing group health plan entirely, COBRA coverage ends and is considered exhausted.)

- The person is not eligible under a group health plan, Medicare or Medicaid and/or does not have other health insurance coverage.
- The person did not lose their most recent health coverage due to nonpayment of premium or fraud.

Once COBRA has been exhausted, a person has 63 days to file an application to purchase a guaranteed issue HIPAA policy with an insurance company or health plan. All carriers that sell individual health care policies must offer their two most marketed individual plans to HIPAA eligibles regardless of

health status. If the person accepts a conversion policy or a short-term policy after exhausting COBRA, he or she gives up HIPAA eligibility. Note that a conversion policy is not a HIPAA policy.

When applying for a HIPAA policy, a person can present a Certificate of Creditable Coverage from his or her insurance company or health plan as part of the application process. The certificate is a written statement from the insurance company or health plan showing the length of time the person has been covered. The certificate can be used to prove the required 18 months of continuous coverage when applying for a HIPAA policy.



Financial Management for Physicians

SOME SIMPLE TIPS

After being a physician in training, your new income as a practicing physician will seem substantial. However, with limitless opportunities to spend money, you may find it difficult to save. This is the time to develop a “saving” lifestyle and spend money wisely. For the next three to five years your time and energy will likely be focused principally on your profession and family rather than on financial planning for the future. Financial considerations are important to make now, however, and the following list presents some simplified rules and suggestions for both new and seasoned physicians:

- Remember, it’s not how much you make, but how much you keep that counts!
- Learn to live on 75 percent or less of your income.
- About 25 percent of you will leave your first job within 18 months. Rent housing the first year or two until you are sure of your job, that you like the area and know the good school districts for your children.
- Eliminate/avoid revolving (credit card) debt. Pay off all credit cards monthly.

- Hire a bookkeeper to do your office and home accounting and bill paying.
- Fund retirement plans to the maximum possible.
- Given the tax incentives to fund retirement plans, funding your retirement plan may be as important as paying off your medical education loans or buying your first house. The earliest years of retirement plan funding are the most important because they have the longest time to grow. Have your retirement contribution deducted from your paycheck directly into your retirement plan every pay period, so you “never see it,” even if you are in solo practice and paying yourself.
- Before incurring expensive management fees, consider that (historically and on average) approximately 85 percent of financial planners and stock brokers do worse than the No-Load S&P Index 500 Mutual Funds.
- Buy disability insurance first before term life insurance when you have dependents. Do you even need life insurance? It depends. As a young physician, if you are single, with no dependents, and no co-signers on your loans or debts that would burden others upon your death, what purpose would life insurance serve for you?
- If you are a practice owner, make tax-deductible investments in your practice (marketing, revenue-producing skills and instrumentation).

BUDGETING AND DEBT MANAGEMENT

A personal budget can be an excellent tool to keep track of your monthly expenses, assist you in managing your debt, and help you plan for future events. To construct a basic expense budget, you will need to estimate the monthly costs of your needs. These costs include rent/ mortgage, medical education loan repayments, auto loan payments, auto maintenance, insurance (disability, life and health), food, clothing, household expenses and entertainment/travel. If you own a car or a home, you must also plan for annual expenses such as auto insurance, home insurance and property taxes.

For most of you, your income taxes will be taken out of your paycheck, so you will not have to budget for them. However, if you are self-employed or

have supplemental income from other sources (i.e., moonlighting, investments, etc.), then you must budget for the federal and state taxes owed on that income. Last, but certainly not least, set aside about two months’ worth of salary as “emergency funds” for unexpected events.

Creating and Organizing a Personal Budget

Creating a budget, as illustrated below, will help you gain a clearer understanding of where your money is being spent and how, if necessary, you can trim expenses to meet your financial goals (e.g., paying down your medical education debt, opening a savings account, buying a home).

Finances	Budget	March	April	May	June
Total monthly income (after tax)	\$2,800	\$2,800	\$2,800	\$2,800	\$2,800
Rent	\$850	\$850	\$850	\$850	\$850
Medical education loan payment	\$250	\$250	\$250	\$250	\$250
Car payment/auto expenses	\$400	\$425	\$375	\$420	\$395
Utilities (gas, electric, water)	\$50	\$50	\$50	\$50	\$50
Cable/home phone	\$70	\$75	\$75	\$75	\$75
Cell phone	\$60	\$55	\$60	\$60	\$65
Groceries	\$150	\$170	\$140	\$170	\$150
Restaurants/coffee shop/bars	\$450	\$450	\$475	\$500	\$480
Clothes/shoes	\$150	\$100	\$130	\$200	\$175
Travel	\$150	\$110	\$140	\$100	\$100
Gifts	\$70	\$75	\$80	\$50	\$60
Total expenses	\$2,650	\$2,610	\$2,625	\$2,725	\$2,650
Net surplus/deficit	\$150	\$190	\$175	\$75	\$150
Deposit into savings account	\$150	\$190	\$175	\$75	\$150

When looking at your specific financial goals, here are some questions to consider:

- How soon can I pay off my credit card debt?
- Do I need to save for a wedding or a new car?
- When do I want to purchase a home?
- Do I plan to have children in the near future?
- Do I have plans for a big vacation?
- What type of investments do I want to make?

- What kind of activities/sports/hobbies are important to me?
- Can I start saving for retirement through a 401(k) plan or individual retirement account (IRA)?
- What current expenses can I sacrifice/limit right now so that I can meet my financial goals sooner?

Interpreting Your Credit Score

A credit score is a number that is calculated based on your credit history to give lenders a simpler “lend/don’t lend” answer for people who are applying for credit or loans. This number helps the lender identify the level of risk of repayment they may be taking if they lend to someone. While the same end result can come through reviewing the actual credit report (which lenders usually do), the credit score is quicker and less subjective. The system awards points based on information in the credit report, and the resulting score is compared to that of other consumers with similar profiles. With this information, lenders assess how likely someone is to repay a loan and make payments on time. A high credit score makes it possible to get instant credit at places like electronics stores and department stores.

The credit score most commonly used by lenders is known as a FICO score, and each of the three national credit bureaus, Equifax, Experian and TransUnion, have their own version of the FICO score with their own names. Some lenders also have their own scoring methods. Other scoring methods may include information such as your income or how long you’ve been at the same job. In addition to banks and lenders, landlords, merchants, employers and insurance companies may base their decisions on a person’s credit score.

Your credit score can range from 300 to 900. Although the exact formula is proprietary information, the following is an approximate breakdown of how a credit score is currently determined:

- Roughly 35 percent of the score is based on payment history. The score is affected by

how many bills have been paid late, how many were sent out for collection, any bankruptcies, etc. The more recent, the worse it will be for the overall score.

- Another 30 percent of the score is based on outstanding debt. How much do you owe on car or home loans? How many credit cards do you have that are at their credit limits? The more cards you have at their limits, the lower your score will be. A good guide is to keep your credit card balances at 25 percent or less of their limits (e.g., \$1,250 balance on a \$5,000 credit limit).
- An additional 15 percent of the score is based on the length of time credit has existed. The longer you’ve had established credit, the better it is for your overall credit score, because more information about past payment history can more accurately predict future actions.
- Another 10 percent of the score is based on the number of credit inquiries. If you’ve applied for a lot of credit cards or loans, you will have a lot of inquiries on your credit report. Multiple inquiries could indicate that you are taking out a lot of debt because you are in some kind of financial trouble (even if you haven’t used the cards or gotten the loans). The more recent the inquiries, the worse for your credit score. FICO scores only count inquiries from the past year.
- The remaining 10 percent of the score is based on the types of current credit. The number of loans and available credit from credit cards you have makes a difference. There is no magic number or combination of types of accounts that you shouldn’t have. These actually come more into play if there isn’t as much other information on your credit report on which to base the score.

You can obtain your [credit report and score](#) online. *(This link will take you off the APA website. The APA is not responsible for the content of other websites.)*

Increasing Your Credit Score

Since your credit score is based on your current credit report, your score changes every time your credit report changes. Financial advisors offer the following advice on how to improve your credit score:

- Review your credit report and correct any errors you find. Getting rid of inaccurate information can sometimes improve your score dramatically.
- Because the ratio of your debt to your credit limit is so important to your credit score, it is no longer recommended to close all old accounts, which would unfavorably raise that ratio. Moving all debt from several accounts to one account and closing the old accounts is only recommended if the credit limit on the new account is the same as all of the old accounts combined. Requesting a credit increase is a good way to maintain your debt-to-credit ratio. Because creditors also look at the average age of your accounts, that is another reason to keep old accounts open.
- Reduce your balances on credit cards.
- Pay your bills on time—this will affect your credit score the most.
- Minimize the number of inquiries on your credit report to only those that are necessary.
- It is not recommended to open new credit card accounts just to increase your available credit as a means of raising your score—you raise your risk of credit theft and fraud.

If you are turned down for a loan because your score is too low, obtain a list of reasons for that low score and make the necessary improvements. It will take time, but actively working on obtaining and maintaining good credit will pay off when you need it for your first home mortgage. The key is to get credit only when you need it (unless you're trying to establish credit), and then use it carefully, make your payments on time and keep your balances low.

As discussed in the beginning of this chapter, all credit financing is not bad and, in fact, some debt—when used wisely—can be a building block for creating wealth. But one of the secrets to being

smart with your money is being able to differentiate between what financial advisors call “good debt” and “bad debt.”

WHAT IS “BAD DEBT”?

Bad debt usually refers to using credit cards to purchase disposable items or durable goods, and not paying the balance in full. Every month that you make a partial payment on your credit account you are charged interest. The disposable or durable item you purchased continues to lose value, and the amount you paid for it continues to increase.

The theory of “debt to purchase a depreciating asset equals bad debt” is easily applicable to the purchase of clothes. Generally speaking, clothes are worth less than 50 percent of what you pay for them when you walk out of the store. When debt (credit card not paid in full, on time) is borrowed to pay for those clothes, that's bad debt. By using debt in this manner, you could be spending up to 175 percent of the cost of these goods. To see exactly how bad this debt is, use the [real cost of paying the minimum on your credit card](#) calculator.

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Credit Cards

Credit cards do have many benefits. Most significantly, they enable us to have what we want now, and let us pay for it later. In fact, credit cards provide interest-free debt for up to 45 days from the date of purchase, depending when in your billing cycle your purchase is made. If you carry a balance from month to month, the interest rate charged on that balance is one of the key factors to consider in choosing a credit card. Experts suggest that a low, fixed-rate credit card is better than a low, variable-rate credit card. Card companies can raise their fixed-rate cards when interest rates go higher, but change is not automatic and they need to give you 15 days' notice.

With a variable-rate card, your rate can move regularly and without any prior notification.

Information about when a card company can raise your rate is often written in fine print buried in the mail they send you. If you are carrying a balance each month (not paying the bill in full),

this information is very important to you and not just “junk mail.” The credit card company may be informing you that your low promotion interest rate doubles the first time you are late with a payment.

Produced by the Federal Reserve Board, [Guidelines for choosing a credit card](#) is an additional resource you may wish to consult. (This link will take you off the APA website. The APA is not responsible for the content of other websites.)

Be Honest With Yourself

You must be honest about when and how much you pay on your credit card bills. Although paying off the entire balance each month is a great goal, if it is not a realistic one, you could be paying over 20 percent on top of your purchases, and you could be risking your credit score! It's also critical not to miss payments, even if you are only paying the minimum. If no payment is made within 30 days of the payment due date, credit card companies may report that to the credit bureaus. Caution should also be taken when applying for retail store credit cards. The potential savings (10 to 20 percent off) gained by opening a retail store credit card can be lost, because of the high interest rate on the card, if you fail to pay the bill in full by the due date.

When applying for a credit card, make sure you confirm with the card issuing company that they are offering what you think they are offering. Go over it with them, then ask if they can give you an even better rate—their best offer may not be the first deal they offer you. Remember to pay attention to the APR, annual fee, grace period, penalties, late payment charges, over-the-limit fees, interest rates on any cash advances, and under what circumstances the card company can change your interest.

WHAT IS “GOOD DEBT”?

Good debt is investment debt that creates value: medical education loans, real estate loans, home mortgages and business loans are all examples of good debt. Additionally, taking on debts that are tax-deductible and debts that produce more wealth in the long run are also good debts. Generally, taking out debt with a lower interest rate, in order to pay off a debt with a higher interest rate, can be a beneficial use of financing. Typically, financing for something

that is considered “good debt” is usually available for lower interest rates than financing for something that is “bad debt” (e.g., credit cards, cash advances).

SHORT-TERM SAVINGS

In addition to the funds that you should set aside for emergencies (liquid investments or cash equal to or greater than two months of your salary), you should also save monthly for specific financial goals in the near future, such as a wedding, a new car or a vacation. The following [savings calculator](#) can help you figure out how much to save each month. Once you have determined how much you need to save and how long you have to reach your goal, you can look at some short-term savings vehicles to maximize your savings. (This link will take you off the APA website. The APA is not responsible for the content of other websites.)

Basic Savings Options

Basic investment vehicles that require little research and usually involve very little, if any risk, are the following:

- **Savings accounts and money market accounts.** These are often the first savings vehicle that a person will utilize to begin saving money. Interest rates can vary, especially between traditional “brick and mortar” banks (e.g., JP Morgan Chase, Bank of America, Wells Fargo, Citibank) and online banks (e.g., HSBC Direct, ING Direct). Free consumer-based internet sites such as [Bankrate](#) make it easy to compare interest rates across multiple banks. This has resulted in competition among banks and an opportunity to obtain higher interest rates on your savings. (This link will take you off the APA website. The APA is not responsible for the content of other websites.)
- **Certificate of Deposit.** A certificate of deposit (CD) is a specialized deposit you make at a bank or other financial institution that is held until its maturation date. The interest rate on CDs is usually about the same as that of short- or intermediate-term bonds, depending on the duration of the CD. Interest is paid based on the terms of the CD. When the CD reaches maturity, you receive the money you originally deposited plus the accumulated interest. This convenient

[CD interest calculator](#) lets you enter a deposit amount and see how compounding interest increases a CD's value. (This link will take you off the APA website. The APA is not responsible for the content of other websites.)

PLANNING FOR RETIREMENT

When thinking about retirement, your investment horizon is extremely important. Your investment horizon is the length of time, in years, that you invest before you begin to use the money. For example, if you invest for your retirement in 25 years, your investment horizon is 25 years. Investment horizon is also called your time horizon.

Investment horizon is also influenced by another point in time—the duration over which you expect to use the money.

For example, if you retire in 25 years and live for another 30 years, your investment horizon is 25 years but your need to live off your retirement fund extends the remaining 30 years. You need some of the money upfront, but the rest of it can be invested for future withdrawals. This practice of taking out periodic amounts from a growing lump-sum investment is called annuitization.

As a rule, the longer your investment horizon, the more aggressive you can afford to be as an investor. That's because you have more time to recover from declines in asset prices that inevitably occur.

Compounding interest and your investment horizon can be powerful forces that help you achieve your retirement goals. Compounding occurs when the money you have saved earns interest, that earned interest is added to the principle (money you already have in savings), and then that total earns interest. With contributions and compounding interest over 40 years, you could save a substantial amount of money for retirement. For example, let's assume you earn \$35,000 a year as a resident and contribute 4 percent of your salary to a 401(k) (this investment vehicle is explained below). The total contribution to your 401(k) is \$116.66 month or \$1,400 a year. (Since this contribution is made before taxes, what is actually deducted from your paycheck is \$87.49 a month or \$1,049 per year, assuming a 25 percent

tax bracket; in essence, the government is financing part of your retirement.) Assuming for the next 35 years you stay at the same salary and contribute the same percentage while earning 8 percent per year, at retirement you will have more than \$132,000 in your retirement account. Starting contributions five years later would result in about \$97,000 in your retirement account. This is the power of early retirement planning.

As your career advances and your salary increases, your contributions should also increase. Get help [calculating your needed savings](#) based on your investment horizon and anticipated financial needs after retirement.

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Assessing Risk Tolerance

Having a basic understanding of investment risk can help you to make wise asset allocation decisions. Risk tolerance is a measure of your willingness to accept investment risk in exchange for higher potential returns. For example, if you're an aggressive investor, you're likely willing to accept the risk of losing some of your investment capital (that means a negative rate of return or partial loss of your initial investment) in exchange for earning higher potential returns. Aggressive investors invest in growth stocks and growth funds, which are mutual funds that invest in growth stocks.

A conservative investor, on the other hand, is less willing to accept risk, even for higher potential returns. Capital preservation (your original investment) is a top priority for conservative investors. As a result, they tend to favor conservative investments such as certificates of deposit, money market accounts and government bonds.

RETIREMENT ACCOUNT OPTIONS

There are a number of specially designed accounts to create retirement savings, and many of these accounts allow you to deposit money directly from your paycheck before taxes are taken out. The following are specialized accounts that allow the account holder to invest in securities within certain tax code restrictions:

- **401(k)**—a retirement savings vehicle offered by employers that is named after the Internal Revenue Code section in which it is covered. Contributions to a 401(k) plan are taken out of your paycheck before taxes, so your pre-tax dollars make up your 401(k) plan. If you contribute, your employers may match up to a certain percentage of your salary towards your 401(k). Other employers will contribute independently towards your 401(k) or participate in a “profit-matching” in which you receive an annual amount based upon your company’s previous fiscal year results. Early withdrawals generally will be subject to taxes and a penalty. Rates of return vary on these plans depending on what the plan is invested in.
- **IRA**—an Individual Retirement Account (IRA) is a tax-deferred retirement fund that you won’t pay taxes on until you withdraw your funds. Withdrawals are taxed at regular income tax rates, not at the lower capital gains rates. If you qualify, some or all of your current IRA contribution may be tax deductible.
- **Roth IRA**—differs from a traditional IRA in that it provides no tax deduction up front on current contributions. Instead, it offers total exemption from federal taxes when you cash out to pay for retirement or a first home. A Roth IRA can also be used for certain other expenses such as education or unreimbursed medical expenses without paying a penalty (but any earnings that are withdrawn are subject to income taxes unless you are over age 59 1/2). Roth IRAs have tighter income restrictions than traditional IRAs. Taxpayers who participate in corporate retirement plans and don’t qualify for deductible contributions to the traditional IRA can often take advantage of a Roth IRA.
- **SEP plan**—A simplified employee pension (SEP) plan is a special kind of Keogh-individual retirement account. SEPs were created so that small businesses could set up retirement plans that were a little easier to administer than normal pension plans. Both employees and the employer can contribute to a SEP.

MUTUAL FUNDS AND SECURITIES

A mutual fund combines, or pools, investors’ money and then uses that money to buy securities. Some mutual funds are actively managed by professionals and some track the returns of an index such as the S&P, Dow Jones, or NASDAQ. Actively managed mutual funds usually have higher management fees and costs than mutual funds that track an index. Pay close attention to a mutual fund’s prospectus, which provides its investment objective(s) and various fees. The purpose of mutual funds is to create buying power, ease of diversification, less self-management, and access to professional money management.

Because the value of securities fluctuates with the market, the balance in your account will also fluctuate, which may include gains or the loss of your initial investment. While various types of securities are discussed, below, please consult a professional financial advisor or brokerage for advice and more in-depth research.

- **Bonds**—are known as “fixed-income” securities because the amount of income the bond generates each year is “fixed,” or set, when the bond is sold. As an investment, bonds are very similar to CDs, except that they are issued by the government or by corporations instead of banks. Bonds have different risks depending on whether you are investing in U.S. Treasuries, corporate bonds, or junk bonds. The higher interest payments received by junk bond holders vs. U.S. Treasury Bond holders is compensation for increased risk tolerance, which was discussed above.
- **Stocks**—are a way for individuals to own parts of businesses. A share of stock represents a proportional share of ownership in a company. As the value of the company changes, the value of the share in that company rises and falls. Stocks can, and do, fluctuate substantially. Please weigh your risk tolerance before determining (1) if stocks are the right investment vehicle for you and (2) what type of stock (value, growth, income, foreign) best fits your investment style and time horizon.
 - ◆ **Value stock**—is a stock or sector that investors see as relatively undervalued. Value

investors use such measures as price-to-earnings (P/E) and price-to-book (P/B) ratios to determine relative valuations and make investment decisions.

- ◆ **Growth stock**—is a stock or sector that investors see as relatively focused on increasing revenues and earnings. Some growth stocks focus more on growing revenues. Growth stocks tend to not pay dividends. Instead, they retain any earnings and invest them in additional growth opportunities.
- ◆ **Income stocks**—seek to generate dividends, a source of cash that appeals to some conservative investors. Income stocks tend to have higher dividend yields and often represent mature companies and industries such as utilities, financial-services firms and large-cap stocks.
- ◆ **Foreign stock**—these are stocks of companies registered outside of the United States. There are several specialized categories of foreign stock funds, including international, country, regional and emerging market funds.

Capital Gains

A capital gain is the profit realized on the sale of an asset that was purchased at a lower price. The most common capital gains are realized from the sale of stocks, bonds, precious metals and property. Short-term capital gains and long-term capital gains have different tax attributes. Short-term capital gains are gains that are realized when an asset is sold within one year of the purchase of the asset. Currently, these gains are taxed at the owner's income tax rate. Long-term capital gains are gains realized when an asset is sold more than one year from its purchase date.

FINANCING YOUR CHILDREN'S EDUCATION

If you have children, or plan to have children, you should also have a plan for their futures. The following are a few alternatives to help you secure a child's financial future while concurrently taking advantage of tax benefits.

529 plans

A 529 plan is an education savings plan operated by a state or educational institution designed to help families set aside funds for future college costs. As long as the plan satisfies a few basic requirements, the federal tax law provides special tax benefits to you, the plan participant (Section 529 of the Internal Revenue Code). 529 plans are categorized as either prepaid or savings, although some have elements of both. Educational institutions can offer a 529 prepaid plan (for their institution) but not a 529 savings plan. Current advantages and disadvantages of 529 plans include:

- **Ease of use**—once you decide which 529 plan to use, you complete an enrollment form and make your contributions (or sign up for automatic deposits in the account). Plan assets are managed either by the state or by an outside investment company hired as the program manager. You don't receive a Form 1099 to report taxable or nontaxable earnings until the year you make withdrawals. For most plans, you can change to a different investment option in a 529 savings program every year or you may rollover your account to a different state's program provided no such rollover for your beneficiary has occurred in the prior 12 months. There is no federal limit on the frequency of these changes if you replace the account beneficiary with another qualifying family member at the same time.
- **Open eligibility**—everyone is eligible to take advantage of a 529 plan, and the amounts you can put in are substantial (more than \$300,000). Generally, there are no income or age limitations.
- **Tax implications**—although your contributions to the plan are not deductible on your federal tax return, your plan investment grows tax-deferred, and distributions to pay for the beneficiary's college costs come out federally tax-free. The tax-free treatment was made permanent with the Pension Protection Act of 2006. Your state may offer some tax breaks as well (like an upfront deduction for your contributions or income exemption on withdrawals) in addition to the federal treatment.

- **Control**—with few exceptions, the beneficiary has no rights to the funds. You decide when withdrawals are taken and for what purpose. Most plans even allow you to reclaim the funds for yourself any time you wish, although the earnings portion of the “non-qualified” withdrawal will be subject to income tax and an additional 10 percent penalty tax.
- **Penalty on non-qualified distributions**—it is possible to withdraw money from the account for non-education purposes, however, the earnings portion of non-qualified withdrawals is subject to income taxes and a 10 percent federal penalty.
- **Impact on financial aid**—these accounts usually do not affect eligibility for financial aid, a Hope Scholarship or Lifetime Learning Credit.
- **Different states, different programs**—some state plans do not offer all of the benefits that others do. States may have different residency requirements, contribution limits, program fees, portfolio options and flexibility.

Uniform Gifts for Minors Act and the Uniform Transfer to Minors Act

Prior to 529 plans, the Uniform Gifts for Minors Act (UGMA) and the Uniform Transfer to Minors Act (UTMA) were the most tax efficient ways to save for college and transfer wealth to children and grandchildren. UGMA and UTMA are virtually the same in all respects. In establishing an UGMA/UTMA account, the individual who will be responsible for overseeing and management of the account is referred to as the “custodian.” The person who opens the account can differ from the individual whose name appears as the custodian. The custodian is legally bound to judiciously manage the funds in the UGMA/ UTMA account. Upon reaching the age of majority, the minor can then assume control over the account, even if the minor disagrees with the wishes of the custodian.

- **Ease of use**—UMGA established a simple way for a minor to own securities without requiring the services of an attorney to prepare trust

documents or the court appointment of a trustee. The terms of this trust are established by a state statute instead of a trust document. UTMA is similar but also allows minors to own other types of property, such as real estate, fine art, patents and royalties, and for the transfers to occur through inheritance. UTMA is slightly more flexible than UGMA.

- **Tax implications**—UGMA/UTMA accounts are subject to the \$12,000 Gift Tax Exclusion. This allows an individual to give up to \$12,000 per year to another person without being subject to the Gift Tax. The first \$850 in earnings each year is free from federal taxes and the next \$850 is taxed at the child’s earned income tax bracket. Assessed taxes on earnings that exceed these levels are based on the custodian’s earned income tax bracket.
- **Control**—since UGMA/UTMA accounts are considered the child’s assets, the child gains full control of them at age 18 or 21, depending on the state. When the minor becomes an adult, neither the donor nor the custodian can place any restrictions on the use of the money. At that time, the child can use the money for any purpose whatsoever; consequently, there is no guarantee that the money will be used for educational purposes.
- **Penalty**—no penalties per se; however, since the UGMA and UTMA accounts are in the name of a single child, this money cannot be transferred to another beneficiary or back to the parent.

However, the custodian can spend the money for the benefit of the child, so long as the expenses aren’t “parental obligations” or otherwise benefit the custodian. If used for “parental obligations,” the IRS may require that the parent pay taxes on that money. Parental obligations are expenses a parent is normally expected to provide for his or her child, such as food, clothing, medical care and shelter. But if the child wants a computer or to go to summer camp, it is usually acceptable to spend the child’s money on those expenses.

- **Impact on applying for student financial aid—**UGMA/UTMA accounts have an impact on a child's eligibility for financial aid because the child owns those assets. Parents who expect to receive need-based financial aid for college should not save money for college in the child's name. The loss of aid eligibility typically outweighs the minimal tax savings gained through the child's lower tax bracket.
- **Rollover ability—**UGMA/UTMA accounts can be rolled over into 529 plans. In converted plans, qualified education benefits are considered an asset of the student if the student is an independent student and an asset of the parent if the student is a dependent student, regardless of whether the student or parent owns the account. There are other technical aspects to

this type of transfer so a financial planner or accountant is recommended.

For more in-depth explanations of the topics discussed, visit the following sites:

(The following links will take you off the APA website. The APA is not responsible for the content of other websites.)

- [Bankrate.com](https://www.bankrate.com)
Various financial calculators, resources, and advice.
- [Federal Reserve Board](https://www.federalreserve.gov)
Find news and resources related to the banking industry
- [Mortgage101.com](https://www.mortgage101.com)
Mortgage calculators, interest rates and advise



Loan Forgiveness, Repayment and Consolidation

There are numerous resources pertaining to this area. To start, you should be aware of the following resources:

- The AAMC has the most comprehensive *state and federal repayment, loan and scholarship database*.
- *IBR info* is a resource that explains the Income Based Repayment (IBR), public service loan forgiveness (PSLF) and Pay as you earn (PAYE) options.
- To consolidate public loans, go to the Federal Student Aid Office of the *United States Department of Education*.

LOAN FORGIVENESS PROGRAMS

These are programs where your lender (the federal government) actually forgives a portion of your student loan balance under certain conditions or if you meet certain requirements.

The forgiveness with the greatest interest to residents transitioning to practice is the Public Service Loan Forgiveness (PSLF) program. With PSLF, the federal government will forgive a portion of a borrower's balance under certain conditions after the borrower has worked in public service

for a minimum of 10 years. Considering that many nonprofit employers are considered public service by the federal government, it is not surprising that many residents are considering this program.

LOAN REPAYMENT PROGRAMS

With loan repayment programs, an organization will provide a specified amount of money to help you pay down your student loans in exchange for a service commitment after the completion of residency. These programs are sometimes referred to as loan repayment assistance programs.

Some notable examples include the National Health Service Corps, the Indian Health Service, the National Institutes of Health and various branches of the armed forces. Moreover, as you see from the AAMC database, there are also loan repayment programs offered by community and for-profit hospitals.

Organizations offering loan repayment programs do not forgive the debt, since they did not make the loan to you. Instead, they provide significant financial assistance in repaying your loans in exchange for your service commitment after you finish your program.

Resources available for psychiatry residents:
(These links will take you off the APA website. The APA is not responsible for the content of other websites.)

- [National Health Service Corps Loan Repayment Program](#) (for students and residents)
- [NIH Loan Repayment Programs](#) - clinical research
- [Loan Repayment/Forgiveness Scholarship Programs database](#) - maintained by the AAMC

Important Considerations

When assessing loan forgiveness and repayment programs, ensure you understand the contractual obligations and service commitment. Also, what will happen if you fail to deliver on those requirements? If an institution has agreed to pay part or all of your loans, will that institution also pay the additional taxes since it will likely be considered taxable income? Be very cautious about agreeing to any terms in which the institution wants to pay your student loans directly and then forgive them over

time. If you need or want to leave before the end of the contract, you may face a situation in which the loan amount is accelerated (i.e. due in full).

LOAN CONSOLIDATION

The loan consolidation space is much like getting a mortgage on a house. It can be a complex endeavor if you don't have a remedial understanding of the options in relation to the loan amount, your time horizon for payment, your financial situation and the trends in interest rates. The following information is meant to guide you. Also, it's recommended that you seek the advice of a financial consultant instead of solely relying on the company selling you a loan product.

Private vs. Public Student Loan Consolidation

Private student loans cannot, in general, be consolidated with federal student loans. The low interest rates on federal consolidation loans are not available for private education loans. If you are offered the opportunity to refinance your public and private student loans together, approach the situation with caution. Generally, federal consolidation loans offer superior benefits and lower interest rates for consolidating federal student loans. To consolidate your federal loans, go to the [U.S. Department of Education](#). The website provides good information about the advantages and potential disadvantages of consolidating public loans.

Consolidating Private Student

Private student loans are often available with a variable rate or fixed rate. There are several variables to consider when weighing both options. The most suitable option will be the one that best meets the needs of the individual applicant, so not everyone will come to the same conclusion about their preferred loan. This is the reason that APA has not endorsed one carrier or product but has instead opted to provide you with the information necessary to make an informed decision.

Choosing between fixed and variable interest rates can be difficult. Often the initial interest rate on a variable-rate loan is more attractive than that of a fixed-rate loan with a similar term. However, since the interest rate on a variable rate loan can

change, comparing initial interest rates is not enough. Borrowers should also take a longer-term view, considering how market interest rates tend to rise and fall in cycles. Three factors that students and parents should consider before consolidating private loans:

- Before making a choice, borrowers should think about whether or not they would be comfortable with such fluctuations in interest rates and the resulting changes in their loan payments? With the possibility of such rate swings, many borrowers would prefer the security and predictability of fixed loan payments.
- Borrowers should also consider the term of the loan. The longer the term on a variable rate loan, the longer the time period the borrower has to be ready to accommodate fluctuations in interest rates and the accompanying impact on your family's budget.
- Finally, borrowers should consider timing. Although no one knows whether, when, or how much interest rates will change, common sense seems to indicate that rates will increase in the near term. When borrowers choose between variable and fixed rate loans, they must remember to factor this into their decisions.

Fixed vs. Variable Rate Private Student Loans

Variable Rates

- **Variable rate will be based on an underlying rate index:** The most commonly used rate indexes in student lending are *Prime or LIBOR*, which are the London interbank offered rates.
- **How the rate changes:** As the rate index goes up or down, your loan rate will also fluctuate. Rate adjustments may occur monthly, every 3 months, or possibly at other timeframes depending on the structure of the loan.

For example, applications that use 3-month LIBOR take the average daily LIBOR rate over the previous quarter-year, and apply that rate to the application moving forward, until it is recalculated 3 months later. Four times a year, that rate on the application has a chance to change. Find out the rate index used on the

application to know exactly how the rate may change and when.

- **Rate floor and rate cap:** There may be a minimum low rate associated with the loan. Referred to as the rate floor, the interest rate associated with your loan will never go below this minimum. The rate cap is the maximum amount the rate could increase to in the future, given the performance of the underlying rate index on the application. The rate on the loan does not exceed the cap, even if the index keeps going up.
- **Variable rates and risk mitigation:** The big advantage to variable rate loans today is that they may provide a very low interest rate now. However, the borrower assumes the risk that rates may increase in the future and result in higher and/or less predictable monthly payment. A strategy used by some borrowers is to aggressively pay down debts that have low variable rates so that if rates rise in the future, a sufficient amount of principal has been repaid to prevent interest costs from going too high.

Fixed Rates

- **Fixed rate loans are locked in:** A fixed rate loan has the same interest rate and monthly payment, which creates a very predictable repayment schedule for the term of the loan.
- **Value and cost of predictability:** Knowing that the fixed payment will never increase in the future is important for some borrowers. However, there is no way the rate can reduce in the future, unless refinancing to a new loan with a lower rate.
- **The cost of the guaranteed rate:** The loan may carry a fixed rate, but it may be much higher than a variable rate option. This is because the financial institution assumes risk of general market rates increasing above the rate applied to the fixed rate loan. For example, if you have taken out a fixed rate loan with a rate of 7% and market rates rise to 9%, the bank must still continue to charge only 7%. However, if market rates remain low, while the loan rate remains high, the borrower has to keep making the same payment.

- **Pre-payment penalties:** This is a provision in your loan documents that states you will pay a penalty if you pay off the loan before the end of the term. A financial institution assumes risk when making a fixed rate loan and also tries to keep its rate of return predictable over the term of the loan. A pre-payment penalty may exist where a borrower makes payments that are greater than the scheduled amount due, paying

off more principal and therefore reducing the amount of interest that could accrue. Review your loan documents to understand if a penalty may be applied since you may be able to get the provision removed simply by asking.

For a list of lenders that offer private student loan consolidation, go to [this website](#).



Housing: Buying vs. Renting

There are literally thousands of resources available on buying and renting housing, each with differing degrees of usefulness. The purpose of this section is to assist you in obtaining the most useful and relevant resources available to (1) help you make a decision on whether to rent or buy and (2) if you decide to buy, to prepare you for, and guide you through, the home buying process.

BUYING VS. RENTING

If you are beginning to assess (1) the types of houses available, such as single family, townhome, condominium or multi-family homes, (2) your space needs, (3) the lifestyle you expect and how that will influence your choice, and (4) the pros and cons of both renting and buying, this resource can help [guide your thinking](#). (This link will take you off the

APA website. The APA is not responsible for the content of other websites.)

Use this [calculator](#) to compare the monthly cost renting a home with the cost of buying property. This information will give you a better financial picture of the costs and benefits of each based on your circumstances.

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BUYING A PROPERTY

Buying a home has historically been considered a good investment. Before looking at properties, get a mortgage pre-qualification or pre-approval letter by contacting a lender. What is the difference between pre-qualification and pre-approval? The

pre-approval process is much more complete than pre-qualification. For pre-qualification, the loan officer asks you a few questions and provides you with a pre-qualification letter. Pre-approval includes all the steps for a full loan approval, except for the appraisal of the property (which helps to determine value) and the title search (which ensures there are no liens against the property).

Obtaining a pre-approval can help you to determine a realistic price range before you begin a search and it makes an offer to purchase a property stronger because the seller knows you will obtain financing. Once you are pre-qualified, set a price range for your search based on your budget, the anticipated expenses associated with owning a home and a savings plan for unanticipated expenses (at least two months of living expenses but preferably six months). Next, [establish criteria for your home search](#), including type of house, location, features, etc. Be prepared to list the features you need and those that you want—this will provide you with a starting point to help narrow your search. Regardless of how much you like a property outside your designated price range, avoid buying more than your budget allows. Assuming too much mortgage expense may result in a default, especially if you leave yourself little savings for unanticipated expenses.

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When you are ready to obtain a mortgage to finance your home purchase, the following factors will influence the interest rate and, therefore, the total cost of the home over the life of the loan:

- **Size of down payment**—large down payments (20 percent or greater) will get you the best available rates; smaller down payments of 5 percent or less will bring higher rates because you are offering less equity as collateral. It is often recommended that you put 20 percent down, if you have the ability, so that you can get a lower rate and pay less interest over the long run.
- **Amount financed**—a larger amount will result in more interest paid over time.
- **Loan term**—loan terms can be from five to 30

years in length. Short- and long-term loans have advantages and disadvantages. The links below will take you to documents that discuss these advantages and disadvantages in detail.

- **Adjustable vs. fixed rate**—an adjustable rate mortgage may initially give you a lower rate than a fixed interest mortgage, but your payments for an adjustable rate mortgage are subject to change if interest rates adjust. Fixed rate mortgages do not fluctuate since the interest rates have been fixed or “established” for the life of the loan.
- **Credit and income level**—your credit quality and income level will also affect your interest rates because they determine your FICO score, which is used when calculating loan terms. If you have excellent credit and your income surpasses the amount of debt you owe, you will likely receive a lower rate. However, if your monthly income is insufficient to meet your minimum debt obligations, you will likely receive a higher interest rate, if you can obtain financing, even if you have a good FICO score.

The following resources go into great detail and can assist you in understanding real estate terms, making decisions about loan terms (e.g., fixed vs. adjustable rate mortgages), settlement costs and your rights as a consumer.

(These links will take you off the APA website. The APA is not responsible for the content of other websites.)

- [How to shop, compare and negotiate a mortgage](#) (PDF) Produced by the Federal Reserve Board
- [A consumer's guide to adjustable rate mortgages](#) (PDF) Produced by the Federal Reserve Board
- [A consumer's guide to mortgage lock-ins](#) (PDF) Produced by the Federal Reserve Board
- [Mortgage calculator to determine your monthly mortgage payments](#)

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For additional information about this resource, please contact Jon Fanning, Chief Membership & RFM-ECP Officer at jfanning@psych.org.

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