Statistical Profile of APRN and PA Residency/Fellowship Programs and Program Directors

Association of Postgraduate PA Programs

Association of Postgraduate APRN Programs

2025

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Message from the Presidents

APGAP

Postgraduate residency and fellowship programs for advanced practice providers (APPs) are highly effective at preparing advanced practice registered nurses (APRNs) and physician associates (PAs) to succeed in specialty clinical practice. This preparation is especially important in today's challenging environment of fast-paced settings, physician shortages, and increasingly complex patients.

Despite the importance of these programs, detailed, reliable information on APP fellowship structure and leadership trends remains limited. To close this gap, we created the *Statistical Profile of APRN and PA Residency/Fellowship Programs and Program Directors*.

The Association of Postgraduate APRN Programs (APGAP), together with APPAP, has collected and synthesized this data to bring transparency to the field. Our goal is straightforward: document how these programs are organized, who leads them, and what resources support them—so educators, administrators, and researchers can have informed conversations as they strategically work to prepare the future workforce for high-quality, modernized patient care delivery.

Our summary draws from responses provided by program directors at the 2023 APPAP/APGAP Conference. It covers:

- Director profiles (background, responsibilities, institutional support)
- Program basics (specialties, enrollment size, locations, funding sources)

The resulting report is a synopsis of postgraduate APP training as it stood in 2023.
It should be noted that this data composite is purely descriptive work. It does not evaluate training quality, compare program outcomes, or set strategic benchmarks. It exists to help key stakeholders who seek a better grasp of these programs and to lay groundwork for future studies.

Special thanks to the report authors for their dedication and to the program directors who shared their insights – this project depends on your participation. We hope you find the information valuable to your programs and teams.

Michelle Dawson, MSN, RN, AGACNP-BC
President, Association of Postgraduate APRN Programs

APPAP

Postgraduate training programs for physician associates (PAs) and advanced practice registered nurses (APRNs) play an increasingly important role in preparing advanced practice providers (APPs) for complex healthcare environments. As these programs continue to evolve, there remains a clear need for accurate, descriptive data that outline how programs are structured and how they are led. The *Statistical Profile of APRN and PA Residency/Fellowship Programs and Program Directors* was developed to address this need.

The Association of Postgraduate PA Programs (APPAP) is dedicated to advancing postgraduate PA education through collaboration, professional development, and scholarship. Central to this mission is the systematic collection and dissemination of information that describes the current landscape of postgraduate training. By documenting program and leadership characteristics, APPAP and APGAP aim to promote transparency and support informed dialogue among educators, institutions, and researchers.

This report presents descriptive data collected from program directors who participated in the 2023 APPAP/APGAP Conference. The data capture key characteristics of program directors, including professional background, role responsibilities, and institutional resources, as well as core features of residency and fellowship programs such as specialty focus, size, geographic distribution, and funding models. The findings provide a snapshot of postgraduate APP training at a single point in time.

The purpose of this survey is informational. It does not assess program effectiveness, compare outcomes, or establish standards. Rather, it serves as a resource for those seeking to better understand the scope and structure of postgraduate PA education and to support future research efforts.

I extend my sincere thanks to the authors of this report for their collaboration and commitment to advancing research in postgraduate PA education. I am also grateful to the program directors who contributed their time and perspectives, making this work possible.

Richard Cassa, PAC, MPAS, MBA
President, Association of Postgraduate PA Programs

About Data Collection & Methodology

Introduction

Since the formal association of clinical post-graduate PA educators formed in 1988 and NPs in 2014, APPAP and APGAP have collected data on programs and program directors to understand the landscape and challenges programs and directors are facing. This data also may provide other researchers with a snapshot of descriptive data to generate hypotheses and to conduct their own research. Research on clinical post-graduate training programs and trainees is more important than ever as these programs face calls for standardization and quality consistency. Research on this topic has previously been published in venues such as *BMC Medical Education, JAAPA*, *JPAE,* and specialty journals such as *Western Journal of Emergency Medicine, Orthopaedic Nursing,* and *Journal of Hospital Medicine*. Additionally, NCCPA has turned more attention to studying the demographics and outcomes of these programs. APPAP and APGAP stand poised to support and collaborate with researchers in this area and hope this report will provide value to its members for years to come. Finally, this report will be followed up with additional data collection at the 2026 APPAP/APGAP Conference in Chicago, Illinois.

Data Editing and Analysis

Data reflected in this report includes Program Director responses from the 2023 APPAP/APGAP Conference which took place in Salt Lake City, Utah. The survey was provided to conference attendees during the conference in October 2023. 104 of 146 conference attendees responded (71.2% response rate). However, an underlying limitation to the data is that those Program Directors not attending this conference were not able to participate. Nonetheless, the following report provides unique insight into a large sample of PA and NP Program Directors, including types of compensation, funding source for programs, and stipend amounts for fellows/residents. Responses were examined for consistency and potential errors. In cases of obvious error or inconclusive data, responses were not included in the analysis. The number of responses to individual items varies due to the differing response rates. Analyses of the data consist of descriptive statistics. Researchers who are interested in further studies regarding this data are encouraged to fill out an external data form found on the APPAP website under "Research." External data requests will be reviewed during Research Advisory Workgroup meetings which happen about once each month.

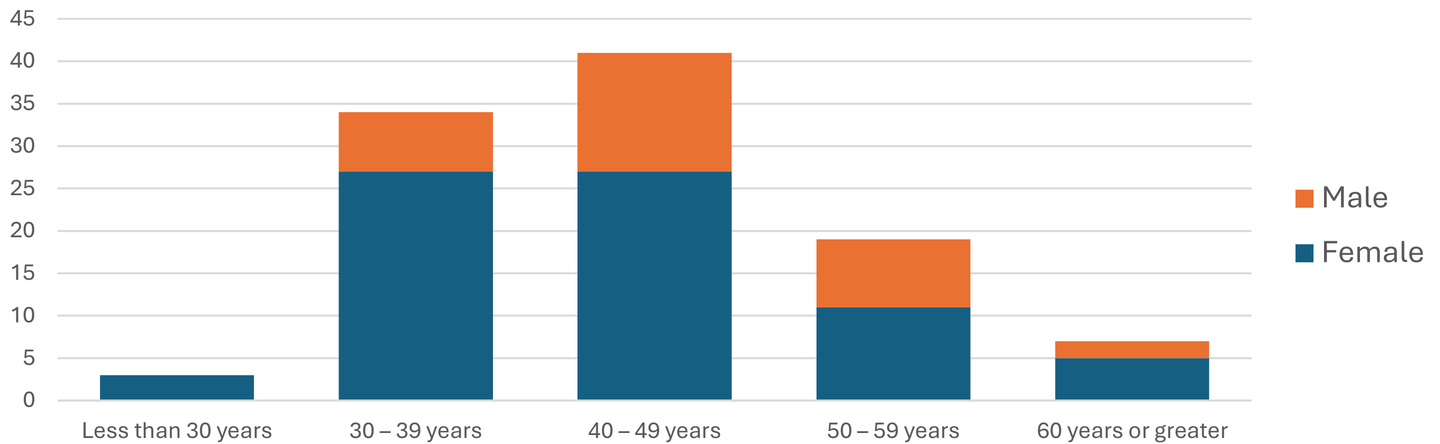
About APPAP and APGAP

The Association of Postgraduate PA Programs (APPAP) and the Association of Postgraduate APRN Programs (APGAP) are national professional organizations that support the development and advancement of postgraduate clinical training programs for physician assistants and advanced practice registered nurses, respectively. These organizations provide networking opportunities, leadership development resources, program directories, mentorship initiatives, and educational programming for program directors and faculty. APPAP and APGAP also serve as convening bodies for collaboration, dissemination of best practices, and dialogue regarding curriculum design, competency development, and program sustainability. While distinct from formal accrediting entities, both organizations contribute to the maturation of postgraduate training by promoting professional standards, shared scholarship, and peer support among programs. Their growing membership reflects the expansion of APP postgraduate education nationally and underscores the increasing need for coordinated leadership, faculty development, and structured program guidance within this evolving educational landscape.

Program Director Demographics and Characteristics

Program Directors by Age and Gender

Females less than 49 years old represent the majority of PDs



Number of PDs by Age Group

	n	Percent
Less than 30 years	3	2.88
30 – 39 years	34	32.69
40 – 49 years	41	39.42
50 – 59 years	19	18.27
60 years or greater	7	6.73
TOTAL	104	100.00

Number of PDs by Gender

	n	Percent
Female	73	70.19
Male	31	29.81
Non-binary	0	0.00
Prefer not to answer	0	0.00

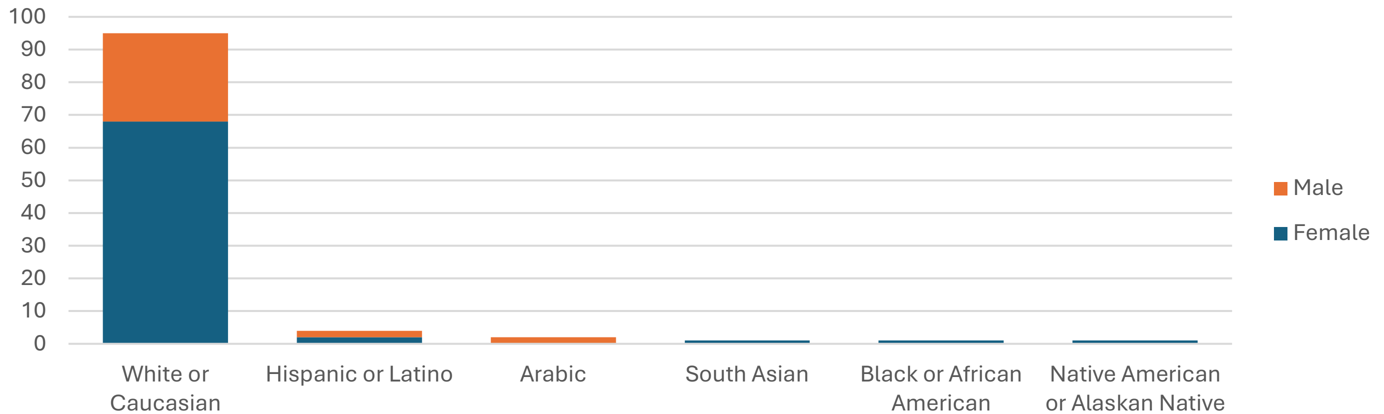
Age/Gender Combined

Count of Age	**Gender**		
Age	Female	Male	**Grand Total**
Less than 30 years	3	0	3
30 – 39 years	27	7	34
40 – 49 years	27	14	41
50 – 59 years	11	8	19
60 years or greater	5	2	7
Grand Total	**73**	**31**	**104**

Your age in years at the time of this survey

Which of the following best describes you?

Race and Ethnicity of Program Directors



PDs by Race/Ethnicity

	n	Percent
Arabic	2	1.92
Asian or Pacific Islander	0	0.00
Black or African American	1	0.96
Hispanic or Latino	4	3.85
Multiracial	0	0.00
Native American or Alaskan Native	1	0.96
South Asian	1	0.96
White or Caucasian	95	91.35
Prefer not to answer	0	0.00

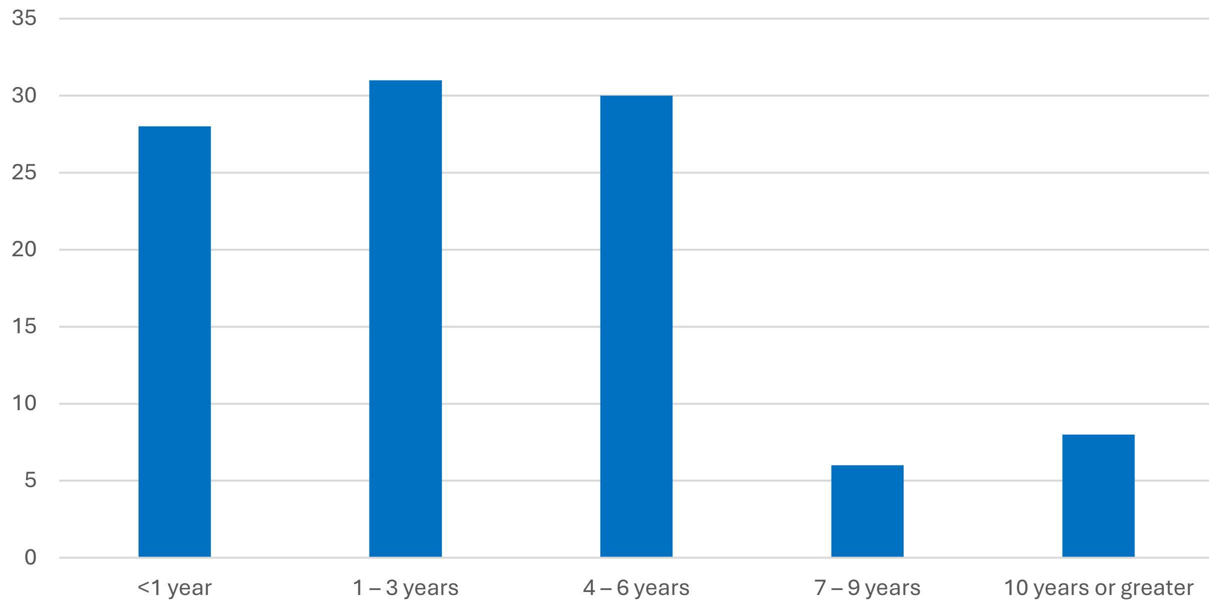
PD Race/Ethnicity by Gender

	Gender		
Ethnicity	**Female**	**Male**	**Grand Total**
White or Caucasian	68	27	95
Hispanic or Latino	2	2	4
Arabic	0	2	2
South Asian	1	0	1
Black or African American	1	0	1
Native American or Alaskan Native	1	0	1
Grand Total	**73**	**31**	**104**

Which of the following best describes you?

Years of Experience as a Program Director

Most PDs have <6 years experience in role



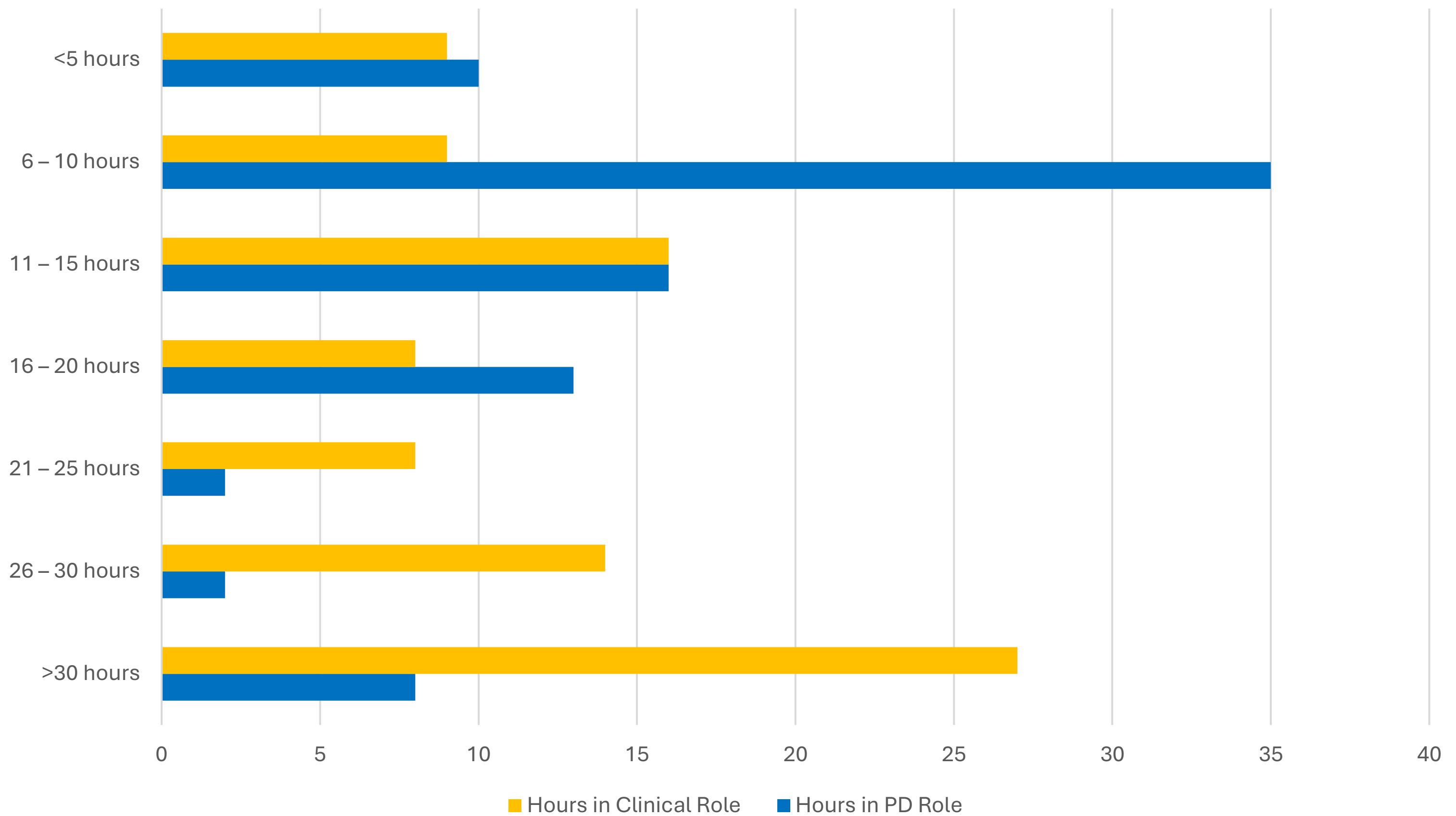
PD Years of Experience

	n	Percent
<1 year	28	26.92
1 – 3 years	31	29.81
4 – 6 years	30	28.85
7 – 9 years	6	5.77
10 years or greater	8	7.69
Missing/Blank	1	0.96

How many years have you been a Fellowship/Residency Program Director?

Hours Spent Per Week in Program Director and Clinical Roles

Many PDs are balancing role with full-time clinical work



PD Hours in Admin Role

	n	Percent
>30 hours	8	7.69
26 – 30 hours	2	1.92
21 – 25 hours	2	1.92
16 – 20 hours	13	12.50
11 – 15 hours	16	15.38
6 – 10 hours	35	33.65
<5 hours	10	9.62
Missing/Blank	18	17.31

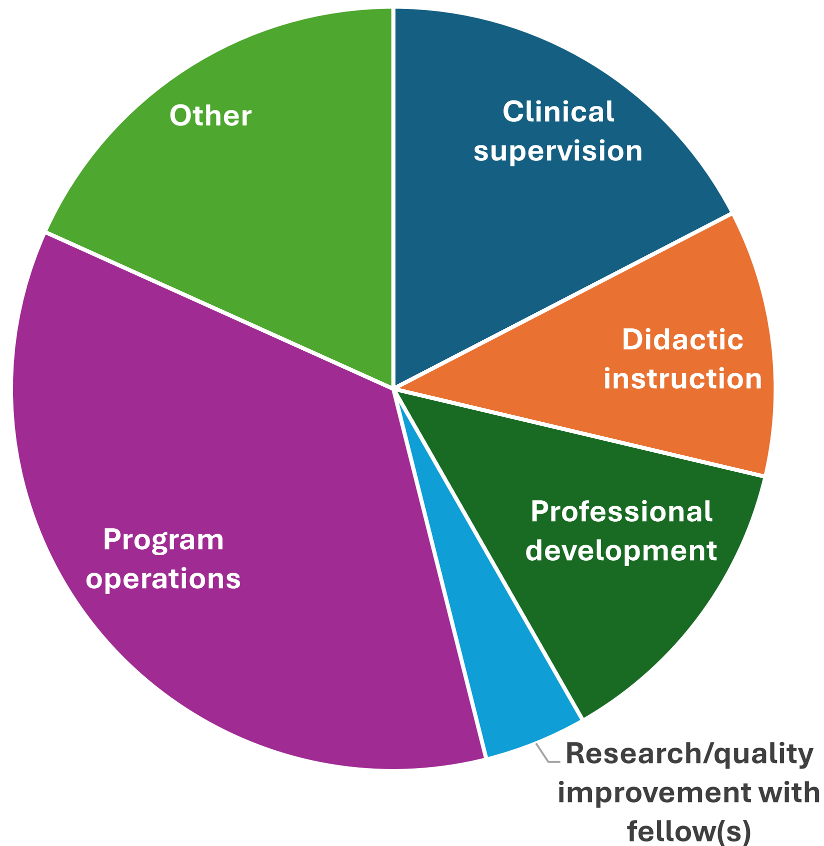
PD Hours in Clinical Role

	n	Percent
>30 hours	27	25.96
26 – 30 hours	14	13.46
21 – 25 hours	8	7.69
16 – 20 hours	16	15.38
11 – 15 hours	8	7.69
6 – 10 hours	9	8.65
<5 hours	9	8.65
Missing/Blank	13	12.50

How many hours per week do you typically spend in your role as the Fellowship/Residency Program Director?
How many hours per week do you typically spend performing clinical duties?

Distribution of Effort within Program Director Role

Program operations was the most common and highest percentage of effort task

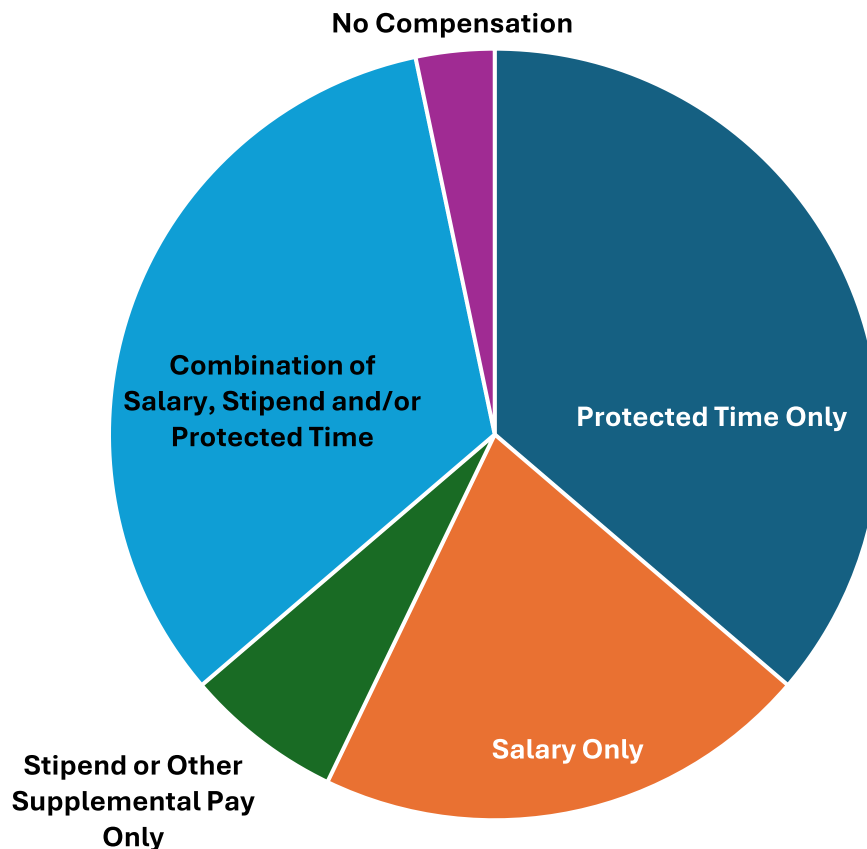


Types of tasks and average effort as PD

	n	Percent	Average %
Clinical supervision	85	81.73	20
Didactic instruction	87	83.65	13
Professional development	83	79.81	15
Research/quality improvement with fellow(s)	74	71.15	5
Program operations	88	84.62	41
Other	38	36.54	21
Missing/Blank	15	14.42	

Report the percentage of time (do not include "%") you spend performing the following duties in your role as Program Director.

Program Director Types of Compensation

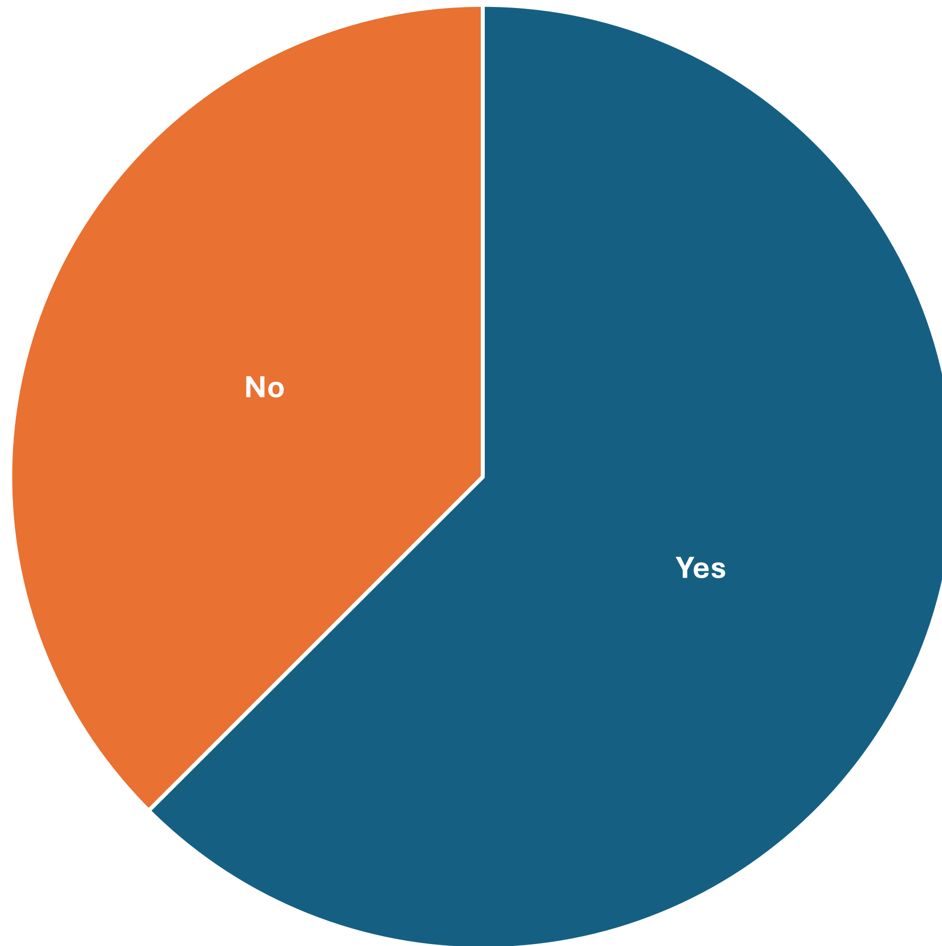


Types of Compensation

	n	Percent
Protected Time (Shift Reduction, Administrative Time) Only	33	31.73
Salary Only	19	18.27
Stipend or Other Supplemental Pay Only	6	5.77
Combination of Salary, Stipend and/or Protected Time	30	28.85
No Compensation	3	2.88
Missing/Blank	13	12.50

Which of the following do you receive as compensation for your Fellowship/Residency Program Director responsibilities?

Perception of Adequate Compensation



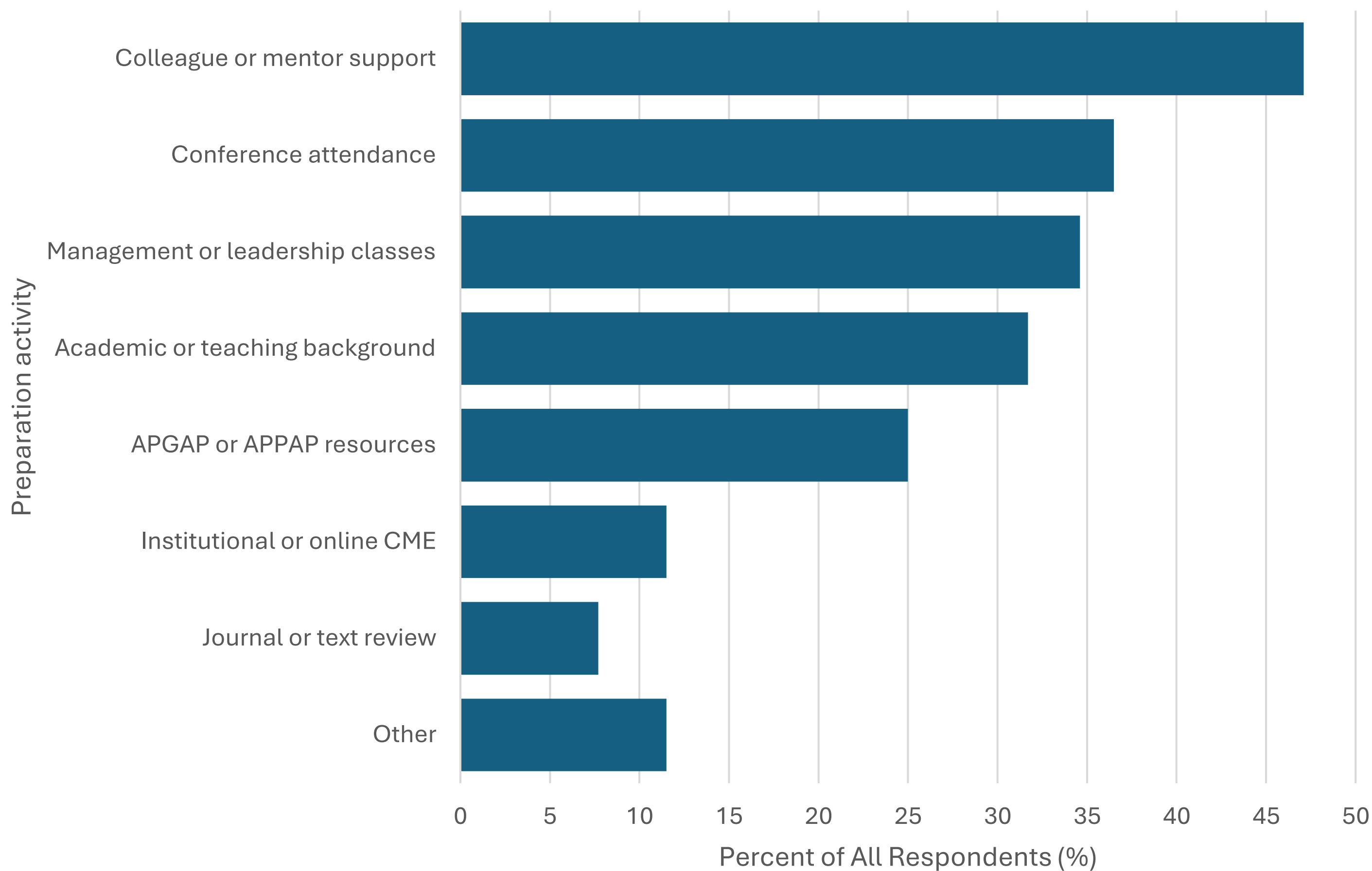
Perception of adequate compensation

	n	Percent
Yes	55	52.88
No	33	31.73
Missing/Blank	16	15.38

Do you feel you have adequate compensation to effectively perform your duties as Program Director?

Preparation for Program Director Role

Preparation for the PD role includes a combination of informal and formal activities

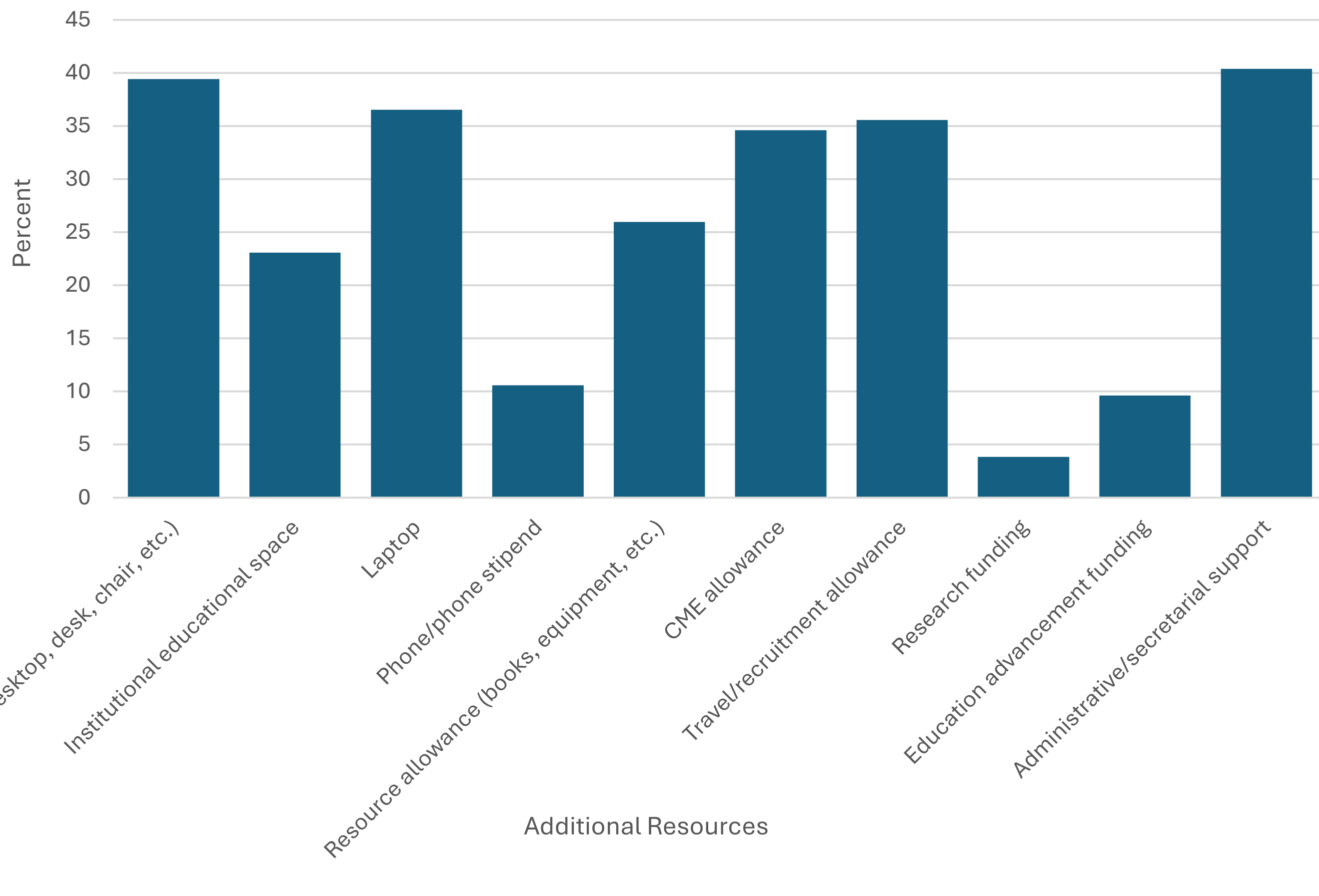


Preparation Activity

	Respondents (n)	Percent of All Respondents (%)
Colleague or mentor support	49	47.1
Conference attendance	38	36.5
Management or leadership classes	36	34.6
Academic or teaching background	33	31.7
APGAP or APPAP resources	26	25.0
Institutional or online CME	12	11.5
Journal or text review	8	7.7
Other	12	11.5

What activity best prepared you for your role as Program Director?

Additional Resources for Program Directors



Additional Resources for PDs

	n	Percent
Institutional workspace (desktop, desk, chair, etc.)	41	39.42
Institutional educational space	24	23.08
Laptop	38	36.54
Phone/phone stipend	11	10.58
Resource allowance (books, equipment, etc.)	27	25.96
CME allowance	36	34.62
Travel/recruitment allowance	37	35.58
Research funding	4	3.85
Education advancement funding	10	9.62
Administrative/secretarial support	42	40.38
Missing/Blank	25	24.04

Do you receive any of the following as a part of your Fellowship/Residency Program Director role?

Challenges for Program Directors

Ranked-Ordered Challenges

	Mean Rank	Respondents Ranking in Top 3 (n)	Percent of All Respondents (%)
Lack of consistent or adequate program funding	3.9	39	37.5
Lack of personal compensation or protected time	4.0	50	48.1
Lack of program support personnel	4.9	28	26.9
Lack of access to clinical experiences for fellows	5.1	21	20.2
Lack of access to didactic resources for fellows	5.2	20	19.2
Lack of hospital administrative support	5.3	17	16.3
Lack of program director training	5.8	10	9.6
Lack of strong candidates	5.9	22	21.2
Lack of research/QI support or opportunities	6.6	11	10.6
Saturation of learner groups (students, residents, etc.)	6.9	23	22.1

Respondents: 86, Missing/Blank: 18

Scale: 1 = Most challenging, 10 = Least challenging

Respondents ranked each challenge from most challenging (1) to least challenging (10). Percentages reflect the proportion of respondents ranking an item among their top three challenges. Mean rank values are presented for descriptive comparison; lower values indicate greater perceived challenge.

Rank the following from most challenging (1) to least challenging (10).

Perceived Accreditation Importance

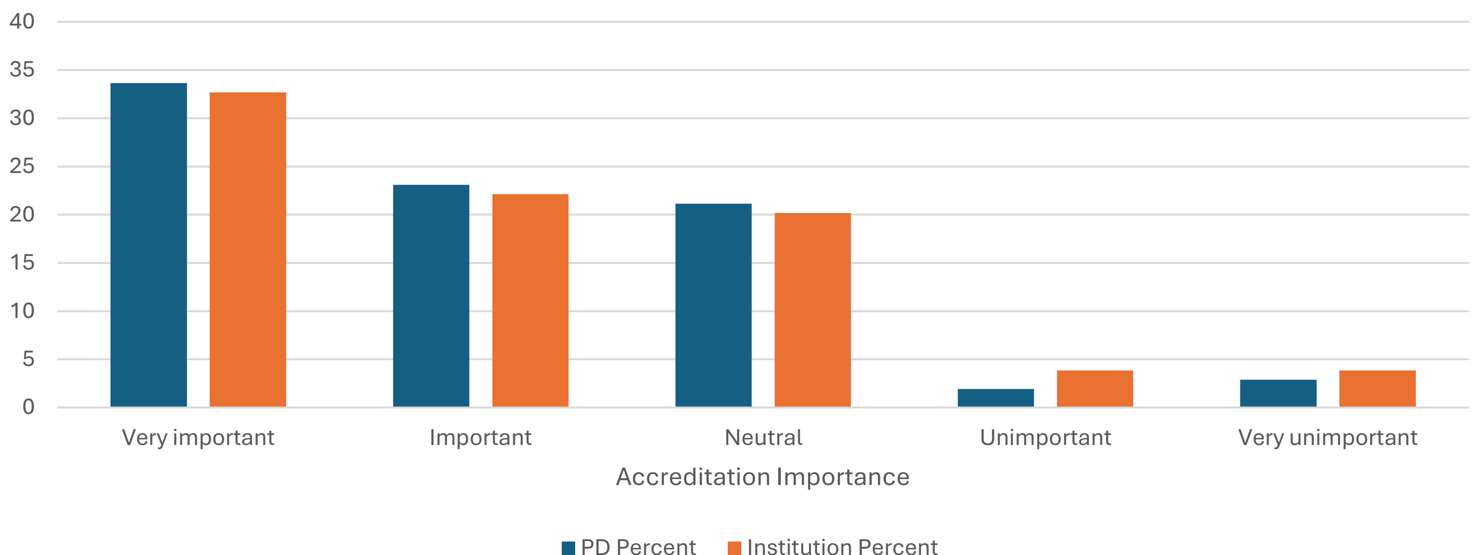
Perceived Accreditation Importance to PD

	n	Percent
Very important	35	33.65
Important	24	23.08
Neutral	22	21.15
Unimportant	2	1.92
Very unimportant	3	2.88
Missing/Blank	18	17.31

Perceived Accreditation Importance to Institution

	n	Percent
Very important	34	32.69
Important	23	22.12
Neutral	21	20.19
Unimportant	4	3.85
Very unimportant	4	3.85
Missing/Blank	18	17.31

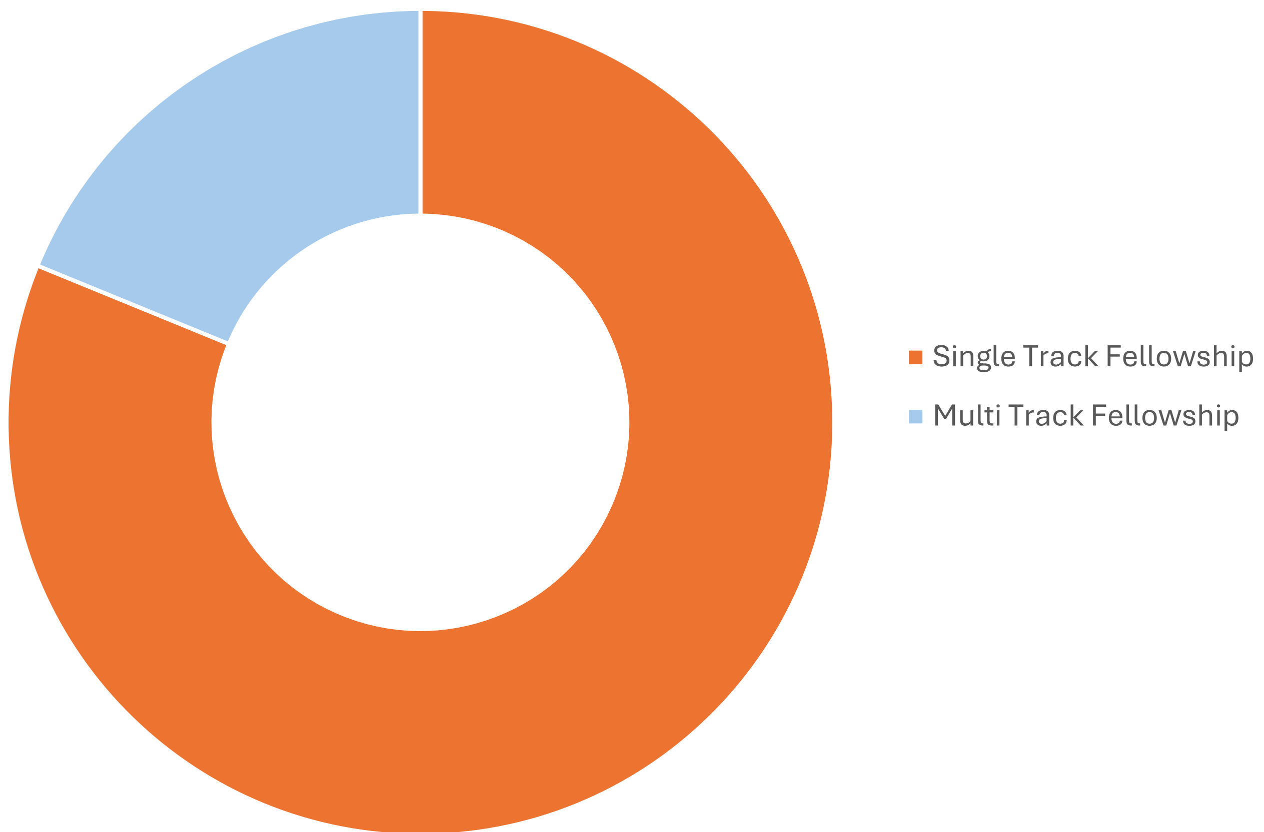
Accreditation importance similar between PD and Institution



How important is the accreditation or future accreditation of your program to you as the Program Director?
How important is the accreditation or future accreditation of your program to the institution?

Program Characteristics

Types of Programs



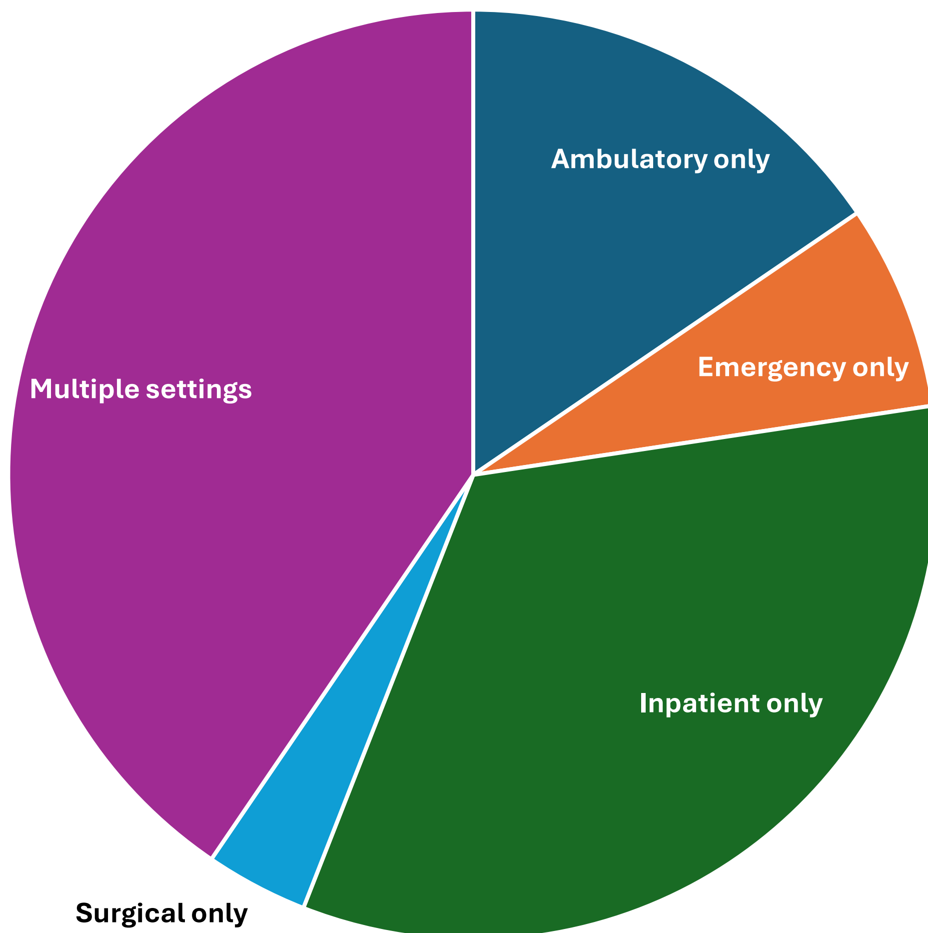
Program Type

	n	Percent
Single Track Fellowship	82	78.85
Multi Track Fellowship	19	18.27
Missing/Blank	3	2.88

How would you characterize the program you oversee?

Practice Setting of Programs

Most programs take place in multiple settings or inpatient only



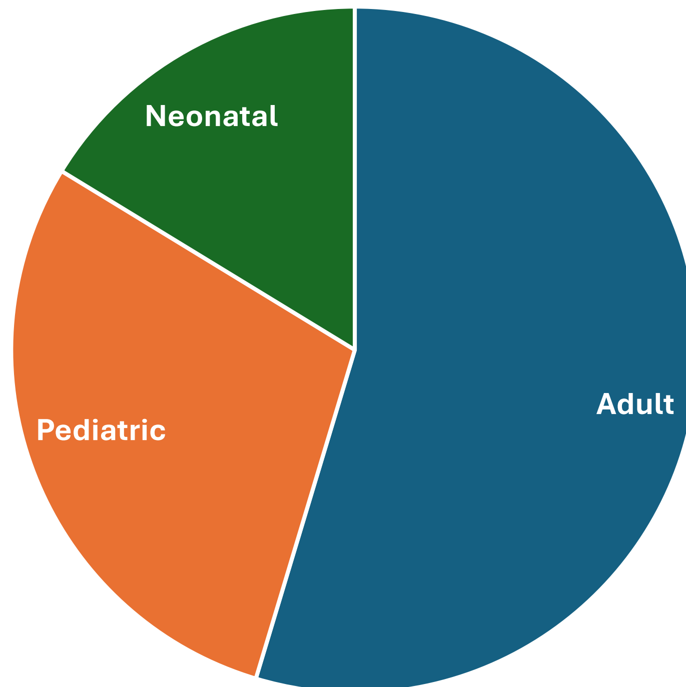
Practice Setting of Program

	n	Percent
Ambulatory only	13	12.5
Emergency only	6	5.77
Inpatient only	28	26.92
Surgical only	3	2.88
Multiple settings	34	32.69
Prefer not to answer	16	15.38
Missing/Blank	4	3.85

Please select the setting, population and list specialty or specialties offered through your Fellowship/Residency

Patient Population of Programs

Most programs focus on adult patients; however, pediatric and neonatal programs are also common



Patient Population of Program

	n	Percent
Adult	47	45.19
Pediatric	25	24.04
Neonatal	14	13.46
Missing/Blank	18	17.31

Please select the setting, population and list specialty or specialties offered through your Fellowship/Residency

Specialties Offered at Programs

Specialties at Programs

	Mentions (n)	Percent of all respondents (%)
Critical Care	20	19.2
Oncology / Hematology-Oncology	9	8.7
Orthopedics / Orthopedic Trauma	7	6.7
Primary Care / Family Medicine	6	5.8
Hospital Medicine	5	4.8
Emergency Medicine	5	4.8
Surgery (general / CTS / trauma)	5	4.8
Psychiatry	4	3.8
Behavioral Health	3	2.9
Neurosciences	3	2.9
Pediatrics (incl. PICU / pediatric acute–critical care)	3	2.9
Pulmonology	2	1.9
Urgent Care	2	1.9
Cardiology	2	1.9
Cardiac Critical Care	2	1.9
Neonatology / NICU	2	1.9
Transplant Medicine / Hepatology	2	1.9
Acute Care (non-ICU specified)	2	1.9
Rheumatology	1	1.0
Dementia Care	1	1.0
Home-Based Medicine	1	1.0

Specialty tracks were collected via a free-text survey item. Counts represent specialty mentions and are not mutually exclusive. Percentages are calculated using the total number of survey respondents (N = 104)

Please select the setting, population and list specialty or specialties offered through your Fellowship/Residency

Distribution of Programs

Programs by State

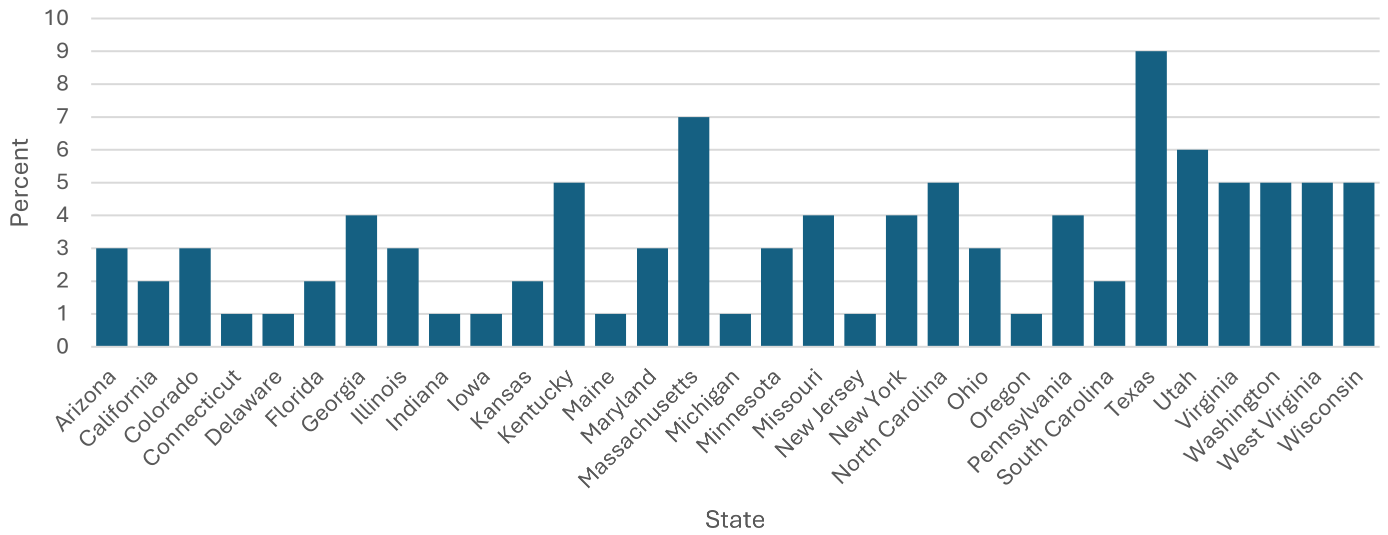
State	n	Percent
Arizona	3	2.88
California	2	1.92
Colorado	3	2.88
Connecticut	1	0.96
Delaware	1	0.96
Florida	2	1.92
Georgia	4	3.85
Illinois	3	2.88
Indiana	1	0.96
Iowa	1	0.96
Kansas	2	1.92
Kentucky	5	4.81
Maine	1	0.96
Maryland	3	2.88
Massachusetts	7	6.73
Michigan	1	0.96
Minnesota	3	2.88
Missouri	4	3.85
New Jersey	1	0.96
New York	4	3.85
North Carolina	5	4.81
Ohio	3	2.88
Oregon	1	0.96
Pennsylvania	4	3.85
South Carolina	2	1.92
Texas	9	8.65
Utah	6	5.77
Virginia	5	4.81
Washington	5	4.81
West Virginia	5	4.81
Wisconsin	5	4.81
Missing/Blank	2	1.92
TOTAL	104	100.00%

Programs by Region

Region	n	Percent
Region 1 - Northeast	14	13.46
Region 2 - Southeast	41	39.42
Region 3 - Midwest	27	25.96
Region 4 - West	20	19.23
Missing/Blank	2	1.92

What state(s) are you currently working as Fellowship/Residency Program Director?

Program respondents were in several states in the U.S.



The Southeast and Midwest represented approximately 2/3 respondents

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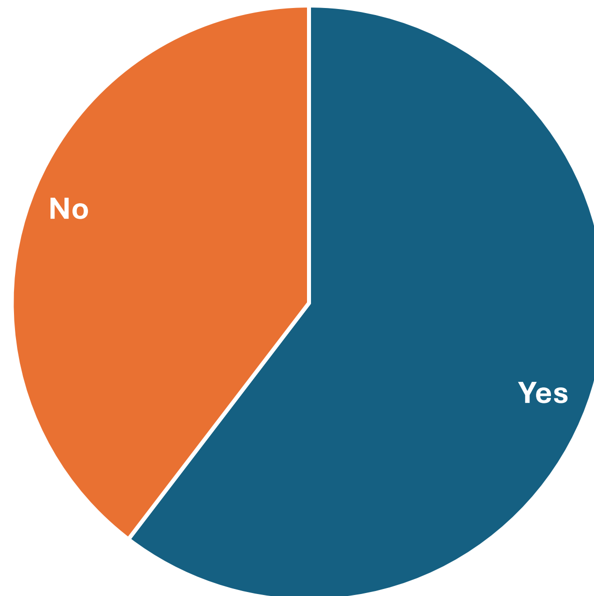
Adjacent Programs at Same Institution

Most APP post-grad programs have adjacent post-grad programs at the same institution

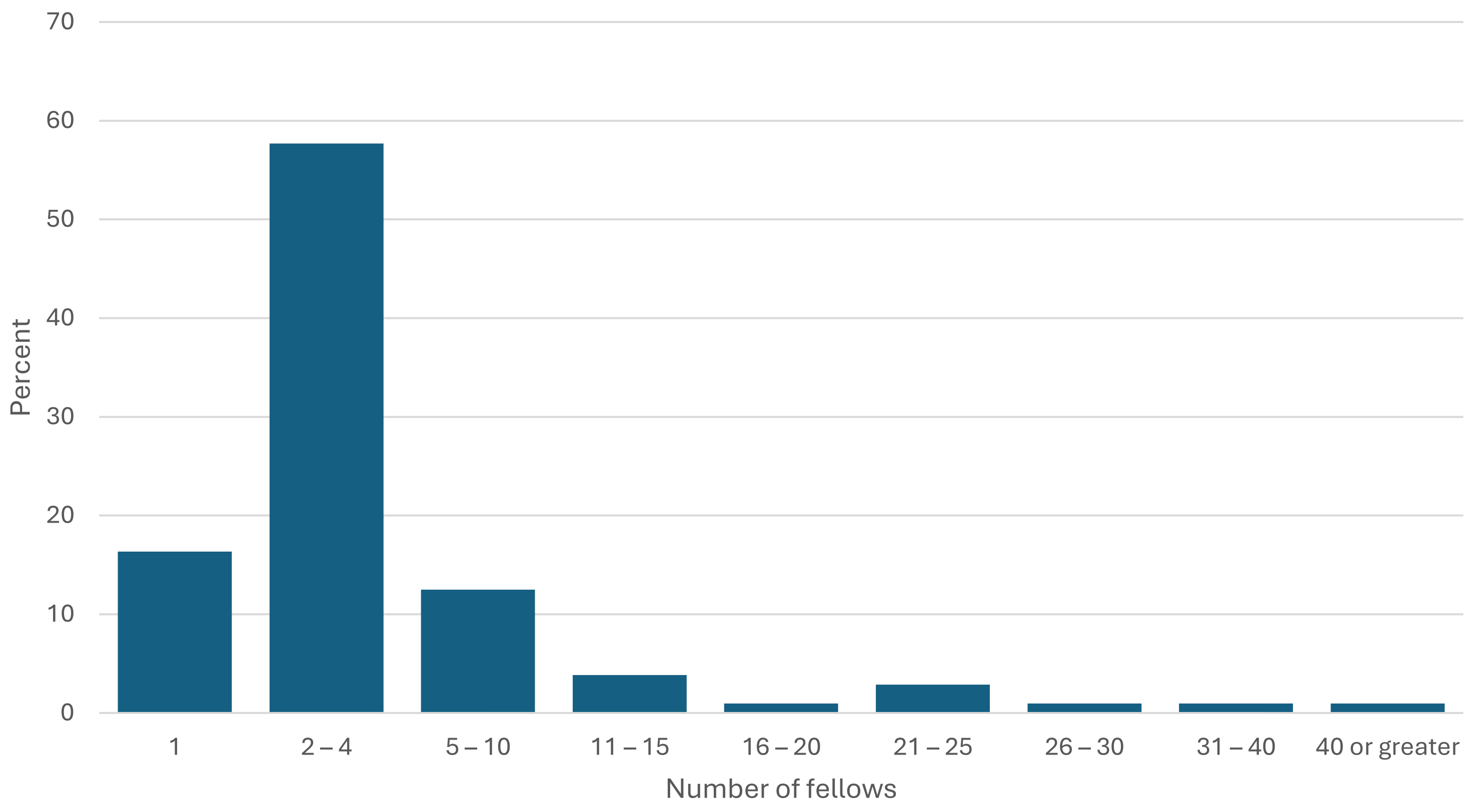


Adjacent APP Fellowship/Residencies at Same Institution

	n	Percent
Yes	61	58.65
No	40	38.46
Missing/Blank	3	2.88

Are there other Advanced Practice Provider Fellowship/Residency programs at your institution that are not associated with yours?

Number of Fellows Enrolled per Program



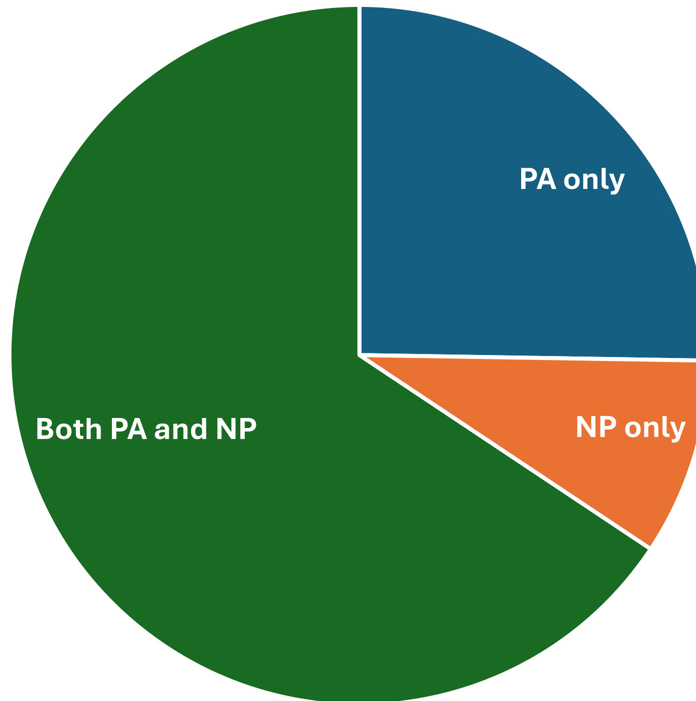
Number of Fellows Annually

	n	Percent
1	17	16.35
2 – 4	60	57.69
5 – 10	13	12.5
11 – 15	4	3.85
16 – 20	1	0.96
21 – 25	3	2.88
26 – 30	1	0.96
31 – 40	1	0.96
40 or greater	1	0.96
Missing/Blank	3	2.88

How many Fellows do you typically enroll into your Fellowship/Residency annually?

Professions Accepted into Programs

Nearly 2/3 of programs accept both PAs and NPs



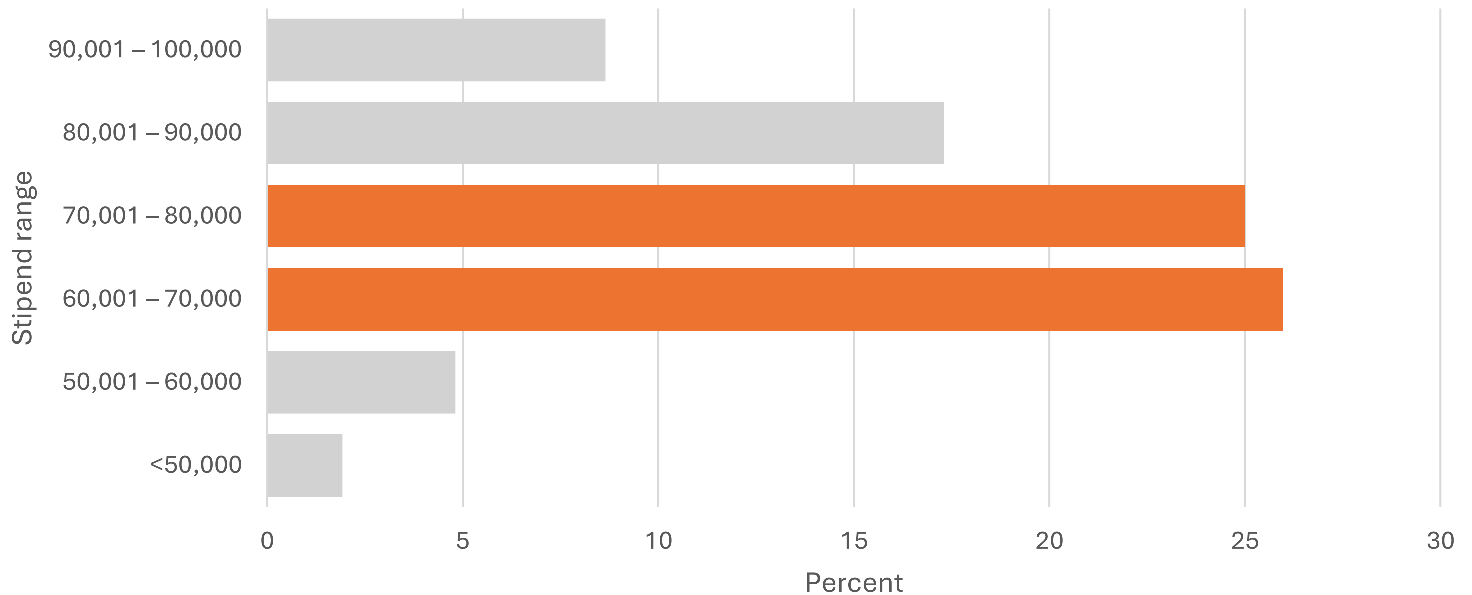
Professions Accepted into Programs

	n	Percent
PA only	25	24.04
NP only	9	8.65
Both PA and NP	65	62.50
Prefer not to answer	2	1.92
Missing/Blank	3	2.88

Which profession(s) do you accept into your Fellowship/Residency?

Stipend Range and Benefits Eligibility for Fellows

Greater than half of programs pay stipends between 60-80k per year



Stipend Range

	n	Percent
$90,001 – 100,000	9	8.65
$80,001 – 90,000	18	17.31
$70,001 – 80,000	26	25.00
$60,001 – 70,000	27	25.96
$50,001 – 60,000	5	4.81
< $50,000	2	1.92
Missing/Blank	17	16.35

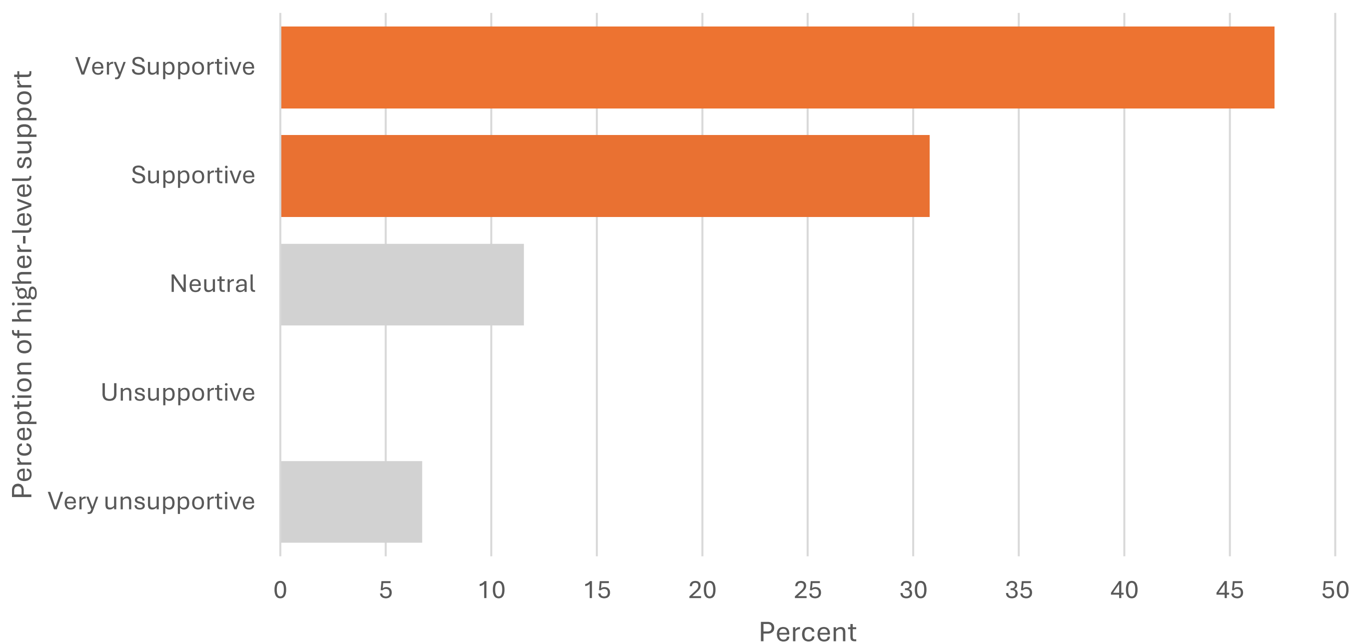
Benefits Eligibility

	n	Percent
Yes	86	82.69
No	2	1.92
Missing/Blank	16	15.38

Most programs also offer benefits as part of compensation

What is the current stipend range for your Fellow/Resident?
Are Fellows/Residents eligible for benefits packages at your institution?

Perception of Higher-Level Support



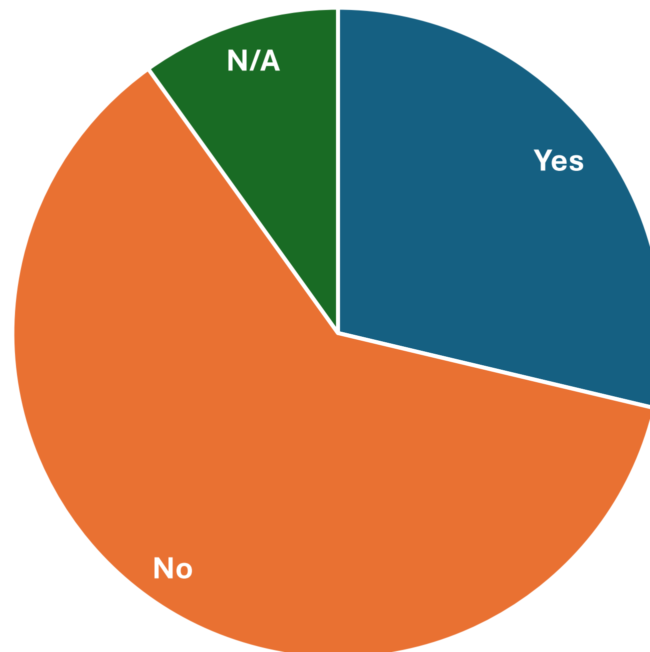
Perception of higher-level support

	n	Percent
Very Supportive	49	47.12
Supportive	32	30.77
Neutral	12	11.54
Unsupportive	0	0.00
Very unsupportive	7	6.73
Missing/Blank	4	3.85

What is the perception of your hospital administration or C-suite about your Fellowship/Residency Program?

Perception of Competition Between APP and Physician Learners

Most PDs do not perceive competition between APP fellows/residents and physician fellows/residents



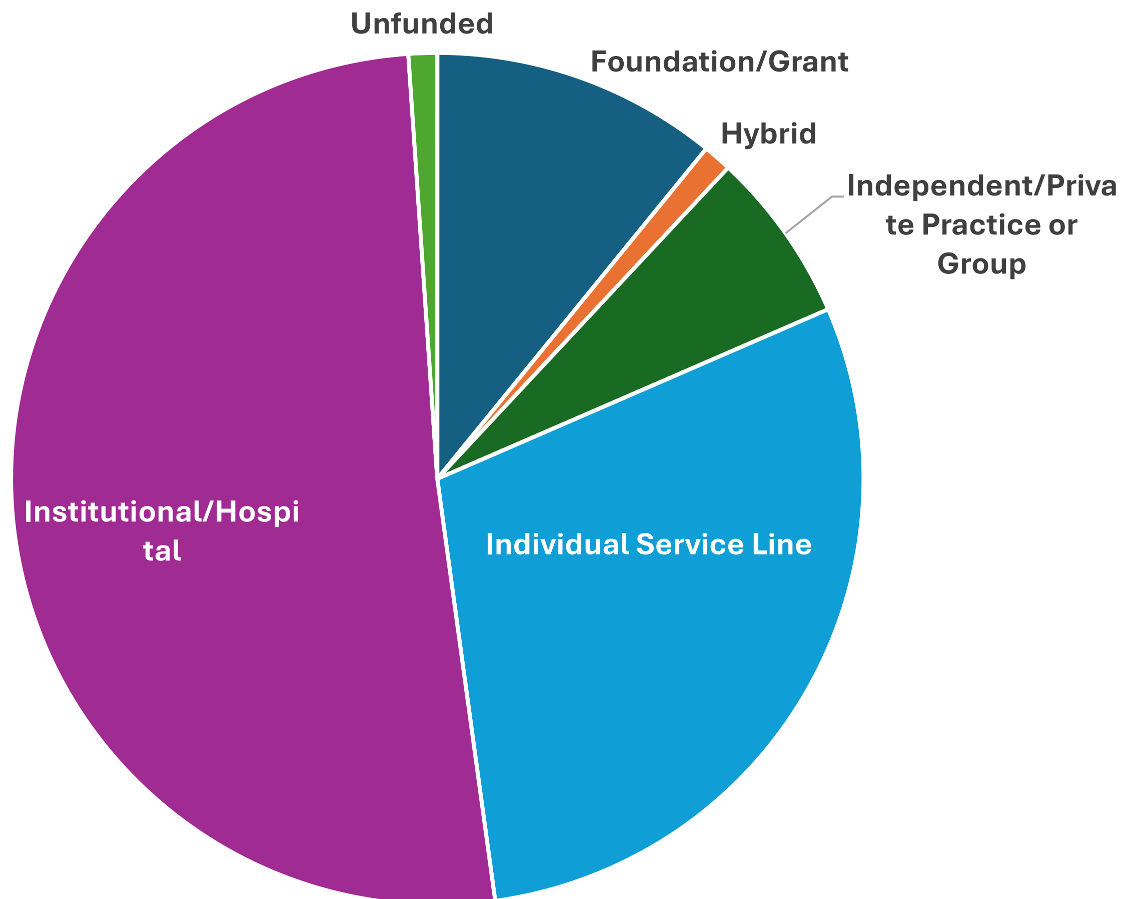
Perception of Competition

	n	Percent
Yes	29	27.88
No	62	59.62
N/A (Not affiliated with medical school or physician residency)	10	9.62
Missing/Blank	3	2.88

Is there a perceived competition between your Advanced Practice Provider Fellows/Residents and your Physician Fellows/Residents?

Primary Funding Source of Programs

Programs are mostly funded by the institution, individual service line, or foundation/grant

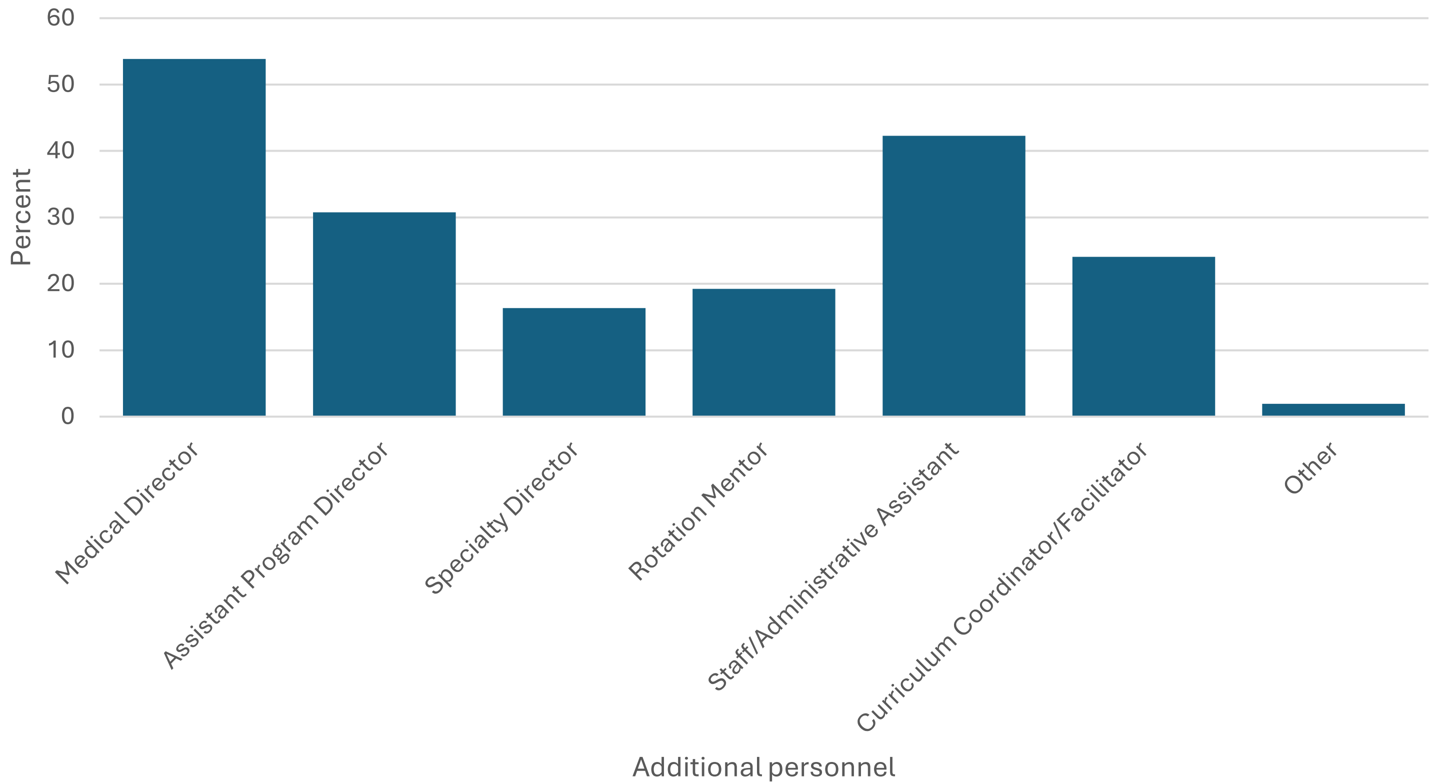


Primary Funding Source

	n	Percent
Foundation/Grant	10	9.62
Hybrid (Institutional and Service Line)	1	0.96
Independent/Private Practice or Group	6	5.77
Individual Service Line	27	25.96
Institutional/Hospital	47	45.19
Unfunded	1	0.96
Missing/Blank	12	11.54

What is the primary funding source for your Fellowship/Residency Program?

Additional Personnel in Programs



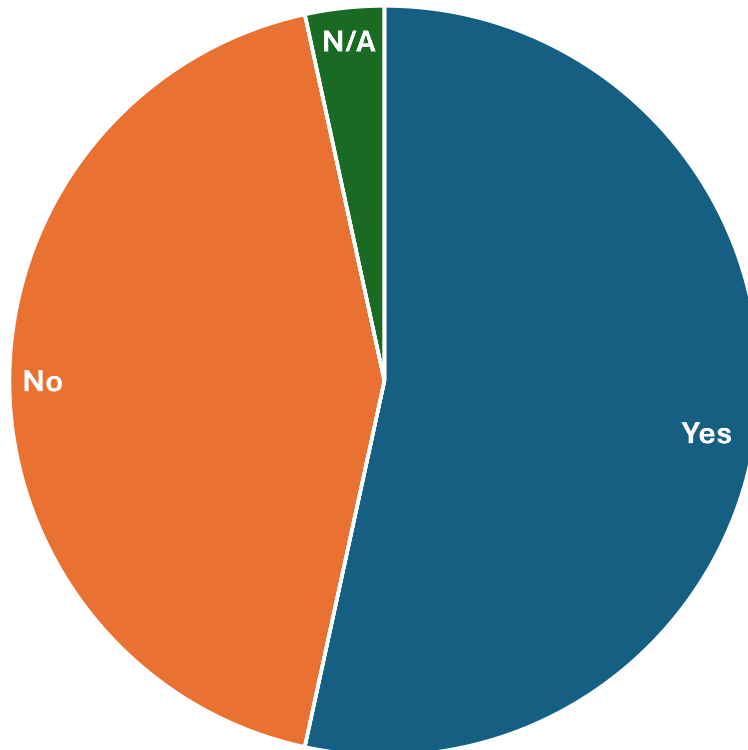
Additional Personnel

	n	Percent
Medical Director	56	53.85
Assistant Program Director	32	30.77
Specialty Director	17	16.35
Rotation Mentor	20	19.23
Staff/Administrative Assistant	44	42.31
Curriculum Coordinator/Facilitator	25	24.04
Other	2	1.92
Missing/Blank	22	21.15

If you have any additional staff or faculty as a part of your Fellowship/Residency Program, please check all that apply.

Additional Personnel Compensation

Additional personnel are sometimes compensated, sometimes not



Additional Personnel Compensation

	n	Percent
Yes	47	45.19
No	38	36.54
N/A	3	2.88
Missing/Blank	16	15.38

Are additional staff or faculty as a part of your Fellowship/Residency Program compensated?

Appendix

Qualitative Reports

Thematic analysis was conducted through the use of Google Notebook LLM for the following questions: why compensation is adequate or inadequate, the competition effect between APP learners and MD/DO learners on the training environment, and variables for effective interprofessional learning. Raw, anonymous qualitative data from the survey respondents were input into the generative AI tool with executive summary reports being provided for each. Each of the analyses were reviewed by this report's authors from APPAP and APGAP for content validity and accuracy.

Why Compensation is Adequate or Inadequate

This executive summary synthesizes the results of a recent survey on Program Director (PD) compensation. The analysis provides leadership with a clear, data-driven understanding of sentiment regarding the adequacy of compensation and is intended to inform future strategies for PD support and retention. The survey posed the question, "Do you feel you have adequate compensation to effectively perform your duties as Program Director?" to a group of 88 respondents.

The primary finding is that while a majority of Program Directors (62.5%) feel their compensation is adequate, a significant minority (37.5%) do not.

The specific breakdown of responses is as follows:

- *Adequate Compensation ("Yes"):* 62.50% (55 respondents)
- *Inadequate Compensation ("No"):* 37.50% (33 respondents)

While the overall sentiment is positive, the qualitative feedback from the significant minority who feel compensation is inadequate reveals critical and consistent thematic concerns that warrant a deeper strategic review.

Analysis of Dissatisfaction: Key Thematic Concerns

Analyzing the detailed feedback from the 33 respondents who feel their compensation is inadequate provides critical insight into the root causes of this sentiment. Understanding these drivers is essential for developing targeted interventions aimed at mitigating leadership burnout, ensuring sustained program quality, and retaining key talent. The comments reveal three interconnected areas of concern where a failure in one area, such as support, directly exacerbates another, such as workload imbalance.

Workload and Time Allocation Imbalance: A consistent theme among dissatisfied Program Directors is the mismatch between the role's demands and the time allotted or protected for administrative duties. Respondents noted that the position often requires significantly more time than is formally recognized, with one commenting that the role "takes >40 hrs a week." This sentiment is echoed by others who explicitly state the "Need more time to perform duties" and a desire for "more time dedicated to fellowship training." The core issue is a workload that consistently exceeds compensated hours, leading to feelings of being undervalued and overworked.

Insufficient Administrative and Financial Support: Beyond time constraints, Program Directors frequently cite a lack of essential support structures as a primary driver of dissatisfaction. This includes inadequate "Budget support" and a lack of dedicated "Medical Director support" to help manage responsibilities. The challenge is compounded by limited administrative capacity, with directors noting they receive "no admin time with administration responsibilities." The issue of a "(non existent) budget" was highlighted as particularly problematic, forcing directors to manage program needs without the necessary financial resources. This scarcity of foundational support forces Program Directors to absorb

these responsibilities themselves, directly contributing to the workload and time imbalances described previously.

Perceived Compensation Inequity: Concerns about compensation are often framed in terms of both external market rates and internal equity. Several directors feel their pay is not aligned with a proper "market analysis" for a role of this complexity. Furthermore, there is a clear perception of internal inequity. One director highlighted this by stating they are "on the same level as an APP department lead but do significantly more," suggesting that the compensation structure does not accurately reflect the comparative scope and responsibility of the Program Director role.

These interconnected challenges of time, support, and equity stand in contrast to the factors cited by those who feel their compensation is adequate, which offer a potential model for improvement.

Factors Contributing to Perceived Adequacy

Understanding the drivers of positive sentiment among the majority (62.5%) is crucial for identifying and replicating successful support and compensation models across the organization. The feedback from this group points clearly to a central theme: the provision of sufficient dedicated time and resources is a key determinant of satisfaction.

Respondents who feel fairly compensated frequently cite having a "fair balance of work required vs. compensation." This balance is often achieved through formal, protected time allocations. For example, successful models include having "50% of our time/salary dedicated to the fellowship" or having a contract that provides "2 days a week dedicated/protected for this position." These arrangements demonstrate a tangible organizational commitment to the role, which fosters a sense of being adequately supported and valued. This contrast clearly identifies protected time and dedicated resources as the most critical levers for ensuring Program Director effectiveness and morale.

Strategic Implications for Leadership

The survey findings present a nuanced picture of Program Director compensation. The primary strategic implication is that *while overall sentiment is positive, the concerns raised by a significant minority of Program Directors regarding time, support, and pay equity represent a critical risk to program stability and leadership retention.* The feedback strongly suggests that compensation adequacy is not solely a matter of salary but is intrinsically linked to the structural support provided for the role. The consistency of themes across the dissatisfied group indicates that these are not isolated issues but systemic challenges. Therefore, leadership should prioritize a targeted review of time allocations, administrative support structures, and budget resources for the Program Director role to ensure the long-term health and success of our programs.

Do you feel you have adequate compensation to effectively perform your duties as Program Director? Why?

Competition Effect on Training Environment

This document provides a thematic analysis of qualitative feedback from program directors responding to the survey question, "How does the competition affect your training environment, ability to recruit, trainee experience, etc.?" The varied and detailed responses offer a critical window into the on-the-ground realities of managing multiple trainee programs within a shared clinical space.

The purpose of this analysis is to categorize the diverse responses into distinct themes, providing a structured overview of the challenges, dynamics, and operational impacts of competition. By synthesizing these perspectives, this document aims to inform strategic planning, institutional policy review, and efforts to optimize the clinical learning environment for all trainees.

The following analysis organizes the feedback into four key themes. It begins with the central conflict over clinical and procedural opportunities, explores the resulting inter-professional dynamics, details the tangible impacts on program operations, and concludes by examining perspectives that report a neutral or mitigated impact of competition.

The Core Conflict: Competition for Procedural and Clinical Opportunities

The availability of procedural and clinical training opportunities is a finite, high-stakes resource within academic medical settings. Unsurprisingly, the feedback from program directors identifies direct competition for these essential learning experiences as the central point of contention and the primary driver of tension in the training environment.

The survey responses consistently highlight a challenge rooted in scarcity. Directors describe "limited procedural volume" (Response #6) and the general difficulty of "obtaining procedural time" (Response #22) as fundamental problems that affect clinical training opportunities (Response #8). This limited volume creates an environment where "Procedures and new admits consults are competitive" (Response #13). The competition is often between specific trainee groups, with feedback noting how the presence of multiple programs "limits the number of cases PA residents can first assist" (Response #23) and can "reduce [the] number of advanced procedures our PA fellows practice" (Response #24).

This competition is further complicated by systemic factors that create a clear hierarchy for accessing learning opportunities. Several responses point to preferential treatment for certain trainees due to accreditation requirements. One director explicitly states, "The physician fellows get preference for procedures" (Response #25), while another notes that their fellows "defer to residents given ACGME requirements for procedures" (Response #29). This codifies a system where one group must yield to another, leading to a profound sense of programmatic displacement. As one director powerfully stated, "It does feel like we're being pushed out" (Response #29).

The direct consequence of this resource competition is a more challenging and often diminished trainee experience. The burden of navigating this environment often falls to program leadership, with one director noting, "We just need to be assertive and advocate for our trainees to assure they are getting experience they need" (Response #11). In some cases, the competition actively "displaces PA residents from seeing those cases" (Response #20), preventing them from accessing essential learning opportunities. The

severity of this issue has escalated beyond individual programs, with reports that "The OME office has had it's inquiries with a concern around critical care procedure experiences" (Response #15), indicating that the conflict is now on the radar of institutional leadership. This core conflict over resources sets the stage for the interpersonal and cultural effects it creates.

Inter-professional Dynamics and Perceptual Tensions

The competition for clinical resources creates significant cultural and political liabilities, undermining the institutional goal of effective inter-professional collaboration and potentially exposing the organization to risks related to morale and trainee attrition. The feedback reveals a complex and often strained dynamic between different professional groups, particularly physicians or residents and Advanced Practice Provider (APP) trainees.

The responses paint a picture of an environment marked by perceptual tensions and cultural challenges. To illustrate the complexity of the situation, the feedback can be categorized into contrasting viewpoints on the state of the inter-professional environment.

Evidence of Friction and Negative Perceptions	**Evidence of Adaptation and Positive Dynamics**
Feedback describes a "negative interaction with physicians and the APP fellows" (Response #2).	Some view the situation as a manageable "process of culture change" (Response #3).
There are explicit concerns from physicians that APPs are "stealing procedures and education" (Response #5).	Despite challenges, one director notes that "the relationship between APP fellows and residents appears to be good" (Response #28).
Some programs have received "anecdotal feedback about... [an] unwelcoming environment" for APP fellows (Response #28).	

These contrasting perceptions indicate that while direct conflict and negative sentiment exist, there are also signs of evolving and adaptive relationships. The situation appears to be in a state of flux, suggesting that institutional culture is a critical variable in either exacerbating or mitigating the tensions arising from resource competition. These cultural impacts, in turn, influence the concrete, operational decisions that programs are forced to make.

Tangible Impacts on Program Structure and Recruitment

The pressures created by competition for clinical resources and the resulting inter-professional tensions are compelling program directors to make tangible, high-consequence decisions about program size, scope, and trainee numbers. These are not abstract concerns; they are translating directly into structural limitations on educational programs, representing the logical, albeit detrimental, endpoint of the unresolved competition for clinical opportunities.

The feedback cites several specific programmatic adjustments being made as a direct consequence of competition. Faced with being "pushed out" of clinical opportunities, programs are adopting a defensive, recessive posture by constraining their own growth:

- **Hiring and Rotational Limits:** Competition directly "Limits the rotations and number of fellows we hire" (Response #18), restricting the program's ability to expand its educational mission.
- **Reduction in Class Size:** In another instance, concerns over competition have already "lead to reduction of class size" (Response #26), a significant strategic decision to scale back the program.

The topic of recruitment presents a potential strategic blind spot. One director states directly, "I don't believe it affects recruiting" (Response #19), suggesting that applicant pools remain strong. However, this perception may not account for the deterrent effect of the documented negative environmental factors. Reports of a "negative interaction" (Response #2) and an "unwelcoming environment" (Response #28) are significant liabilities that likely influence the decisions of discerning applicants, creating an unmeasured recruitment risk. However, it is crucial to note that this high level of impact is not a universal experience for all programs.

Perspectives of Neutrality and Emerging Challenges

For a balanced analysis, it is important to recognize that the impact of competition is not uniform across all institutions. A subset of the feedback indicates that some programs are experiencing a neutral, non-existent, or nascent impact. These perspectives provide important context, suggesting that acute conflict is not an inevitable outcome.

Several responses reflect a minimal or undeveloped experience with competition. One director offered a simple and direct assessment of the impact as "Neutral" (Response #9). Another response was "na" (Response #14), indicating the question was not applicable. For a new program, the impact is still "Unknown as we are just starting our first program" (Response #4).

The significance of these responses lies in their diversity. A "Neutral" response may indicate a successfully managed environment, whereas "n/a" and "Unknown" suggest that competition is not yet a relevant factor due to program maturity or structure. This variation demonstrates that widespread negative impact is not a foregone conclusion and that institutional factors play a key role in mediating these competitive pressures. The feedback, in its entirety, presents a spectrum of experiences from acute conflict to neutral observation, which is critical for developing nuanced, rather than one-size-fits-all, institutional policies.

Conclusion: A Strategic Overview of Competitive Pressures

This thematic analysis of program director feedback reveals a clear and consistent set of challenges stemming from competition in the clinical training environment. The core findings identify three primary areas of impact: intense competition for finite procedural and clinical experience, significant friction in inter-professional relationships, and concrete programmatic limitations—including reductions in class size and hiring—being implemented in response.

Collectively, the responses paint a compelling picture of the fundamental tension between the institutional goal of expanding advanced practice provider (APP) training programs and the finite clinical

and educational resources within academic medical centers. While some programs report neutral or managed environments, the predominant feedback points to a growing strain that affects the quality of the trainee experience, cultural dynamics, and the strategic growth of educational programs.

This structured overview of director concerns underscores the urgent need for a robust institutional governance framework for allocating educational resources, clear protocols for de-conflicting training needs, and proactive investment in inter-professional team-building initiatives. Such measures will be foundational for balancing educational equity, ensuring high-quality training experiences, and fostering a collaborative learning environment for all trainees.

How does the competition affect your training environment, ability to recruit, trainee experience, etc.?

Variables for Effective Interprofessional Learning

This document presents a thematic analysis of qualitative responses from a recent Program Director Survey. The analysis focuses specifically on responses to the question, "What are institutional or programs variables that enabled all learner types learners to symbiotically learn together?". A total of 48 responses were provided, forming the complete dataset for this report. The goal of this analysis is to distill the key factors and conditions that program directors identify as essential for creating integrated, mutually beneficial learning environments for trainees across different medical disciplines.

The raw, qualitative survey data was analyzed to identify, categorize, and synthesize recurring concepts and patterns. Through an iterative process of review and coding, responses were grouped based on shared ideas and underlying principles. This process resulted in the identification of four primary themes that encapsulate the key enablers of integrated learning environments as described by program directors.

The subsequent sections of this report will detail each of these identified themes, supported by direct, anonymized examples from the survey responses.

Theme 1: Integrated Educational Structures & Shared Didactics

A significant number of program directors identified structured, shared learning activities as a primary variable for enabling symbiotic education. This theme highlights the strategic importance of creating a common academic foundation for all learner types through integrated didactic curricula. These formal educational structures serve as the initial and most consistent point of contact for interprofessional learning, establishing a shared language and knowledge base from the outset.

Program directors cited a spectrum of shared educational frameworks, weaving a cohesive academic ecosystem for all learners. This included formal didactic sessions delivered in various formats—from in-person and pre-recorded lectures to multi-modal approaches—and extended to institutional-level activities like grand rounds and specialty-specific conferences. The strategic use of Joint Accreditation to provide Continuing Education (CE) opportunities applicable to multiple professions was also noted as a key structural enabler. Foundational to all these activities was the simple, yet critical, act of scheduling and protecting dedicated curricular time for this shared learning. The value placed on these integrated structures is evident in the responses:

We use in person lectures/pre recorded didactic lectures, simulations, shadowing, and one on one case review.

CE programming. Nexplanon training was done as a large group this year. We are Joint Accredited to do this and can provide joint educational opportunities.

Combining APP fellows with our MD fellows didactic curriculum.

This analysis suggests that leveraging shared didactic curricula is a highly effective and efficient strategy. It not only fosters a common knowledge base but also promotes early collaboration in a structured, low-

stakes academic environment. By learning the same foundational material together, trainees from different disciplines begin to build the mutual understanding necessary for effective teamwork in more complex clinical settings. These formal structures provide the essential academic scaffolding upon which informal and practical collaboration can be built.

Theme 2: A Unifying Institutional Culture of Collegiality and Respect

Beyond formal curriculum, a pervasive institutional culture rooted in mutual respect, shared goals, and vocal leadership support emerged as a critical enabler of symbiotic learning. Program directors emphasized that structural integration alone is insufficient; it must be supported by an environment where interprofessional collaboration is valued, expected, and modeled from the top down. This cultural foundation is essential for the success of any interprofessional initiative, as it fosters the psychological safety required for learners to engage openly across disciplinary boundaries.

Key cultural components identified in the survey responses include:

- **Shared Goals and Collegiality:** An explicit focus on common objectives and a spirit of cooperation rather than competition.
- **Strong Leadership Support and Buy-in:** Active and visible support from departmental and institutional leaders who champion interprofessional education.
- **Mutual Respect for All Professions:** A foundational belief in the value and unique contribution of every member of the healthcare team.
- **A "One Team" Organizational Approach:** A deliberate effort to break down professional silos and foster a unified identity.

The importance of leadership in setting this tone was a recurring point. As one director noted, a "one team" philosophy, supported by institutional committees and shared best practices, creates an environment where integration can thrive.

Strong buy in to organizational one culture "one team" allows sharing and inclusion of the interprofessional trainings across professional groups. Committee of non-GME professional training supported by Division of Education and Training where all program best practices are shared.

Another respondent highlighted the direct impact of leadership in fostering a climate of mutual respect:

Strong leadership and setting a great example of professional respect for all.

Ultimately, these cultural variables create an ecosystem where collaboration is not just an initiative but the institutional norm. A positive and inclusive culture transcends specific activities, shaping daily interactions and creating an environment where asking questions, sharing knowledge, and working together across professions feel natural and encouraged. This cultural bedrock is what allows the practical, hands-on collaborations to be truly effective.

Theme 3: Interprofessional Clinical and Practical Collaboration

While shared didactics and a positive culture create the foundation, program directors identified hands-on, collaborative experiences in clinical and practical settings as the mechanism for translating theory into practice. This theme encompasses the active, applied side of symbiotic learning, where trainees from different disciplines work together on tangible tasks and patient care activities. These experiences move beyond theoretical knowledge to the applied practice of interprofessional teamwork, building functional trust and a deeper understanding of each profession's role.

The survey responses detailed a wide range of practical, collaborative activities, including joint academic projects, integrated skills development in simulation labs, and direct clinical interactions like shared rotations. The following quotes illustrate the variety and impact of these hands-on activities:

Research projects and educational activities

Group learner activities through Simulation, procedural skills workshops, interpersonal learning activities…both groups of APP and MD fellows complete for learning, understanding of ACGME procedure that residents must complete.

Work closely with MD Fellows

The unique value of these applied activities lies in their ability to make interprofessional collaboration tangible. As learners work side-by-side, they develop a practical appreciation for the distinct responsibilities, skills, and perspectives of their colleagues, as noted by one respondent who emphasized the importance of understanding the "different schedule and responsibilities from the MD Residents and Fellows." This direct experience builds mutual respect and clarifies roles, which are essential for developing the high-functioning teams required for modern, patient-centered care. These activities are the critical link that transforms shared knowledge into effective, team-based clinical practice, and they depend on a solid logistical framework to be successful.

Theme 4: Strategic and Logistical Alignment

The final theme identified is that effective symbiotic learning is underpinned by deliberate institutional and programmatic alignment. This theme covers the crucial, often invisible, structural and logistical enablers that facilitate the seamless integration of different learners. While curriculum and culture provide the "what" and "why" of interprofessional education, strategic alignment provides the "how." Without this foundational scaffolding, even the best-intentioned initiatives can fail due to practical barriers.

Program directors pointed to several key logistical variables that are critical for success:

- **Clear Protocols and Scheduling:** The establishment of clear protocols, trusted interdepartmental relationships, and strategic scheduling was identified as essential for managing the complexities of interprofessional collaboration and ensuring smooth operations (Response #33).
- **Concurrent Program Structures:** Designing programs to run in parallel, such as having a fellowship run concurrently with an MD and Pharmacy fellowship, creates natural and consistent opportunities for learner interaction and shared experience (Response #34).

- **Defined Professional Roles:** A critical strategic element is the clear delineation of roles to ensure that learners from different disciplines complement, rather than compete with, one another. This fosters cooperation by establishing that opportunities for trainees do not encroach on or compete with those of other learner types (Responses #28, #47).
- **Shared Faculty and Resources:** Utilizing shared faculty who are responsible for teaching across disciplines creates consistency and reinforces a unified educational approach, particularly when this integration begins early in the graduate education of all professions (Response #22).

While less visible than a shared curriculum or a vibrant culture, these foundational elements are non-negotiable for creating a sustainable and scalable interprofessional education model. They represent the deliberate, strategic thinking required to move from isolated collaborative events to a truly integrated learning system. This logistical architecture is what enables all other efforts to succeed and scale over the long term.

Conclusion: Synthesis of Key Enablers

The successful integration of medical learners from diverse professional backgrounds is not the result of a single initiative but a multi-faceted, systematic approach. This thematic analysis of program director responses reveals four interconnected pillars that are essential for creating an environment of symbiotic learning. Lasting success hinges on the strategic combination of Integrated Educational Structures, a Unifying Institutional Culture, hands-on Practical Collaboration, and deliberate Strategic and Logistical Alignment.

These findings provide a clear and actionable framework for program leaders. By assessing their current initiatives against these four key themes, institutions can identify areas of strength and opportunities for development. Ultimately, this analysis underscores that fostering a new generation of collaborative-ready healthcare professionals requires a conscious and comprehensive strategy that aligns the academic, cultural, practical, and logistical dimensions of medical education.

What are institutional or programs variables that enabled all learner types learners to symbiotically learn together?