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From Residency to
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By Jerald Kay, M.D.
David Bienenfeld, M.D.

The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry
Announcements

1993 AAP Annual Meeting

"Something Special for Our Medical Students" is the theme of the 1993 Annual Meeting of the Association for Academic Psychiatry, March 10-13 in Charleston, South Carolina. The meeting will focus on successful recruitment and teaching strategies to attract medical students into psychiatry. The keynote speaker will be Dr. Herbert Pardes, Vice President for Health Sciences, Dean of the Faculty of Medicine, and Chair of the Department of Psychiatry at the College of Physicians and Surgeons, Columbia University. Following his address, a panel of respondents will review the recent Recruitment Conference and discuss specific issues in minority recruitment.

AAP meetings offer both structured and informal opportunities for academic psychiatrists to meet, share information and ideas, and discover areas of mutual interest. Workshops are slated on recruitment issues; junior, middle, and senior faculty development; psychotherapy supervision; teaching techniques; clinical decision making; moonlighting; and other issues central to the lives of academic psychiatrists. AAP Section Meetings (Residency Training, Medical Student Education, Child and Adolescent Training, Consultation-Liaison, Geriatric Psychiatry) enable members to address issues in their particular areas of specialization. Less structured presentations, called Free Universities, offer opportunities for informal sharing of innovative ideas and programs.

Between workshops and discussions, members can meander through the neighborhood, Charleston's picturesque Central Market District. For more information and Free University submission forms, contact Mary P. O'Loughlin, AAP Executive Office, Department of Psychiatry, Mt. Auburn Hospital, Cambridge, MA 02238 (phone 617-499-5198).

1993 AADPRT Midwinter Meeting

The 1993 American Association of Directors of Psychiatric Residency Training Midwinter Meeting will take place January 14-17, 1993, at the San Diego Marriott Hotel and Marina. The theme for this meeting reflects three areas of interest to psychiatry training directors: manpower, curriculum, and economics.

The meeting opens with workshops for new training directors on the essentials of running a psychiatry residency program. There will be input from the regulatory agencies and opportunities to network with colleagues informally and through Regional Caucuses, the Child and Adolescent Caucus, and Small Program Caucuses. Our meeting offers a busy schedule of educational workshops on a wide variety of topics, a report on the Recruitment Conference held recently in Chicago, and discussion of the implications for training programs in general psychiatry and child psychiatry.

The Harvey Shein Memorial Lecture will be given by Joseph T. Coyle, M.D., Chair of the Consolidated Department of Psychiatry at Harvard Medical School. The Presidential Forum will feature a talk by Jonathan F. Borus, M.D., on the impact of economics on psychiatric education.

The meeting site overlooks San Diego Bay, and we have scheduled a free afternoon to take advantage of San Diego's recreational attractions. Tours to the San Diego Zoo, La Jolla, and Tijuana will be available for interested conferences participants.

AADPRT members will receive registration information in late October. If you are not a current member of the AADPRT and would like to receive information about this meeting, please call the Executive Office at 203-241-6856 to be added to our mailing list.
Published in Conjunction With

The 9th World Congress of Psychiatry

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Related Sessions for each chapter will be presented at the 9th World Congress in the official languages of the World Congress.
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By James H. Shore, M.D.

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4 Letters to the Editor provides a forum for the presentation of pilot studies in psychiatric education and for lively debate of published articles.

5 Medical Education Abstracts condense articles most relevant to academic psychiatry from prominent journals in medical and psychiatric education.
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The Big Chill

The Transition From Residency to Managed Care Nightmare

Glen O. Gabbard, M.D.

Even though concerns about managed care are a source of extraordinary distress among psychiatrists today, many residents are not being provided with adequate preparation and training to deal with those concerns. When young psychiatrists leave their training programs and enter practice, they are experiencing profound demoralization. Much of their dysphoria appears to be a result of the impact of specific aspects of the managed care system on the preexisting psychological characteristics of psychiatrists. Preventive strategies to minimize this impact are discussed.

There can be little doubt that managed care is the number one issue in psychiatry today. At present, more than 70% of employees are under some form of managed care arrangement (1), with many predicting that the percentage could soar to 80–90% by the middle of the decade. In a recent article published in Clinical Psychiatry News (2), results of a survey were reported in which 889 psychiatrists were asked to identify the single greatest source of dissatisfaction about their careers. Their response was overwhelming: 55% identified “government, insurance company, managed care interference; paperwork, red tape.” The nearest competitor, “balancing practice and family/personal needs; stress/demands of profession,” drew only about one-fourth of the total responses. Similarly, when the same group was asked to identify the major issues facing psychiatry, 42% answered, “dealing with intrusions by government, insurance companies, managed care; reimbursement for services.”

In spite of the unequivocal relevance to the field of dissatisfaction with managed care, academic psychiatry has been slow to respond. In a 1990 survey of all psychiatry department chairs in the United States (H.S. Moffic and H. Prosen, unpublished), only 37% indicated that their psychiatry departments were involved in any aspect of managed care, and, even more alarming, only 19% indicated resident involvement with managed care.

My concern about the discrepancy between the intensity of distress among psychiatrists out in practice and the relative lack of attention the topic receives in residency programs is not simply a worry that we are not teaching our residents the ABCs of economic survival. A far greater source of concern is the psychological impact of the overregulation, scrutiny, and loss of autonomy inherent in the managed care environment. A widespread erosion of morale seems to be sweeping the profession as a result of the changes in the economics of...
mental health care delivery. I have encountered this disillusionment in four different settings: 1) in my daily work with over 30 psychiatrists and residents in the Menninger Hospital; 2) as a classroom instructor of residents in the Karl Menninger School of Psychiatry and the University of Kansas School of Medicine; 3) in a series of interviews I have been conducting among private practitioners; and 4) in my experiences in the consulting room. As a psychoanalyst and psychotherapist who treats colleagues, I have noted the increasing frequency with which the managed care scene has become part of the presenting complaints when a colleague seeks treatment.

To understand fully the effects on the contemporary psychiatrist of the sudden plunge into managed care, we must first understand the psychology of the physician. The psychological expectations of the practice of medicine that we all bring on board with us as we set sail on our psychiatric careers are dashed asunder on the rocks of unrelenting scrutiny, external review, and loss of professional control. An examination of the interface between the physician's internal world and the economic system encountered in the external world will provide us with the most comprehensive understanding of the "big chill" that is encountered by young psychiatrists entering practice in the contemporary culture of modern medicine.

**PSYCHOLOGICAL IMPACT OF MANAGED CARE ON PSYCHIATRISTS**

Psychological studies of physicians (3–5) suggest that a handful of character traits are commonly found in people who choose careers in medicine. These include perfectionism, chronic self-doubt, guilt feelings, an exaggerated sense of responsibility, and a conflicted attitude toward both dependency and anger. These psychological characteristics taken as a group paint a picture of a compulsive, driven individual who is striving for perfection and who is convinced that tireless self-sacrifice is the path to winning approval from others.

Newly trained young psychiatrists leave their residencies and enter a mental health marketplace that offers a bewildering array of managed care options. I would define managed care as any plan that relies on utilization review, or some other third party, to intervene between a patient and physician to decide what is necessary or appropriate care for the patient by setting limits on benefit payments, services, or providers. The most common arrangement under which the majority of employees in this country are covered is indemnity insurance with associated utilization management. In these standard fee-for-service plans, insurance companies frequently hire managed care firms to serve as external utilization reviewers whose job it is to determine "acute medical necessity" for every hospitalization. Other forms of managed care are the health maintenance organizations (HMOs), of which there are currently over 600 with more than 37 million members (6); preferred provider organizations (PPOs); and professional review organizations (PROs).

After a 4-year residency in which they have learned about the sanctity of the doctor-patient relationship and the privilege and responsibility of clinical decision making conferred on them by virtue of their being physicians, freshly minted psychiatrists encounter a rude awakening. "Patients" no longer have "doctors." Instead, "consumers" of health services are matched with "providers." Physicians are no longer in charge. Instead, they are beholden to health care brokers and professional case managers.

To appreciate the full psychological impact of this startling confrontation with economic realities, it may be useful to consider how each of the aforementioned psychological characteristics of physicians interacts with the characteristics of the managed mental health care environment.
Perfectionism

The natural perfectionistic strivings of psychiatry residents are reinforced by supervisors and professors who teach that treatment decisions should be based on empirical research and clinical experience so that optimal individualized treatment is provided for each patient. When newly graduated psychiatrists attempt to implement this admirable approach in clinical work, they discover that the managed care system operates under totally different assumptions. Quality is defined by managed care firms as an acceptable outcome with the lowest possible expense. Considerations of cost containment supersede issues of clinical excellence.

After 3 years in practice Dr. A. became aware of a huge discrepancy between what she had been trained to do and what she was actually able to do in practice. In the HMO that employed her, she was seeing highly disturbed patients who were suffering from Axis I conditions complicated by Axis II disorders, but she was allotted only three outpatient appointments each to treat them. She felt increasingly overwhelmed by the challenge she confronted, and she eventually sought psychotherapy for herself to deal with her depression.

In Bibring’s (7) classic paper on the psychodynamics of depression, he noted the tension in the ego between ideals and reality. The depressed individual becomes acutely aware of the gap between the idealized self-image and a realistic assessment of the self. This psychodynamic understanding of depression is an apt description of Dr. A.’s intrapsychic state. She had been trained to deliver the best and most effective treatment for the psychiatric disorders she had encountered. What she was actually able to do within the constraints of her HMO fell far short of that ideal.

One of the farthest-reaching effects of the burgeoning number of external utilization reviewers has been a steady decline in the average length of stay on inpatient units.

Although psychiatry as a profession may be guilty of abuses in certain cases, a subgroup of patients continues to require extended hospital treatment (8). Psychiatrists working in extended hospital settings committed to doing definitive treatment on difficult populations have been severely affected by the cost containment measures leading to shorter lengths of stay.

Dr. B. was a 36-year-old psychiatrist specializing in adolescent inpatient treatment. Over a 4-year period, he had developed an inpatient unit where he did comprehensive evaluation and treatment of difficult adolescents. He had established a reputation as the local expert in his city, and he prided himself on his ability to develop therapeutic alliances with teenagers who had severe personality disorders and could not get along with anyone else.

About a year ago, aggressive utilization review from managed care firms became increasingly prominent in his geographical area, and as a result, the average inpatient stay on his unit went from 5 months to 2 weeks. Dr. B. felt completely demoralized. He gave up trying to form relationships with the patients he treated because he lacked sufficient time. He simply performed a triage function involving a rapid diagnostic assessment and referral to a postdischarge environment that might prevent a catastrophe from happening. He compared himself to a medic on a battlefield trying to identify which of the wounded might be saved with emergency first aid and which were lost causes. He poignantly noted that he no longer felt he could deliver the kind of treatment he was trained to provide.

Chronic Self-Doubt

The ambiguity in psychiatry regarding the optimal treatment for a particular disorder provides fertile ground for exploitation by managed care firms. Because of the psychiatrist’s natural tendency to indulge in self-doubt, we are vulnerable to the intense and unrelenting scrutiny of external reviewers. The repeated accusations by reviewers that we are either fraudulent or incompetent
strikes at the very core of our self-esteem. One psychiatrist’s decision to administer ECT to a patient was challenged daily by a reviewer with rude, insulting comments implying that she was incompetent. After three days of badgering, she broke down in tears in a meeting with her supervisor, exclaiming, “I don’t deserve to be treated this way! I know what I’m doing.” Another psychiatrist with over 30 years of experience said that dealing with reviewers had become the most emotionally stressful part of his job—much worse than working with difficult patients. At an unconscious level, some psychiatrists may experience this scrutiny as having their true limitations or weaknesses “found out” or “discovered.”

Dr. C., a private practitioner retained by an HMO, was referred a patient with generalized anxiety disorder. A reviewer called Dr. C. to ask what kind of treatment he was prescribing for the patient. When he replied that he planned to see the patient for six sessions of brief psychotherapy, the reviewer asked if Dr. C. would mind if she came and observed a psychotherapy session to determine whether it was helpful and to decide whether she would approve further sessions.

After Dr. C. recovered from his sense of shock that anyone would have such blatant disregard for privacy or confidentiality, he explained to the reviewer that the patient’s ability to open up in therapy would be severely compromised by having a third person present. The reviewer accepted his explanation and did not insist on attending. She explained that she was new to the field and had no mental health background. Dr. C. experienced a deep sense of demoralization that his experience, skills, and judgment were being challenged by a reviewer who knew nothing about psychiatric treatment.

Guilt Feelings

Physicians in general, and psychiatrists in particular, tend to be driven by a somewhat tyrannical conscience (3,4). Integrity and ethics are important to the vast majority of practitioners. In today’s climate, many psychiatrists report a sense of shame and guilt about the compromise of integrity that is inherent in mental health practice. A number of psychiatrists feel that they are having to “play the game” with the managed care industry to make a living. Because many HMOs limit the number of outpatient appointments to 8 or 10, many psychiatrists are taking patients into brief psychotherapy when they know that their problems are so complex and profound that much longer term treatment is required. Economic factors, rather than scientific and clinical data, are now dictating treatment choice. As bizarre as it may sound, a psychologist working in one of the largest HMO systems in the United States has now published a book reporting that the majority of patients can be successfully treated with a single session of psychotherapy (9).

Guilt feelings are further heightened by the complicated decision-making process regarding inpatient admissions in the HMO setting. The psychiatrist must repeatedly wrestle with the conflict between cost containment on the one hand and compassion for the patient and family on the other. Many HMO physicians feel as though they are “double agents” (10,11) who are viewed by the family as advocates of the insurance company’s cost containment policy rather than advocates for the patient’s best interests. Concerns about cost containment and the psychiatrist’s own financial welfare are seriously interfering with the clinician’s ability to maintain an empathic stance with patients and to place their clinical needs above financial pressures (12–14).

Exaggerated Sense of Responsibility

In the best of economic times, psychiatrists are prone to feel a great deal of responsibility for adverse outcomes, especially suicide. Even though we all know rationally that suicidal patients who are determined to kill themselves will ultimately find a way no matter how many measures we take to pre-
vent such tragedies, the legal profession has the notion that psychiatrists may be responsible when suicide occurs. Moreover, a recent study (15) concluded that the stress level associated with a patient’s suicide is often equivalent to that associated with a family member’s death. Suicides are one of the most devastating events in a psychiatrist’s professional life.

Prior to the intrusion from the managed care industry, the psychiatrist at least had the authority to make a decision to hospitalize a patient when there was a high index of suspicion that suicide was imminent. External reviewers have now taken that option away from psychiatrists in many cases. They will argue that community standards dictate that only patients who have a definite suicide plan are in imminent danger and require an inpatient setting.

As all clinicians know, a significant percentage of patients who are intent on killing themselves will not communicate a plan for fear that someone will try to stop them from carrying out their suicide attempt. In such cases a clinician may nevertheless see sufficient signs of suicidality to hospitalize the patient. Frequently, though, the reviewer will countermand the psychiatrist’s order and not precertify because the patient has no suicidal plan, justifying the decision as being the “community standard.” If the patient is already hospitalized, reviewers frequently will deny reimbursement for continued hospitalization because the patient only has ideation rather than a plan. If an irate psychiatrist challenges this decision and asks, “Are you saying that I should discharge a suicidal patient?”, the reviewer will simply reply, “Oh, no, I’m not saying the patient should be discharged; I’m only denying further reimbursement.” With this response, reviewers attempt to remove themselves from liability.

Dr. D., a young psychiatrist in private practice for about 5 years, had developed a specialty in treating borderline patients. After a number of managed care organizations began to take over psychiatric practice in her area, however, she became increasingly exasperated at the number of hoops she had to jump through to get the required treatment for suicidal patients. She was spending approximately 1 hour making phone calls to reviewers for every 1 hour of patient care because of the need to justify on a daily basis the ongoing need for hospitalization. Agreements on the phone were then followed by elaborate forms required by the managed care firm to document medical necessity. Even after the round of phone calls and extensive documentation, she found that denials for hospitalization were becoming more and more frequent.

She finally reached the reluctant conclusion that she could no longer tolerate the countertransference anxiety associated with treating borderline patients in a nonhospital setting. She could not shake the feeling that she was essentially responsible for these patients, and the anxiety that they might kill themselves without the appropriate structure was too much for her to bear. Although she felt guilty about turning her back on this group of patients, she felt she had no choice. When I asked her where such patients were getting treated, she responded, “I don’t know. They’re probably not being treated.”

**Conflicts About Overt Expressions of Anger**

Daily accusations of incompetence or fraudulence create a highly adversarial climate in clinical practice today. Psychiatrists have difficulty in adversarial situations, whether they be litigation settings or external utilization review, because by nature they are much more comfortable with conciliatory efforts. Their preference is to resolve conflict and reflect on their own contributions as opposed to rigidly defending themselves while attacking their adversaries.

Reviewers, however, may present themselves in a highly adversarial manner. One reviewer for a managed care firm phoned a psychiatrist treating an inpatient and told him to switch from one antidepressant to
another. When the treating psychiatrist asked the reviewer to identify himself, he refused to give his name. In a situation in which I personally was involved, a reviewer asked me to justify why a patient was in the hospital. When I responded, I was only able to get a few words out of my mouth before he interrupted me and sarcastically asked, “Do you really think that hospital treatment will help this patient?”

Another measure of the hostility in the current environment is the removal of autonomy from psychiatrists.

Dr. E., a psychiatrist who had recently graduated from our program at Menninger, set up practice in a major metropolitan area. Shortly after his arrival, a new managed care firm called a meeting with a group of psychiatrists practicing in that geographical region. The medical director of the firm said bluntly and straightforwardly to the group, “Get this straight—you’re no longer in charge.” He went on to tell them that they had to apply to be on a list of approved providers. Anyone expressing an interest in doing dynamically oriented or long-term therapy was excluded from the list. Dr. E. succinctly stated the three criteria required: “You have to be quick, cheap, and willing to submit to their control.”

After the “hostile takeover” by this managed care group, Dr. E. said the atmosphere changed dramatically within the city. He said he felt he could no longer treat patients without someone looking over his shoulder and controlling him. His credibility was being questioned constantly, and he found himself chronically angry and smoldering with resentment even during psychotherapy sessions. He noted that he had to be wary of a new form of countertransference when treating patients under review. Occasionally he found himself overtly blaming the company during therapy. At other times he would get frustrated and angry at the patients for not taking more of an activist role in arguing with the insurance company and becoming advocates for continued treatment.

Dr. E.’s dilemma is reflective of a specific risk inherent in the managed care environment. It is always tempting to try to establish a therapeutic alliance with a patient by joining forces against a common enemy and directing all hostility and aggression outside the therapeutic dyad onto a third party (8). Utilization reviewers are convenient “bad objects.” However, if a psychiatrist succumbs to that temptation, the negative feelings within the therapeutic relationship may not get worked through.

Premature discharge from inpatient units may also lead to considerable hostility by the families of patients. Following the deinstitutionalization movement in the public sector, the streets were the recipients of the former inpatients of state hospitals. We are now seeing an analogous deinstitutionalization movement in the private sector engineered by aggressive utilization review. In this instance the recipients of the inpatients forced out of hospitals are the families.

Such families report tremendous resentment at having to stay home and jeopardize their jobs while attempting to function as nurses or mental health technicians without training and without backup (16,17). Justifiably overwhelmed by the expectations thrust upon them, they often take out their anger on the psychiatrist rather than on the insurance company or managed care firm.

Conflicts About Dependency

Many psychiatrists deal with their repugnance toward dependency by taking care of others. Unfortunately, the current state of affairs in mental health care delivery systems affects the psychiatrist’s dependency issues in two different ways. First, the number of patients available has been dramatically curtailed by cost containment measures. Some psychiatrists feel a loss of self-esteem and an embarrassing sense of dependency because they can no longer sustain themselves economically and have to look for institutional positions to support them. Second, the loss of professional auton-
omy is felt by many as a blow to their healthy sense of independence. One psychiatry resident who left her career in social work to become a psychiatrist made a poignant comment in this regard: “When I was a social worker, I never felt I had the autonomy I needed to practice independently. So I spent years in medical school to become a psychiatrist. Now I’ve ended up feeling the same way.”

TOWARD A SOLUTION

In the face of the sweeping changes in mental health care delivery and reimbursement, it is easy to feel hopeless and powerless. As individuals, psychiatrists may feel that little can be done to stem the tide. Some have even thought of changing specialties or taking early retirement. Clearly, one thing we cannot do is stick our heads in the sand. There is no turning back at this point. Managed care is here to stay.

One course of action is imperative. We must prepare our residents for the big chill awaiting them. As recently as 1986, in a survey of graduating psychiatric residents, Bashook and Weissman (18) found that none anticipated working in an HMO setting, a completely unrealistic expectation in today’s climate. We must provide clinical assignments that are firmly entrenched in the managed care systems so that managed care is demystified for residents. One preventive measure to address the psychological demoralization of such settings is for residents to gain experience with managed care while working side by side with or under the supervision of senior role models. Then trainees can learn to incorporate financial factors into comprehensive treatment planning.

Another useful approach to help residents gain more of a sense of mastery is to educate them about the social forces in the health care environment. Managed care did not emerge in a vacuum. Medical costs have risen at a staggering annual rate. Psychiatry as a profession must also be alert to its own contributions to the current situation.

Further, we need to provide didactic classroom instruction on tactics and techniques that are helpful in dealing with outside reviewers. These include invoking the appeal process, requesting a reviewer who is knowledgeable about the patient under review, documenting a reviewer’s harmful “harassment” in the patient’s chart, and reporting abuses to the APA hot line.

In addition to these individual strategies, I think we should encourage our residents to get involved at an organizational level because there are a number of positive developments currently in the works. Insurance companies and managed care firms are now increasingly concerned about litigation and liability. Reports are now appearing in the literature that document patient suicides as a result of managed care strategies such as the use of bachelor’s-level case managers to save money, the disruption of the doctor-patient relationship by frequent contract changes, and interference with continuity of care (19). Similarly, HMOs are worried that limiting coverage is leading to greater potential liability. Finally, 26 states now have laws that regulate utilization review companies, and the American Psychiatric Association has developed model legislation to be used by other states. These laws mandate, among other things, that review companies must release the criteria by which they evaluate medical necessity and must employ knowledgeable reviewers.

Despite the cautionary tales I have recounted herein, many managed care reviewers are sensitive and concerned individuals who want the best quality of treatment for their clients. They have been open to our educational efforts and have listened when we have had differences of opinion. Many firms are willing to work collaboratively with the profession, and we should be educating the industry as well as our residents. If the tapestry I have woven here is heavy with themes of demoralization and depres-
sion, much of that response can be related to lack of preparation for the chilling effect of the contemporary scene. To be forewarned is to be forearmed. Things will probably get worse before they get better. I don’t want to apologize for being the harbinger of bad tidings. After all, as Isaac Bashevis Singer once said, “If you keep saying things are going to be bad, you have a chance of being a prophet.”

A version of this article was presented as the Shein Memorial Lecture at the Annual Meeting of the American Association of Psychiatric Residency Training Directors, New Orleans, Louisiana, January 18, 1992.

References

Commentary

The Role of the Residency Training Director in Psychiatric Recruitment

Jerald Kay, M.D.
David Bienenfeld, M.D.

Over the last four years, there has been a significant decrement in the number of United States medical graduates entering psychiatry residencies. As Table 1 shows, in 1988, 745 selected first-year positions in psychiatry through the National Residents Matching Program (NRMP). By 1989 this number decreased to 722, and it continued to decline in 1990 to only 664 students. By 1991, only 641 matched in psychiatry, representing a 14% drop from 1988 (1). In the 1992 match, a mere 526 U.S. medical graduates selected PGY-1 positions in psychiatry through the NRMP, fully 29% fewer than four years earlier (S.H. Weissman, NRMP, unpublished data).

Women medical students, who now make up 40% of all entering medical school classes and who have previously elected psychiatry in disproportionately high numbers, appear not to be choosing psychiatry as heavily. From 1989 to 1990, there was a 10% decrease in the number of women medical students selecting psychiatric residencies (2). Although increasing numbers of women selected careers in psychiatry over the decade 1978 to 1987, their numbers in our specialty grew at a lower rate than for medicine in general. The number of women in all specialties nearly doubled in that 10-year period, compared with a 61% increase in the number of women psychiatrists (3).

It has never been clear exactly how many psychiatrists are needed in the United States. Some have argued for training fewer psychiatrists than are presently being trained (4). Others, such as the Council on Graduate Medical Education in a recent report, advocate increasing by the year 2010 the number of child psychiatrists by 9- to 10-fold and the number of general psychiatrists by as many as 15,000 (5). Residency training directors, on the other hand, assess recruitment adequacy in light of service or staffing needs in conjunction with national and local manpower needs. At this point, however, there is a consensus that we are in the midst of a serious psychiatric recruitment decline.
NATIONAL RECRUITMENT AGENDAS

A similar crisis in recruitment prompted the field in 1980 to organize a national psychiatric recruitment conference in San Antonio, Texas. The 101 comprehensive and broadly focused recommendations produced by this conference are organized into seven categories. The categories and some of the recommendations are:

1. **Admissions and premedical considerations.** Psychiatry should become more visible through course participation and through clinical services to undergraduates. Summer job experiences in psychiatry departments should be offered.

2. **Medical student education.** The priority of medical student education in departments of psychiatry should be raised. Career teachers should be fostered and rewarded. Behavioral science teaching should be clinically focused. Integration with other medical specialties should be emphasized. Residents should be involved with medical student teaching.

3. **Medical student socialization.** Psychiatry clubs should be promoted. Recruitment should be active and unambiguous.

4. **Image of psychiatry.** Academic departments should actively pursue public relations activities.

5. **Careers.** Public-sector careers should be encouraged. Psychiatry should be declared a shortage specialty.

6. **Relation to primary care.** Psychiatrists should collaborate with other primary-care specialists in case-centered teaching. The medical identity of the psychiatrist should be clarified and highlighted.

7. **Residency programs and residents.** High-quality programs should be supported and poorer programs eliminated. Female and minority faculty should be recruited. Education should be emphasized over clinical service obligations (6).

Concern regarding adequate numbers of clinical and research child and adolescent psychiatrists sparked the 1989 child psychiatry recruitment conference held in San Diego. The 98 recommendations generated by that conference include many that pertain to general psychiatry recruiting and reiterate some of the principles underlying the San Antonio proposals:

1. **General psychiatry issues.** Expose residents early to child psychiatry. Integrate child and general psychiatry teaching. Increase exposure and summer opportunities for medical students. Remedicalize the teaching of child psychiatry.

2. **Image.** Develop a distinctive description of the subspecialty. Reinforce the identity of child specialists as clinicians particularly skilled in the application of scientifically based techniques, distinct from nonmedical therapists and general psychiatrists.

3. **Public relations.** Develop public information efforts at high schools and colleges. Develop regional medical student symposia. Strengthen collaboration with pediatricians.

4. **Collaboration.** Encourage regular meetings between general and child training

| TABLE 1. U.S. medical graduates entering psychiatry residencies |
|-----------------------------|----------------|----------------|----------------|----------------|
| Graduates                   | 15,919 | 15,630 | 15,398 | 15,427 | 526 |
| Inside match                | 745 | 722 | 664 | 641 | 74 |
| Outside match               | 99 | 32 | 28 | 74 | 715 |
directors. Promote collaborative recruiting mechanisms.

5. **General psychiatry residency curriculum.** Ensure that child residents (fellows) teach general psychiatry residents. Promote a high profile in the clinical and didactic curriculum. Promote mentorship of general psychiatry residents by child psychiatrists.

6. **Medical student education.** Encourage involvement with interdisciplinary courses, e.g., neuroscience. Use the best child psychiatry teachers to train medical students.

7. **Child and adolescent residency.** Have chairs encourage teaching and mentorship. Promote interaction among training directors on educational issues (7).

Several themes emerge as common to both sets of recommendations. Mentorship and modeling are encouraged. High-profile participation in didactic curricula is valued. Collaboration among training directors, and between directors and their chairs, is viewed as essential. Public relations are actively espoused.

**RECRUITMENT RECOMMENDATIONS FOR TRAINING DIRECTORS**

Training directors need particularly to examine their participation in the medical student education programs in their institutions because most residency training programs must rely on the recruitment of their own medical students for at least a portion of their entering residency class. Very few training programs can recruit successfully on a strictly national level. On a more altruistic plane, each training director shares some of the responsibility for recruitment into the field. The strategies that attract students to a psychiatric career ultimately serve the ends of the training director’s home institution. In pursuit of these ends, we present the following principles of effective recruitment. Although directed at the activities of the director of residency training, they apply equally to his or her colleagues who share responsibility for enhanced recruitment, including chairs, directors of medical student education, and other faculty.

1. **Approach medical students early and with enthusiasm.** As residency training director, you should participate in the first- and second-year psychiatry courses in your institution, even if it is only for one lecture in each course. Frequently, initial impressions about a specialty and its residency training program are formed through the first interactions with the representatives of a specialty. Having an introduction to freshman and sophomore classes permits the residency training director to identify students with a potential interest in psychiatry. A nurturing or perhaps even a mentoring process can be initiated by arranging informal meetings or summer research experiences or clinical opportunities.

2. **Teach your residents that teaching medical students is important.** In most programs junior and senior clerks are taught intensively by psychiatry residents, who are therefore vital in the clinical instruction of psychiatry. The residency training director, or a designee, should schedule regular supervisory sessions or orientations to the clerkships. These sessions should not only address student goals and objectives but also discuss teaching techniques and examine problems in teaching some students and subjects. Every resident should receive the pamphlet entitled “The Resident as Teacher,” available from the American Psychiatric Association’s Office of Education (8). Successful clerkships are characterized in part by outstanding resident–student teacher relationships and the supervision of patient experiences that maximize student clinical responsibility.

3. **Develop a good working relationship with the director of medical student education.** It is wise
to develop a formal mechanism whereby the residency training director can be alerted by the director of medical student education or clerkship director about those students who have excelled in the psychiatry rotations and those who have expressed a strong interest in a career in psychiatry. Because residents provide a large fraction of the clinical clerkship teaching, it makes sense for the residency training director to take part in the evolution of educational objectives and clinical curricula for medical students. Some resident teaching activities, such as clinical case conferences, particularly stimulate the interest of medical students. You as training director can help both the clerkship director and yourself by formally opening such activities to students.

4. Develop a good relationship with the dean of student affairs. This person can often refer to you for career counseling those students who are ambivalent or undecided about a career in psychiatry. It is remarkable how many in this group of students ultimately enter psychiatry.

Volunteer to be a formal residency advisor to medical students. This activity provides you with the opportunity to sell your own program in addition to discussing others. Remember that just because students have completed a 6-week psychiatric clerkship in your department, generally on one inpatient unit, you cannot assume that they know very much about your residency training program. Objective discussion of the merits of other programs can impress the student with the integrity of the psychiatric recruiting process, as well as with your confidence in the quality of your department's own program. In some schools it is possible to be an advisor without the responsibility of writing dean's letters, which makes it even easier and less time-consuming.

5. Become a speaker at the career or specialty day program. Most medical schools have a forum for describing postgraduate opportunities to sophomores and juniors. You should be the one identified resource person in your department for careers in psychiatry. Many colleges have premedical clubs that provide an opportunity to introduce careers in psychiatry at an even earlier educational juncture. Addressing these clubs can frequently counterbalance inappropriate biases about the practice of psychiatry as a nonmedical or unsound discipline.

If you are experiencing difficulty in recruiting students from nearby cities or states, develop an annual one-day meeting for these students that presents the excitement and diversity of a career in psychiatry while allowing students to be introduced to speakers from your faculty. Such a meeting is an excellent vehicle for opening new sources for residency applications. In regions that lack the "critical mass" of psychiatry applicants more likely to be found in major urban centers, such a symposium can combine synergistically the resources of several smaller programs, increasing the total regional applicant pool. It is encouraging to students to know that others from their area are interested in psychiatric careers. The regional focus can dispel some of the isolation that discourages applicants at smaller or isolated schools of medicine.

6. Speak to medical student organizations. Become a spokesperson for student well-being and welfare and professional development issues by addressing the American Medical Student Association, the Student National Medical Association, Women in Medicine, etc. on topics such as the dual-career marriage, the medical marriage, medical student and house staff stress, and the impaired physician. Such informal talks provide additional opportunities to identify potential interests in psychiatry and to present the flexibility and latitude of professional activities that comprise a psychiatric career.

These forums, too, provide access to the population of minority medical students with whom psychiatry has been disappoint-
ingly unsuccessful in recruitment. Active identification of minority issues and elaboration of the political and clinical leverage of psychiatry to address these concerns can open the eyes of students who might otherwise regard our specialty as too abstract to meet the needs of minority communities.

7. **Participate in your medical school’s psychiatry club.** If one does not exist in your medical school, offer to be the initial faculty advisor and solicit funding for activities from the chair and other sources. Such a group (10), which often convenes at the homes of faculty members, brings together students with any interest in psychiatry to meet faculty and practicing psychiatrists individually and to hear about relevant topics not covered in formal didactics and rotations. Do not underestimate the power of a psychiatry club to offset the negative social reactions that many students encounter when they express a career interest in psychiatry (11).

8. **Go national.** As training director, you can further the national awareness of your own program by addressing national audiences, participating in APA committees and task forces, and becoming involved with educational organizations such as the Association for Academic Psychiatry. You should also be quick to trumpet the contributions of departmental faculty in research and clinical endeavors of national prominence. Students at the home institution regard such prominence as evidence of the scientific validity of the field as well as the quality of the individual program.

9. **Develop good relationships with other residency training directors.** Your program is in a much better position to be the beneficiary of another training director’s counseling recommendations if you are well known. Attend and become active in psychiatric educational organizations like the American Association of Directors of Psychiatric Residency Training, the Association for Academic Psychiatry, and the American Psychiatric Association. You will become more knowledgeable about other psychiatric residency training programs for your medical students through your familiarity with other training directors. Everyone benefits if you provide these favors for each other.

10. **Undercut negative stereotypes of psychiatrists.** In addition to presenting yourself as a complete psychiatric physician to medical students, you can do much to neutralize negative irrational criticism of the field by serving on high-visibility committees like the curriculum committee in your school of medicine or the graduate medical education committee in your hospital (12). Do not be afraid to educate colleagues tactfully when they make inappropriate comments about psychiatry.

11. **Collaborate actively with hospital administration.** The training director cannot afford to be the passive recipient of dicta concerning the management of clinical sites, resident stipends, allocation of residents among departments, and benefits packages. The size of your own program and the happiness of its residents depend to a large extent on hospital policies. Happy residents recruit medical students. Students base their career decisions partly on quality-of-life issues. If their clinical rotations occur at hospitals where psychiatry residents are treated humanely, they will have more reason to select our specialty. Participation in appropriate hospital committees and nurturing of relationships with hospital administrators furthers these aims.

12. **Take the interview day seriously.** The applicant from a different school who has decided to look at your program will usually have expended considerable time, energy, and expense and will have only one opportunity to form an opinion. The interview day is an indispensable marketing instrument.
The schedule should be stimulating but not exhausting. Every applicant should have generous opportunity to talk with residents and attend clinical conferences. Follow-up questionnaires and/or telephone calls after the match are a useful way to assess students’ perceptions of the interview process (13).

13. **Involve your chair in the residency selection process.** In all but a handful of prestigious institutions where large numbers of students apply for residency training, having the chair interview applicants sends a clear message that education is valued, that the chair is available, and that there is a departmental interest in the individual as well as in the collective program. This involvement also sensitizes the chair to the needs for support of recruitment activities (12).

CONCLUSION

The crisis in psychiatric residency recruitment shows no signs of abating in the near future. Competition between and among residency programs for applicants serves only to affect the distribution of trainees. More pressing to the field is the need to recruit more medical school graduates into the specialty.

Virtually everyone in academia and in freestanding programs is increasingly pressured to generate either salary or institutional support. This pressure, unfortunately, appears to have adversely affected the availability and perhaps the interest of full-time teachers for medical student training programs. The recommendations presented here for residency training directors to enhance recruitment are therefore more critical now than they were five years ago.

These recommendations are consistent with the strategies of national planning groups for residency recruitment, translated into a local level of implementation. The training director should be actively involved in medical student pursuits at his or her own institution, including didactic, clinical, and extracurricular activities. He or she should organize recruiting affairs such as psychiatry career days. The directors in a region stand to benefit from collaborative activities. National involvement of the training director has a positive influence on recruiting from the home institution and others. Collaboration with the chair, the dean, and hospital administrators is essential for molding an environment in which successful recruiting is possible.

These are time-tested and time-worthy activities. They do not require excessive preparation, and they provide a meaningful range of interactions with students and colleagues that ensures a continuous and beneficial involvement with our most critical applicant pool.

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Regular Articles

Gender Influence on Specialists' Ratings of Residency Program Candidates

Paul Rodenhauser, M.D.
Cindy J. Smith, M.D.
Ronald J. Markert, Ph.D.

Sexism has been perceived at all levels of medical education. Although specialty training has been scrutinized from various perspectives, there have been few objective assessments of sexual discrimination in the selection of candidates. This study evaluates the responses of board-certified physicians to fictional residency applicants' personal statements, which were identical except for gender. Male and female physicians from six specialties in which women were overrepresented and six specialties in which women were underrepresented all favored female candidates. Female physicians in both groups rated male candidates as less hardworking than did male physicians. Implications of these and other findings are discussed.

Interest in women in medicine and their particular issues, stresses, and differences from men in medicine is increasing steadily. The number of women physicians in practice doubled between 1970 and 1986 (1). In the late 1980s, women comprised 34% of the medical students in the United States (2) and 44% in Canada (3). 28% of the residents in U.S. postgraduate medical education, and 19% of the full-time medical school faculty (2). In 1990, 38.7% of the entering class (4), 36.2% of all medical students (4), and 29.5% of the residents (5) were women. Although junior faculty positions are being filled increasingly by women (6), few advance in academic medicine, resulting in a dearth of senior female role models and mentors (7). Women physicians are also underrepresented in private and public sector administrative positions (8).

Studies of perceived sexism in medical schools and residencies are well represented in the literature (9–13). Racism has also been studied (12) as have the dual problems faced by black women medical graduates (14). Traditionally, women are found primarily in nonsurgical specialties and especially in primary care specialties. In the mid-1980s, the choice of specialties of men and women had not changed (1). This holds true for honors graduates as well (15). Choice often differs significantly from preference, however (16,17). Ducker (18) reports physician attitudes about male vs. female physicians and their suitability for different specialties and concludes that some physicians find fe-
males unsuitable for surgical specialties.

Many questions arise about reasons for the distribution of women across medical specialties, particularly the underrepresentation of women in certain specialties. Although studies and reports of perceptions and experiences are available (9,12,16), there have been no objective assessments of sexual discrimination in the selection of residency candidates.

With regard to the medical school interview and admission process, reports in the literature on the influence of gender are inconclusive (19). Some studies describe gender differences in behaviors (20,21) and performance (22), whereas others report discrimination against women (23,24). Interviewer behaviors differed according to the applicant's gender in a study by Marquart et al. (19), suggesting "elusive differences" in the evaluation of candidates and the possible value of the gender-matching of interviewers and candidates to enhance fairness. Earlier reports substantiate these findings (25,26).

Recently we reported preliminary findings (27) from a study of gender bias among physicians from 12 specialties, 6 in which women are overrepresented (pediatrics, child psychiatry, obstetrics/gynecology, dermatology, psychiatry, and pathology) and 6 in which they are underrepresented (surgery, otolaryngology, cardiology, neurosurgery, orthopedic surgery, and urology). By use of the mean of seven criteria (grade point average [GPA], class rank, National Board of Medical Examiners [NBME] scores, hard work, sincerity, ability to articulate, and overall rating) as the response (dependent) variable, female candidates were ranked higher than male candidates for entry into residency training. The collective bias of the physicians in this study (male and female physicians of both overrepresented and underrepresented specialty groups) favored female candidates. In addition, the personal interest statements of female candidates were rated higher in GPA, class rank, NBME scores, hard work, and sincerity, and on the overall rating. These findings suggest the possibility that sexism as it is traditionally experienced and understood may have reached a turning point in medical education.

This study represents an extension of our previous work and provides an analysis of male and female practicing physicians' differential responses to residency applicants' personal statements, which were identical except for gender. We also compare male physicians' ratings of male and female candidates with female physicians' ratings of male and female candidates. Analyses are further refined to include comparisons of 1) candidate ratings by male and female physicians in both overrepresented and underrepresented groups and 2) same-gender ratings by male and female physicians for all specialties and for overrepresented and underrepresented groups.

This study is relevant to the specialty of psychiatry for several reasons: 1) psychiatry and child psychiatry are two of the study's six specialties in which women are overrepresented; 2) psychiatry offers expertise in the field of medical education, particularly on behavioral matters; and 3) inherent to psychiatry is the pursuit of mechanisms to influence favorably social problems such as stereotyping, stigma, prejudice, oppression, and sexism.

METHODS

This study was designed to assess the response of practicing specialists to the gender of fictional residency applicants. Personal statements were developed to represent candidacy for residency education at three distinct ability levels: excellent, fair, and poor. At each level the statements were identical except for the gender of the signature. These fictional personal statements were mailed to all board-certified physicians in six underrepresented specialties (less than 12% female residents: surgery, otolaryngology,
cardiology, neurosurgery, orthopedic surgery, and urology) and six overrepresented specialties (more than 38% female residents: pediatrics, child psychiatry, obstetrics/gynecology, dermatology, psychiatry, and pathology) in the state of Ohio. Personal statements indicating interest in a particular specialty were sent only to physicians in that specialty (e.g., psychiatrists were sent only personal statements from psychiatry residency candidates). An equal number of male and female personal statements were mailed.

In a cover letter, recipients were informed that we were studying factors important in residency selection and were asked to read the enclosed statement of interest and evaluate the candidate on a 1 (poor) to 5 (excellent) scale. They were asked to rate the applicants according to six specific categories and also to assign an overall rating. The specific categories were GPA, class rank, NBME scores, hard work, degree of sincerity, and ability to articulate. The physicians were not informed that gender was the variable of interest in the study.

The subjects randomly received one of the six personal statements (excellent, fair, or poor for both male and female candidates). The first paragraph was identical in all statements of interest. The second paragraph was the same for candidates of all three ability levels of both genders but indicated specific interest in 1 of the 12 specialties in the overrepresented or underrepresented groups. The third paragraph in our fictional statement indicated the candidate's academic ability in the form of cumulative GPA, class rank, and NBME Part I scores. The candidate's gender was indicated only by the signature (i.e., Mary Henderson or John Henderson). A total of 2,478 surveys were mailed to the physicians in the underrepresented group, and 3,586 were mailed to the physicians in the overrepresented group. Student's two-tailed t-test was used to compare means between groups. Inferences were made at a significance level of $P = 0.05$.

**RESULTS**

The survey response rate was 33% (1,986/6,064). Male physician ratings of male and female candidates and female physician ratings of male and female candidates are shown in Table 1. By use of the mean of seven criteria, male physicians rated female candidates higher than male candidates. This bias applies to six of the seven rating

| TABLE 1. Male and female physicians’ ratings of male and female residency program candidates |
|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| Universe                                      | Mean Rating of Candidates                       |                                  |
|                                               | By Male Physicians                              | By Female Physicians                 |
|                                               | Male ($n = 837$)                                | Female ($n = 748$)                    |
| GPA$^a$                                       | 2.94                                          | 3.09                                          | 2.76                                          | 3.02                                         |
| Class rank$^b$                                | 2.99                                          | 3.14                                          | 2.85                                          | 2.98                                         |
| NBME scores$^c$                               | 2.90                                          | 3.09                                          | 2.67                                          | 2.94                                         |
| Hard work$^d$                                 | 3.47                                          | 3.61                                          | 3.20                                          | 3.75                                         |
| Sincere$^{e, b}$                              | 3.68                                          | 3.82                                          | 3.66                                          | 3.94                                         |
| Articulate                                   | 3.70                                          | 3.74                                          | 3.74                                          | 3.79                                         |
| Overall$^{f, b}$                              | 3.18                                          | 3.32                                          | 3.00                                          | 3.29                                         |
| Mean of seven criteria$^{g, b}$               | 3.26                                          | 3.40                                          | 3.13                                          | 3.38                                         |

*Note:* There were 1,986 physician responders: 1,585 from male physicians (837 rating male candidates and 748 rating female candidates) and 255 from female physicians (125 rating male candidates and 130 rating female candidates). There were 146 physician responders who did not indicate their gender and thus are not included in this analysis.

$^a$Male physicians rate female candidates higher than male candidates ($P < 0.05$).

$^b$Female physicians rate female candidates higher than male candidates ($P < 0.05$) except Overall ($P = 0.052$).

$^c$Male candidates rated higher by male physicians than by female physicians ($P < 0.05$).
categories: GPA, class rank, NBME scores, hard work, sincerity, and overall rating. By use of the mean of seven criteria, female physicians rated female candidates higher than male candidates. This bias applies to hard work, sincerity, and overall rating (P = 0.052).

For the overrepresented specialties (Table 2), male physicians rated female candidates higher for NBME scores, hard work, sincerity, overall rating (P = 0.051), and mean of seven criteria. Female physicians rated female candidates higher for hard work, sincerity, and mean of seven criteria. For the underrepresented specialties (Table 3), there were no statistically significant differences between male and female physicians because of small sample sizes (n = 10) for the female raters.

Ratings of same-gender candidates were also examined. For ratings of male candidates, male physicians rated male candidates higher than female candidates on hard work (Table 1). Male physicians from the overrepresented specialties rated male candidates higher than female physicians on GPA (P = 0.052), NBME, and hard work (Table 2). For the underrepresented specialties, male candidates were rated higher by male physicians than by female physicians on hard work (Table 3).

Finally, differences between male physicians and female physicians were examined by the ability level of candidates (poor, fair, excellent). There were no differences for the mean of seven criteria. Thus, ability of candidates was eliminated as a confounding variable.

DISCUSSION

Studies have explored the factors that influence program recruitment of residents (28,29) and students' specialty choices (30-32) as well as the factors that are important in the screening process of resident selection (33). Neither cross- nor same-gender influences on the selection of candidates for residency education programs have been reported previously. Our current and previous studies (27) indicate that male and female board-certified physicians in 12 specialties were collectively biased in favor of female candidates for residency training. This outcome can also be interpreted as a bias against male candidates. Beginning in the late 1980s, the literature in medical education began reporting discrimination against men in medical education (9,34,35).

Our data indicate that male and female physicians rated female candidates higher than male candidates for GPA, class rank, NBME scores, hard work, sincerity, and overall rating. Male physicians rated male candidates higher than female candidates on GPA, NBME, and hard work. Female physicians rated female candidates higher than male candidates. However, there were no significant differences between male and female physicians for the mean of seven criteria.

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<th>TABLE 2. Male and female physicians' ratings of male and female residency program candidates in overrepresented specialties</th>
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*Note: Responders in Table 2 = 1,549 male physicians and 252 female physicians, not the 1,585 and 255, respectively, reported in Table 1. Specialty was not identifiable for 39 responders: 36 male physicians and 3 female physicians. Thus, these 39 responders were omitted from the analysis in Table 2.*

*aMale physicians rate male candidates higher than female candidates (P < 0.05), except Overall (P = 0.051). bMale physicians rate female candidates higher than male candidates (P < 0.05). cFemale physicians rate female candidates higher than male candidates (P < 0.05), except GPA (P = 0.052).
physicians rated female candidates higher than male candidates. From the perspective of a pro-female bias (rather than anti-male), inferences from these findings include overcompensation for historical grievances and perceived sexism. Because of the increasing number of women in medicine, members of the medical profession have been subjected to attitudinal shifts in the process of developing new norms. The effects of education and experience may also have influenced the responses in our data set. By necessity and by choice, women have been enlightening the medical profession regarding discrimination.

By use of the mean of seven criteria, neither male nor female physicians were biased toward same-gender candidates. Male candidates were rated significantly lower by female physicians than by male physicians in the hard work category. Conversely, male physicians rated male candidates as harder working than did female physicians. This might correlate with reports of women being seen as having difficulty measuring up to standards of work performance (36), reports of their concerns about the stresses of enduring the long hours and responsibilities associated with clinical training and practice (10), and the bias in this study of female physicians toward female candidates in the hard work category. The notion suggested by our data that women are less hardworking may also derive from the observation that practicing female physicians schedule fewer hours per week (36).

The lower ratings of male candidates by female physicians in the hard work category suggest the possibility of a reaction by female physicians to the “bad press” on women in medicine (37). The female physicians responding to this survey may have worked harder as residents or perceived themselves as working harder. Although the literature on the sequela of oppression in organizations is not explicit, Galbraith (38) postulates a counterreaction of equal magnitude when power is abused. Considering the history of perceived sexism in medicine (9–13), it is interesting that an opportunity such as this anonymous survey for an oppressed group to redress its grievances resulted in disagreement only on who works harder and, to some degree, who performs better academically. For specialties in which women are overrepresented, male physicians view men as academically more accomplished than women. Although there are no objective measurements of which gender works harder in training, one study of residents in internal medicine, a specialty not represented in this study, demonstrated

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that females did not equal their male counterparts in academic performance (39). Although the gender differences in examination performance were relatively small in the study by Day et al. (39), the differences were large on program directors' ratings of humanistic qualities where women were rated higher than men. Among the possible explanations were gender differences in values and emphasis on mastery. Women physicians (and their patients) may attach more importance to the art of care.

To the extent that the findings in this study are generalizable to the attitudes and beliefs of individuals responsible for the selection of residents in residency education programs, these data suggest the need for a concerted effort to abolish stereotyping and other forms of bias that can be self-fulfilling, particularly in an unsupportive environment. Recommendations for additional research on sexual discrimination and its elimination in the practice of medicine and medical education are natural by-products of this study. In particular, the attitudes of women in medicine toward men in medicine (and male patients) invite further study.

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Recruitment of Academic Psychiatrists

Applicants’ Decision Factors

Landy F. Sparr, M.D.

To explore factors influencing academic job seekers, the author surveyed 49 applicants for six regular faculty positions at a university and Veterans Affairs (VA) medical center in Oregon. Candidates used active inquiry (40.0%) and advertisements (35.6%) as their primary search methods, applied for an average of 6.75 jobs, expected the search to take 7.3 months, and confined their search to specific geographical areas (75.5%). In rank order, location, academic position, teaching opportunities, and research opportunities were the most appealing factors; VA hospital setting, fringe benefits, and administrative opportunities had the least appeal. Most applicants were moderately satisfied with current jobs and even more satisfied with psychiatry as a career. Related studies are discussed. Three of the six positions were not filled; the author discusses barriers to successfully recruiting academic psychiatrists.

Psychiatric recruitment has been the subject of literature highlighting strategies for attracting psychiatrists to rural areas (1), state mental health systems (2,3), and positions in the public sector (4–6). There have been numerous articles about encouraging medical students to select psychiatric specialty training (7–11) and about the subjective experience of the academic job hunt (12–18); however, we wondered about decision factors that lead applicants to apply for specific academic positions. For example, it has been speculated that applicants are more likely to take positions in the area where they trained (19,20), make decisions based on non-job-related factors (18,21), and use particular methods (12,15,17,19) (e.g., reading advertisements, active inquiry, friends or colleagues) in searching for a position. We have regularly had vacancies for academic positions and decided to collect data from applicants. We prepared a pilot questionnaire that was designed to generate ideas, gather basic demographic information, and collect data about job search methods and preferences.

METHODS

An anonymous 26-item questionnaire was sent to each applicant who applied for one or more of six primary faculty positions open at Oregon Health Sciences University (OHSU) or the adjacent Department of Veterans Affairs (VA) Medical Center in Portland, Oregon. Most questions were multiple choice; two required responses on a Likert-type scale of satisfaction in which “1” represented strong dissatisfaction and “5” represented strong satisfaction. These six positions were available between 1987 and 1990:

#1: VA Mental Health Clinic Staff Psychiatrist
#2: VA Inpatient Unit Staff Psychiatrist

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All positions conferred regular faculty status at Oregon Health Sciences University and were considered entry-level to midcareer, except position #4, which was more senior. Each position had significant clinical service and/or administrative components, and most involved supervision of mental health trainees. Allocated research time was in the range of 20–25%. Comparable duties are usually described in the literature by the term clinician-researcher (22).

Each position was advertised in Psychiatric News and included a full job description: academic emphasis, qualifications required, name of hiring organization, and exact location. Specifics regarding salary or benefits were not given. Two advertisements, however, characterized salary as "competitive" and benefits as "excellent." With one exception, the positions were advertised in October and November and were to begin at the next academic cycle in the summer.

There were 88 separate applications for the six positions. The questionnaire was returned by 49 applicants, a 55.7% return rate. All forms were anonymous and did not affect applicants' job prospects.

Subjects

We decided to pool the data because when we considered each applicant group separately we were not able to find any significant differences, except for the applicants for the child psychiatry training position, between the groups using independent measures.

Mean age for all applicants was 39.1 years; range = 28–58 years. Forty-two applicants (85.7%) were male and seven applicants (14.3%) female. Thirty-six (73.5%) were married and 13 (26.5%) single; of female applicants, 4 (57%) were married and 3 (43%) were single.

Of 48 applicants who responded to the question, 13 (27.1%) were from the Northeast or the East Coast; 11 (22.9%) from the Northwest; 10 (20.8%) from the Midwest; 9 (18.8%) from California; and 5 (10.4%) from the South.

Most applicants (37 respondents, 63 responses) were at their current location because they trained there (n = 30/37, 81.1%) and/or had family/relatives in the area (n = 28/37, 75.7%). On average, applicants who were not in training were 8.24 years past residency (range = 6 months–28 years). Twenty-two applicants (44.8%) had completed their residency training in the Northwest or West Coast region, 12 (24.5%) had trained in the Northeast or East Coast region, 8 (16.3%) in the Midwest, 4 (8.2%) in the South, 2 (4.1%) in England, and 1 (2.0%) in Canada.

On average, applicants had held 2.3 positions since residency (range = 1–6 positions). The average length of time in the current position was 4.1 years (range = 3 months–15 years). On the Likert-type scale ("1" represented strong dissatisfaction and "5" represented strong satisfaction), their mean level of satisfaction with their current position was 3.45 (SD = 1.19).

All applications were reviewed by search committees. There were five separate committees during the 3-year study period. Applicants were asked to send a curriculum vitae, which was the primary screening tool. The two to four applicants for each position who were believed to be the most qualified were asked for references and invited for a visit. Applicants were usually interviewed by several members of the primary faculty, including all search committee members, the chairman of the department of psychiatry, and the chief of psychiatry at the VA Medical Center.
RESULTS

Although nearly half the applicants (23 candidates, 46.9%) learned about our positions through Psychiatric News, of the 45 usable responses more applicants listed active inquiry (18 candidates, 40.0%) than advertisements (16 candidates, 35.6%) as their primary job search method; the other preferred method was contact with friends, colleagues, or associates (11 candidates, 24.4%). The candidates applied for an average of 6.75 jobs (range = 1–15 jobs). Approximately three-quarters (75.5%) confined their search to certain geographical areas. In this instance, the primary geographical area of interest was the Pacific Northwest, although candidates also restricted their search to the East Coast/New England (9 candidates), the Southwest (4 candidates), California (2 candidates), and the Midwest (2 candidates). Approximately one-third (32.7%) had previously lived in the Pacific Northwest, and 77.6% had visited. Eleven candidates (22.4%) who at least partially limited their search to the Pacific Northwest had never been there.

Table 1 indicates the candidates’ primary reasons for interest in Oregon: 81.6% thought that it “seemed like it would be a nice place to live.”

Candidates were also asked to rank order their reasons for interest in the VA positions. Table 2 shows that the primary appeal was location in Portland, Oregon. Working at a VA hospital, salary, fringe benefits, and administrative opportunities ranked low on the list.

Candidates had allowed an average of 7.3 months (range = 4–17 months) for their job search. Their primary psychiatric orientation was biologic (40.8%), followed by psychodynamic (28.6%), eclectic (18.4%), and behavioral (12.2%). On the Likert-type scale (“1” represented strong dissatisfaction and “5” represented strong satisfaction), their mean level of satisfaction with psychiatry as a career was 4.34 (SD = 0.66).

DISCUSSION

We found that applicants for six academic psychiatry positions used both active and passive job search methods, came from various geographical regions, applied for about six other separate positions, and limited their choice to geographical areas such as the Pacific Northwest (even though approximately one-quarter had never been there). They were more interested in teaching and research opportunities than in salary, fringe benefits, or administrative opportunities; expected to take slightly more than one-half year to find a job; and had a diversified primary psychiatric orientation. Overall, applicants had relatively high satisfaction ratings with their current positions and were even more satisfied with psychiatry as a career.

### TABLE 1. Primary reasons for interest in Oregon

<table>
<thead>
<tr>
<th>Factor</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seems like a nice place to live</td>
<td>81.6</td>
<td>40</td>
</tr>
<tr>
<td>Spent time there as an adult</td>
<td>22.5</td>
<td>11</td>
</tr>
<tr>
<td>Trained there</td>
<td>12.2</td>
<td>6</td>
</tr>
<tr>
<td>Family/relatives</td>
<td>10.2</td>
<td>5</td>
</tr>
<tr>
<td>Spent time there as a child</td>
<td>6.1</td>
<td>3</td>
</tr>
<tr>
<td>Born there</td>
<td>2.0</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: 49 respondents; 66 responses.

### TABLE 2. Primary appeal of a position in a Veterans Affairs hospital

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rank</th>
<th>Raw #</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location (Portland, OR)</td>
<td>1</td>
<td>2.81</td>
<td>32</td>
</tr>
<tr>
<td>Academic position (tenure track)</td>
<td>2</td>
<td>3.03</td>
<td>30</td>
</tr>
<tr>
<td>Teaching opportunities</td>
<td>3</td>
<td>3.52</td>
<td>31</td>
</tr>
<tr>
<td>Research opportunities</td>
<td>4</td>
<td>3.86</td>
<td>29</td>
</tr>
<tr>
<td>Has programmatic areas of interest</td>
<td>5</td>
<td>5.55</td>
<td>31</td>
</tr>
<tr>
<td>Patient care</td>
<td>6</td>
<td>5.70</td>
<td>33</td>
</tr>
<tr>
<td>Salary</td>
<td>7</td>
<td>6.81</td>
<td>32</td>
</tr>
<tr>
<td>VA hospital</td>
<td>8</td>
<td>6.90</td>
<td>29</td>
</tr>
<tr>
<td>Fringe benefits</td>
<td>9</td>
<td>6.97</td>
<td>31</td>
</tr>
<tr>
<td>Administrative opportunities</td>
<td>10</td>
<td>7.0</td>
<td>26</td>
</tr>
</tbody>
</table>
Although we had about 14.7 applicants for each position, three of the six positions were not filled. This was the source of some perplexity. In each instance, job offers were made but turned down by one or two applicants, and the remaining candidates either did not meet departmental needs or withdrew from consideration. In general, unsuccessful applicants did not have the requisite research and teaching focus.

Although no position was filled by a candidate who responded to an advertisement, the majority of applicants learned about it in this manner. In fact, since 1980 we have had 12 separate searches for academic psychiatry positions at the VA and have only hired one person who responded to an advertisement. Others have commented on this phenomenon and note that general advertisements often bring a great number of responses from applicants who do not meet the requirements of the position (23,24). Our study, however, was not designed to allow empirical assessments of the qualifications of the applicant group that responded to Psychiatric News. When we just considered applicants who were offered positions, we discovered they primarily came to us either by active inquiry (e.g., letter to the department chairman) or via our residency training program.

Our applicant cohort was highly interested in the Pacific Northwest. Geographic limitations by applicants have been shown to have primary importance both in searching for residency positions (25) and for postresidency jobs (13–15,19). Goodman (19) notes that most physicians decide to locate in one of three areas: where they or their spouses grew up; where they trained; or California. The trouble, notes Goodman (19), is that the last two locations (and most likely the first) are hardly short of physicians.

In the past 10 years, it has been our subjective impression that recruiting clinician-researchers has become increasingly difficult. Previously, we not only had more applicants but more who met the position requirements. The reasons for this change appear to be multiple and are beyond the scope of this article. Briefly, however, the shortage of clinician-researchers in psychiatry has been recognized by others and has been attributed to lack of formal research training (22,26,27), decrease in number of residents choosing academic careers (28), the past lack of female research mentors as more women entered medical school and psychiatry (21,29), and the lure of private hospital psychiatry (28,30).

Our recruitment focused on clinician-researchers, which mostly eliminated applications from those who required more dedicated research time. Also, some applicants appeared to ignore our solicitation regarding academic experience or aspirations and were simply applying for all advertised jobs in the geographical area. Finally, we lost several candidates because of difficulty finding dual positions for professional pairs. Even though one of our positions may have been attractive to one spouse, the other could not find a comparable fit in the Portland metropolitan area, which has a population of approximately 1.5 million. Less than 15% of applicants in our sample were women, even though women make up more than 23% of all psychiatrists (31). Robinowitz et al. (21) have commented on the small percentage of female applicants for most advertised academic positions. They attribute this to social attitudes, particularly the expectation that male spouses' vocational aspirations have preference. As a result, professional couples must often confine their search to very large metropolitan areas (e.g., New York, Los Angeles, Chicago) so they can both find suitable positions. This problem, which appears to be increasing as more women enter the sciences, has been discussed by several dual-career job hunters (13,14).

Finally, it is obvious that a position in a desirable area is going to attract more candidates who list location as a leading job selection criterion. It would be worthwhile to
repeat this study in other geographical settings and/or at several institutions in a particular area. The second choice (opportunity to teach) probably has more generalizability. Unfortunately, teaching is not the only skill or interest related to academic success.

CONCLUSIONS

Applicants were primarily attracted to our position openings because of desirable location. Also cited were opportunities to teach and do research. Most candidates learned about our positions through advertisements in Psychiatric News. Although affirmative action may require such advertising, we have concluded that it is not a particularly effective way to attract applicants who are eventually employed. A somewhat frustrating finding was the difficulty in locating candidates who fulfilled our job requirements, which, unfortunately, reflects a recent trend in recruitment of clinician-researchers. Even a desirable location could not ameliorate this difficulty.

It is often difficult to make an effective match between an academic department's needs and an applicant's wishes. Cycles of academic recruitment are responsive to many variables. We believe the apparent shift away from clinician-researcher careers may be related to a variety of factors, including the recent upsurge in corporate medicine and the relative decrease in academic salaries, more indebtedness among recent training program graduates, inadequate research training and mentoring, more professional pairs seeking dual employment, more interest in nonstressful (e.g., nonacademic) lifestyles, reluctance to relocate and disrupt family life, and fewer available tenure-track positions, or at least jobs with adequate dedicated research time. Because some of the above factors are responsive to an ever-changing market economy, the future is somewhat unpredictable. Nevertheless, as Burke et al. (22) have maintained, the clinician-researcher gap must ultimately be solved by both financial and training inducements for young researchers.

The author thanks Ms. Mary Moffitt for her assistance in data collection and manuscript preparation.

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Criteria for the Academic Promotion of Medical School–Based Psychiatrists

Ross E. Carter, Ph.D.

The objective of this study was to identify criteria used in recommending faculty for promotion in medical school–based departments of psychiatry. Chairs of 125 departments in the United States were asked to complete a 39-item questionnaire on departmental demographics and the expectations for academic performance of tenure-track, non-tenure-track, part-time, and medical research faculty. Different criteria were reported for the classifications of faculty studied, but not for promotion of the same class of faculty to different academic ranks. The increasing need for faculty to generate revenue blurs the distinction between tenure-track and non-tenure-track faculty and calls into question whether tenure track can practically continue as a faculty classification.

A review of the literature indicates that the various configurations of academic psychiatry have been extensively studied. Statistical data as well as subjective impressions have been reported for curricula (1–5), problems of residents (6–8), recruitment strategies (9–11), the effect of settings in which teaching occurs (12–15), the future of psychiatry and the effects of economics on it (16–18), gender issues (19–22), medical student education (23–24), and both long- and short-term effects of residency education (25–28). Only a few studies have reported on faculty. One (29) describes the medicolegal need to monitor activities of volunteer faculty and describes appointment procedures, but only regarding volunteers. Others (30–32) deal with volunteer status and faculty research.

The present study was carried out in order to obtain data on the criteria used in departments of psychiatry for recommending promotion. The study sought to determine what criteria would be used for the promotion of different classifications of faculty and whether different criteria would be used for associate professor and professor.

METHODS

A listing of departments provided by the American Association of Chairs of Departments of Psychiatry was used to identify 125 medical school–based departments in the United States. Chairpersons were contacted by letter and asked to complete and return a 39-item questionnaire designed for the study. The types of faculty inquired about included full-time tenure-track, full-time non-tenure-track, medical research, and part-time consulting faculty employed outside a department. Definitions were provided to ensure commonality of terms. Because promotion is generally made from assistant professor, that rank was not inquired about except in the case of part-time faculty, where initial appointments may be at the level of instructor.

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Questionnaire items asked about amount of teaching, number of publications, hours of clinical service, letters of recommendation from other institutions, expectations regarding ongoing research, grant support, and time in rank before promotion. Central to the study was one item that required the rank ordering of eight factors according to the emphasis given to each in recommending promotion. These factors were publications, teaching, grant support, ongoing research, clinical service, administrative service, professional membership, and national reputation. It was assumed that the resulting ranks would indicate the comparative importance of each factor for the recommendation of promotion. Because of the population distribution and because the data gathered were nominal and ordinal, the Mann-Whitney U-test, a nonparametric statistic, was used to compare rankings of factors for promotion to associate professor and professor (33).

RESULTS

Completed questionnaires were returned by 66 departments (52.8%). This obtained rate of return is better than the average 30% rate expected in survey studies of the kind reported on here, and it is large enough to indicate that a representative sample was obtained (34–35). Demographic data are shown in Table 1. The mean ± SD of the reported number of full-time psychiatrists on faculty was 27.1 ± 18.8; of part-time psychiatrists on faculty, 33.4 ± 66.0. Full-time psychologists were reported by 95% of departments (n = 63) and in a ratio to psychiatrists of 1:2. Thirty-nine percent of departments (n = 26) reported either full- or part-time social workers. The mean number of residents in training was reported as 38.5 ± 23.5, with approximately three times as many departments reporting training in general and child psychiatry as in general psychiatry alone.

Tenure-Track Full-Time Faculty

The mean rankings of eight factors considered for promotion to associate professor and professor are shown in Table 2. A comparison of the ranking of factors was stati-
tically insignificant (Mann-Whitney $U = 31$, $P = 0.48$), indicating that the same criteria are emphasized in promoting to both academic ranks. Inspection of the mean ranking indicates that, for both associate professor and professor, greatest weight is given to publications, teaching, grant support, and national reputation. Differences between adjacent rankings, however, were of approximately equal magnitude, suggesting an evenness in progression from most to least emphasized factors.

The mean length of time in academic rank before promotion to associate professor was reported as $5.4 \pm 1.57$ years; to professor, $5.2 \pm 1.28$ years. For promotion to associate professor, a mean of $12.6 \pm 6.83$ publications was required; a mean of $25.1 \pm 13.82$ was required for professor. Considerable variation was found in expectation regarding the time spent in clinical service, with $33\%$ of departments ($n = 22$) expecting $30\%$ time but only $7.5\%$ ($n = 5$) expecting $50\%$ or more time. Thirty-six percent of departments ($n = 24$) reported expecting outside grant support for promotion to associate professor; $44\%$ ($n = 29$) for professor. Eighty-four percent ($n = 55$) expected teaching of residents and medical students, whereas $95\%$ ($n = 63$) required letters of recommendation from outside departments for both associate professor and professor.

Non-Tenure-Track Full-Time Faculty

No significant difference was found between the ranking of factors for promotion to associate professor and professor (Mann-Whitney $U = 30$, $P = 0.44$). Greatest emphasis was given to teaching, clinical service, administrative service, and publications. Inspection of the progression of ranking shows approximately the same magnitude of difference between adjacent rankings, indicating an evenness in the decreasing importance of factors for recommendation of promotion.

The mean number of publications expected for promotion to associate professor was $6.15 \pm 4.13$; to professor, $14.0 \pm 9.31$. Fifty percent or more time in clinical service was expected by $60\%$ of departments ($n = 40$); $18\%$ ($n = 12$) expected $40\%$ of the time. All departments expected teaching of medical students and residents for promotion, and $7\%$ of departments ($n = 5$) expected outside grant support. The mean lengths of time before promotion to associate professor and to professor were approximately 5 years, with renewable appointments made for a mean length of $2.05 \pm 1.81$ years.

Medical Research Faculty

No significant difference was found in the ranking of factors considered for recommending promotion to associate professor or professor (Mann-Whitney $U = 34$, $P = 0.52$). For both associate professor and professor, greatest emphasis was given to publications, grant support, and ongoing research. National reputation was emphasized somewhat more for professor than for associate professor.

For promotion to associate professor, the mean number of publications expected was $20.1 \pm 5.92$; for professor, $37.9 \pm 10.63$. Teaching of medical students and residents was expected by $65\%$ of departments ($n = 43$). Although teaching of nonmedical students was not expected of other faculty, medical research faculty were expected to teach graduate students by $89.7\%$ of departments ($n = 59$). Clinical service time of $20\%$ or less was expected by $92\%$ of departments ($n = 61$), with letters of recommendation outside the department expected by $83\%$ of departments ($n = 55$) for promotion to associate professor and by $97\%$ ($n = 64$) for promotion to professor. Outside grant support was expected by $88\%$ of departments ($n = 58$) for promotion to associate professor and by $100\%$ of departments for professor. The rankings of factors used in recommending promotion are shown in Table 3.
Part-Time Consulting Faculty

In contrast to other types of faculty, inquiry about consulting faculty included items regarding criteria for appointment to four academic levels: instructor, assistant professor, associate professor, and professor. The percentages of initial appointments at the four levels were: instructor, 21%; assistant professor, 61%; associate professor, 17%; and professor, 8%. Across all levels, the highest-ranked factor for initial appointment was teaching. The second-ranked factor was clinical service, except for professor, for which publications was ranked second. The third-ranked factors considered for initial appointment at each level were professional membership for instructor, administrative service for assistant professor, publications for associate professor, and clinical service for professor. For reappointment to the same level, teaching and clinical service were ranked first and second. Administrative service was ranked third for instructor and assistant professor. For associate professor and professor, publications and administrative service tied for third-highest ranking. The rankings of factors used in recommending promotion are shown in Table 3.

No significant difference was found on mean rankings of factors considered for promotion when compared for assistant professor, associate professor, and professor (U = 30, P = 0.44; U' = 34, P = 0.52). Length of appointment for part-time faculty was skewed, with 56% (n = 37) appointing for 1 year and 22.7% (n = 15) for 3 or more years. The mean number of hours required to be donated was 88 per year.

CONCLUSIONS

The results of this study indicate that different criteria are used to recommend promotion for different classifications of faculty but that for any one class the same criteria are used to recommend promotion to associate professor and professor. The consistency across the sample of the ranking of the eight factors used as criteria for promotion suggests that there is a high level of agreement among departments regarding what is expected of different classes of faculty as well as of different academic ranks within the same classification of faculty.

The increasing pressure for faculty to generate more revenue through patient care has been pointed out elsewhere (18). The long-term effect on academic activities is unclear, but it is obvious that these activities will be reorganized, with different priorities determined by available time. The logical shift will be away from research and publishing to clinical service and teaching. This change, however, will raise the issue of whether academic freedom can survive in departments of psychiatry in the way that it has been expressed and exercised for so long, by generating ideas and exploring them via research and writing. As clinical service dominates, faculty positions will, more and more, approximate those of the

<table>
<thead>
<tr>
<th>TABLE 3. Mean ranking of factors used in academic promotion of medical research and part-time faculty</th>
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<tbody>
<tr>
<td>Factor</td>
</tr>
<tr>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Medical research faculty</td>
</tr>
<tr>
<td>Publications</td>
</tr>
<tr>
<td>Grant support</td>
</tr>
<tr>
<td>Ongoing research</td>
</tr>
<tr>
<td>National reputation</td>
</tr>
<tr>
<td>Teaching</td>
</tr>
<tr>
<td>Professional membership</td>
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<tr>
<td>Administrative service</td>
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<tr>
<td>Clinical service</td>
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<tr>
<td>Part-time consulting faculty</td>
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<td>Grant support</td>
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</tbody>
</table>
nonacademic practitioner and risk cognitive dissonance regarding definition of self and employment.

The data presented here, however, indicate that the faculty most likely to be affected are those in full-time tenure-track positions. Medical research faculty generate their salaries largely from grants. Part-time faculty are employed outside departments. Non-tenure-track full-time faculty are already heavily involved in clinical service. As full-time tenure-track faculty provide more clinical service, the distinction between them and non-tenure-track faculty blurs, calling into question the criteria to be used for promotion as well as the need for continuing with that track, given trends occurring in academic psychiatry.

One alternative to these trends, which are antagonistic to the research and publication basis of academics, might be that of merging departments of psychiatry with university-based departments of psychology. University-based departments of psychology are most frequently funded independently of revenue from clinical service and are grounded in research. At the same time, many psychology departments face difficulties with providing patient loads for students. With opportunities for clinical service in departments of psychiatry and opportunities for research and publication in departments of psychology, greater cooperation and mixing could prove mutually beneficial and preserve the freedom to publish and research in departments of psychiatry.

Further research on the factors and processes involved in academic promotion is needed. The data presented here are limited in that they reflect departmental judgments rather than the decisions of medical school rank and tenure committees. Even though over 70% of the departments surveyed reported having written policies regarding advancement and tenure, it is unclear how medical school committees regard those recommendations. Further research might, for example, focus on the criteria used by medical school committees and correlate the number of promotions recommended by departments with the number of promotions granted by medical school committees. With such a focus, attention would be given to defining the organizational hierarchies and lines of power within medical schools. These may differ depending on whether the medical school is part of a larger state-supported university or is a freestanding private medical school.

Additional research should also explore further the factors weighed by departments in recommending promotion for each classification of faculty. A limited range of factors and expectations were surveyed in the present study. They were selected because of their face validity and applicability across a range of departments and classifications of faculty. Other criteria not inquired about may exist and may be used for promotion. Further research should also use a more refined sample and obtain prior agreements to participate so that data can be collected in two or more trials in order to produce a fuller and more accurate picture of the actual process of promoting and recommending tenure for faculty and of how criteria vary according to department characteristics. Another limitation is that the questionnaires were completed by departmental chairs and not by chairs of departmental committees on promotion. How well departmental chairs' responses reflect the realities of promotion committees remains questionable. Further research might focus instead on members of those committees as well as on medical school committees.

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Evaluating the Evaluations of Psychiatry Residents

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This survey assessed the perceptions of psychiatry residents and faculty about resident evaluations. Current residents, former residents, and faculty of a psychiatry residency program were asked about the value and effect of feedback in 15 specific areas and rated their preferences for evaluation methods. Residents and faculty most valued feedback that addressed practical clinical skills. Evaluations reportedly improved skills in half of the areas surveyed. Most respondents preferred face-to-face evaluations from individual faculty. This study confirms the value of resident evaluations addressing clinical skills, but it highlights discrepancies in expectations and merits of several methods of evaluation.

Evaluation of psychiatric residents is a required and integral part of resident training. The psychiatric literature comprises policy articles (1,2), individual evaluation programs (3–7), “how-to” papers (8,9), and even an entire book published by the American Board of Medical Specialists (10). Borus and Yager (1), concerned with the high failure rate of board certification applicants and with quality control in residency training, advocate standardization of evaluations throughout residency training. To this end they recommend using in-service examinations, ongoing case logs, and certifications of a resident’s ability to perform medical, neurological, and psychiatric examinations. In a model curriculum for psychotherapy training, Mohl et al. describe a comprehensive system of evaluation for each resident year (2).

Comprehensive evaluation methods successfully used by individual programs include Tasman and Rieder’s simulated critical incident designed to assess attitudes, behavior, clinical skills, and problem-solving ability (3). Rosen et al. developed an evaluation system that uses videotaped interviews to chronicle a resident’s progress over the years (4). Although the resident and faculty response to the evaluation process was informally positive, formal systematic responses were not solicited.

The literature also contains papers giving advice on how to provide useful feedback. Ende, drawing from the business administration, psychology, and education literature, offers guidelines that feedback should be based on firsthand data, deal with

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specific performances, be phrased in descriptive, nonevaluative language, and be limited to behaviors that are remediable (8). Klein examines the rational and irrational factors that may hinder the evaluation process (9).

However, there has been no systematized study, to our knowledge, documenting what individual faculty and residents value and find useful in an evaluation. What specific content of evaluations is valuable from the resident’s perspective and from that of the faculty evaluator? Is the evaluation perceived to effect any change in residents' skills? What kind of evaluation is preferred? In this study, we surveyed the perceived value and usefulness of feedback information, as well as preferred modes of evaluation, as reported by a sample of residents and faculty involved in the process.

METHODS

A 5-page codable questionnaire was mailed in 1989 to all current residents and fellows (n = 51), all former residents who had left residency or fellowship within the last 6 years (n = 63), and all current clinical faculty actively teaching and evaluating residents (n = 55) at a psychiatry residency training program. The current resident group included 43 general psychiatry residents, 7 child psychiatry fellows, and 1 consultation-liaison psychiatry fellow. Recent former residents were included as a study group because they could view training with the added experience of being out in practice and could have a somewhat detached perspective while still being able to remember the evaluation process. Questionnaires were answered anonymously, and participation was voluntary. A follow-up plea was sent to those who had not responded 5 weeks after the initial request.

A potential problem was that some respondents were both former residents from within the last 6 years and current faculty. We decided to define this group as faculty rather than as former residents because as faculty they continued to be actively involved in the evaluation process. The perspective we sought from former residents was that of detachment from the training process.

An overall return rate of 75% (n = 124) was achieved. The response rate of faculty was 87% (n = 47); of current residents, 82% (n = 42); and of former residents, 58% (n = 35). The response rate between groups was significantly different ($\chi^2 = 14.609$, df = 2, $P < 0.005$).

Among those responding, the current resident group was 69% women (n = 27), the former resident group was 51% women (n = 18), and the faculty was 38% women (n = 18). There was a significant difference in the number of years spent as a supervisor-attending physician between male faculty, with a mean ± SD of 14.43 ± 8.66 years, and female faculty, with a mean ± SD of 6.22 ± 4.95 years ($t = 3.64, df = 44, P = 0.001$). Thus, the current resident group was predominantly female, whereas the faculty was predominantly male with many years of teaching experience. The gender composition of the training program as a whole was quite similar to that of survey respondents: 63% of current residents were women, 46% of former residents were women, and 37% of faculty were women. Over the last 10 years the program has had the same training director, and the format and frequency of evaluation have not changed.

The questionnaire asked how often various methods of evaluation were used (written, face-to-face, informal) on a 5-point Likert-type scale ranging from 1 (always) to 5 (never) and which method was preferred. A 3-point Likert-type scale was used to rate the value of feedback and its effect upon resident competence in 15 specific areas (diagnostic skills, empathic skills, ethical behavior, etc.).

Current residents and former residents were told that the survey pertained to evaluations they had received on their clinical
work. They were reminded that the evaluations included written or verbal feedback from supervisors, attendings, seminar leaders, the residency training director, or the chairman. Faculty were directed to answer from their individual perspective as faculty and to base their responses on written and verbal feedback evaluations that were given in their capacity as supervisors, attendings, or seminar leaders. Our data analysis included frequencies and chi-square analysis.

RESULTS

Content of Evaluations

The most highly valued areas of evaluation, as shown in Table 1, were diagnostic skills, interviewing skills, ethical behavior, patient management skills, and empathic skills. Areas that were least valued included comparison with peers and evaluation of research skills. In each of the 15 areas specified in Table 1, we used chi-square analysis to compare current residents with former residents and with faculty; beginning with senior residents; and men with women. No statistically significant differences were found in the chi-square analysis, and therefore results are reported with all groups together.

Because of the potential problem of the overlap group (faculty who were also former residents of this training program within the last 6 years), we also compared the overlap group of faculty (n = 13) with faculty who were not former residents within the last 6 years (n = 34) by chi-square analysis and found no significant differences in any of the 15 areas. In addition, we compared this overlap group with the same chi-square analysis for all other variables and found no significant differences between groups.

Table 2 shows the perceived effect of evaluations on residents' subsequent competence in each of the same 15 areas. In only 8 items did a majority of the respondents feel that the evaluations positively affected clinical performance. Over 75% of respondents believed that evaluations had no beneficial effect on residents' abilities in the areas of research, comparison with peers, and neurological examination. Again, in the areas specified in Table 2 there were no statisti-

<table>
<thead>
<tr>
<th>Skill Area</th>
<th>Of Great Value</th>
<th></th>
<th>Of Some Value</th>
<th></th>
<th>Of No Value</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Diagnostic skills</td>
<td>110</td>
<td>89</td>
<td>14</td>
<td>11</td>
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<td>0</td>
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<tr>
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<td>84</td>
<td>20</td>
<td>16</td>
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<td>0</td>
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<tr>
<td>Ethical behavior</td>
<td>96</td>
<td>79</td>
<td>26</td>
<td>21</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Patient management skills</td>
<td>98</td>
<td>79</td>
<td>26</td>
<td>21</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Empathic skills</td>
<td>93</td>
<td>75</td>
<td>31</td>
<td>25</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fund of knowledge</td>
<td>90</td>
<td>74</td>
<td>32</td>
<td>26</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mental status examination</td>
<td>90</td>
<td>73</td>
<td>32</td>
<td>26</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Multidisciplinary team skills</td>
<td>67</td>
<td>55</td>
<td>55</td>
<td>45</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Case writeups</td>
<td>65</td>
<td>53</td>
<td>54</td>
<td>44</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Neurological examination</td>
<td>59</td>
<td>48</td>
<td>62</td>
<td>50</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Personal style</td>
<td>37</td>
<td>31</td>
<td>73</td>
<td>61</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Teaching skills</td>
<td>36</td>
<td>29</td>
<td>81</td>
<td>66</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Leadership skills</td>
<td>34</td>
<td>28</td>
<td>85</td>
<td>70</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Research skills</td>
<td>21</td>
<td>17</td>
<td>80</td>
<td>66</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Comparison with peers</td>
<td>16</td>
<td>13</td>
<td>72</td>
<td>59</td>
<td>34</td>
<td>28</td>
</tr>
</tbody>
</table>

Note: Total number of respondents = 124.
cally significant differences on chi-square analysis between current residents, former residents, and faculty groups (including an analysis of the overlap group); between beginning and senior residents; or between men and women.

Methods of Evaluation

When respondents were asked which method of evaluation was preferred, most (82%) preferred a face-to-face evaluation with the individual faculty member. The three groups—current residents, former residents, and faculty—did not differ in this preference ($\chi^2 = 2.790, \text{df} = 2$, not significant). Among current residents, the second most preferred method (74%) was evaluations presented in writing by the individual faculty members. This method was significantly less favored ($\chi^2 = 9.238, \text{df} = 2, P < 0.01$) by faculty members (45%) and by former residents (46%). With respect to written evaluations, there was a significant gender difference, with 65% of women preferring a written evaluation compared with 45% of men ($\chi^2 = 4.2, \text{df} = 1, P < 0.05$). This was especially true for current resident women, 81% of whom preferred written evaluations by the individual faculty member.

In this training program, 90% of respondents reported that a written evaluation was usually or always given directly to the training director by the individual evaluator. Forty-two percent of respondents reported that face-to-face evaluations by the supervisor/attending physician were usually or always provided, 39% said that evaluations were usually or always provided during rounds or supervision, and 18% said written evaluations were usually or always given directly to the resident. There were no differences in reported methods of evaluation between current residents, former residents, and faculty, or between genders.

DISCUSSION

This survey of residents, former residents, and faculty confirms that evaluations are generally perceived to be valuable compo-

<table>
<thead>
<tr>
<th>Skill Area</th>
<th>Improved</th>
<th>No Effect</th>
<th>Worsened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewing skills</td>
<td>94  80</td>
<td>22  19</td>
<td>1   1</td>
</tr>
<tr>
<td>Fund of knowledge</td>
<td>91  77</td>
<td>27  23</td>
<td>0   0</td>
</tr>
<tr>
<td>Diagnostic skills</td>
<td>93  76</td>
<td>28  23</td>
<td>0   0</td>
</tr>
<tr>
<td>Patient management skills</td>
<td>89  76</td>
<td>27  23</td>
<td>0   0</td>
</tr>
<tr>
<td>Empathic skills</td>
<td>85  70</td>
<td>34  28</td>
<td>1   1</td>
</tr>
<tr>
<td>Mental status examination</td>
<td>74  63</td>
<td>43  37</td>
<td>0   0</td>
</tr>
<tr>
<td>Case writeups</td>
<td>66  55</td>
<td>53  44</td>
<td>0   0</td>
</tr>
<tr>
<td>Multidisciplinary team skills</td>
<td>62  54</td>
<td>52  45</td>
<td>1   1</td>
</tr>
<tr>
<td>Personal style</td>
<td>48  42</td>
<td>64  56</td>
<td>1   1</td>
</tr>
<tr>
<td>Leadership skills</td>
<td>39  34</td>
<td>74  64</td>
<td>2   2</td>
</tr>
<tr>
<td>Teaching skills</td>
<td>38  33</td>
<td>73  64</td>
<td>2   2</td>
</tr>
<tr>
<td>Ethical behavior</td>
<td>37  32</td>
<td>76  66</td>
<td>0   0</td>
</tr>
<tr>
<td>Neurological examination</td>
<td>25  23</td>
<td>79  72</td>
<td>3   3</td>
</tr>
<tr>
<td>Comparison with peers</td>
<td>21  19</td>
<td>85  75</td>
<td>3   3</td>
</tr>
<tr>
<td>Research skills</td>
<td>14  12</td>
<td>95  82</td>
<td>2   2</td>
</tr>
</tbody>
</table>

Note. Total number of respondents = 124. Percentages for some areas do not add up to 100 because a few respondents (former residents) could not remember specific information.
ponents of psychiatric resident education. Evaluations of clinical skills in particular were highly valued. These general skills (interviewing, diagnosis) are essential universal skills for all areas of psychiatric practice, whereas the items of lesser value are in specific areas (research skills or neurological examination). These areas may be of less interest and therefore of less value to residents. Alternatively, evaluations in these areas may need to be given by faculty of special expertise (i.e., researchers or neurologists) in order to be more highly valued.

We wondered whether a predominance of clinicians biased our study toward clinical skills and away from academic ones. When we focused on former residents and faculty who had listed teaching as their primary practice type, evaluations of academic skills such as teaching or leadership were not valued over clinical skills. None of the respondents listed research as their primary practice type; thus, different results might be obtained in a setting where research faculty are more actively involved in clinical teaching and evaluations.

Evaluations of personality traits were of little perceived value. The items on comparison with peers and personal style elicited a few handwritten comments that such evaluations were “aversive”; these comments appear to represent an opinion that these areas ought to be outside the domain of evaluation, or at least that they are very sensitive areas of evaluation.

It is surprising that the majority of respondents reported that evaluations improved skills in only about half of the 15 areas surveyed. With the exception of ethical skills, the 8 skill areas where feedback was most highly valued were identical to those for which most respondents believed evaluations led to improved resident performance. Perhaps less valued areas are also at a low priority for change. Another explanation may be that ratings of certain evaluation items as less valuable and as not leading to improvement may relate to the standing of those skill areas in the priorities of this specific training program. Comparison with other training programs would be needed. It is also possible that the modest report of improvement reflects a weakness that appears in the evaluation system because an evaluation is viewed primarily as an index of competence at the close of any rotation. When, on the other hand, an evaluation is seen as a tool for building future competence, specific examples can be taken from the resident’s work and suggestions offered that emphasize improvement.

Alternatively, these results may reflect the extent to which the various skills were viewed as being satisfactory when evaluated. A skill evaluated as satisfactory may seem to need less improvement than one rated as less than satisfactory, or may even seem to need no change. In this training program, approximately half of formal written evaluations contain specific content regarding areas that need improvement. Since we did not distinguish between perceived satisfactory and unsatisfactory evaluations in the survey, this question deserves further research.

The evaluation of ethical skills was highly valued but had little perceived impact on performance, suggesting that ethical behavior is unlikely to be changed by evaluative interventions. This may relate to the lack of studies describing interventions that alter residents’ ethical behavior.

Even though face-to-face evaluations were greatly preferred over other methods, this form of evaluation was used less than half of the time. Yet, in this particular training program, the cover page of each written evaluation form encourages faculty to discuss a resident’s evaluation with him or her in addition to turning in the written evaluation to the training director. Thus, the 42% compliance rate for face-to-face evaluations contrasts with the 90% compliance rate for written evaluations. The former are direct confrontations, whereas in the latter either the training director acts as middleman, in-
forming the resident of his or her evaluation, or the resident peruses his or her file of evaluations.

One possible explanation of the low rate of face-to-face evaluations is the anxiety that this method engenders in both residents and faculty. The evaluator may fear inflicting narcissistic injury on the resident or may choose to avoid a confrontation (9). If the resident and attending physician evaluate each other, the evaluations may, in the words of Taintor, constitute “a tacit non-aggression treaty or the effulgence of a mutual admiration society” (11). The resident may already be defensive as an adaptation to the stress of residency (12). For example, very early in their training, residents may be called upon to make frequent clinical assessments of dangerousness and suicidal risk, decisions in which errors could be extremely costly. Often the anxiety associated with being responsible for these decisions is circumvented by avoiding a close examination of the possibility of making errors and the consequences of such errors. Therefore, although faculty and residents agree on the value of face-to-face evaluations, they avoid them. Unfortunately, lack of verbal feedback may cause house staff to generate their own feedback, such as when they read approval or disapproval of their work from a raised eyebrow, a smile, or a frown (8).

An unexpected finding was a gender difference regarding written evaluations. Why would women more than men want written documentation of their evaluations? Women may feel a need to ask for written evidence of their performance because of a lack of informal feedback. Same-sex mentors, social contacts, and informal “networking” that are natural components of professional life for men are often not as available to women (13,14). Women may feel a sense of professional loneliness and isolation that surfaces in a need for concrete evidence of their performance. There may also be a defensiveness, generated by perceived gender bias during undergraduate and medical school education in fields dominated by men (15), that creates a need to “get it in writing.”

Although our results are not necessarily generalizable to other programs, there are several interventions that could facilitate helpful evaluations. Evaluations should emphasize what can be changed and how those changes can be effected, with specific suggestions. Scheduling face-to-face evaluations for a particular time and place might also help to increase utilization of this method. Also, women’s needs for written evaluations should be respected, sufficient mentoring offered, and other informal kinds of evaluations presented.

Our results suggest several areas for future research. Surveys of additional psychiatric training programs could ascertain which results of this survey are generalizable to other programs. Future studies could also compare the validity of evaluations by self-report with program director reports or national measures such as board certification exams or the Psychiatry Resident-in-Training Examination.


The authors thank Rosalind J. Dworkin, Ph.D., for her helpful guidance with this project.

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Interactive Teaching, Medical Students, and Substance Abuse

University and Community Come Together in a New Endeavor

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Agnes Soriano Wallbom, Naomi Siegel, M.S.W.
Lynn Fairbanks, Ph.D., Douglas M. Ziedonis, M.D.

The authors present an innovative approach for providing freshman and sophomore medical students with their initial exposure to the problems of alcohol and other drug abuse. Students in small interactive group seminars teach each other about the major areas of substance abuse: treatment, prevention/education, research, and law enforcement. They are aided by group moderators, by resource professionals, and by recovery teachers as they make field trips, attend 12-step meetings, and get background material. They utilize audiovisuals, role-plays, and programmed patients in a report/debate format. Effects of this seminar on their attitudes have been measured and are presented.

Although substance abuse is recognized as a health problem that has reached epidemic proportions in our society, physicians and medical educators have been slow to develop innovative programs to train health care providers in the diagnosis and treatment of this widespread and debilitating condition. In fact, alcohol is involved in the illnesses of 20% to 50% of general hospital patients in this country, yet less than 5% of the patient population is diagnosed as alcoholic (1). Research on knowledge, attitudes, and skills of physicians has shown that traditional medical education has not prepared physicians to recognize or treat these problems (2).

At UCLA, each medical student chooses to participate in several “selective” small-group interactive teaching seminars (IATs), offered on a large variety of topics, during his or her first 2 years. The basic concept of each seminar is to provide students with an opportunity both to have a self-directed learning experience and to teach one another relevant information, with instructors as moderators, thereby building lifelong learning skills.

We have developed an IAT seminar on substance abuse to expose medical students to a set of experiences affecting their knowledge, attitudes, and skills regarding the diagnosis and treatment of substance abuse (3). The purpose of this article is to present further information, with more detailed dis-
cussion, on selected aspects of this course—as well as to include an evaluation of the effects of the IAT seminar on student attitudes.

THE SUBSTANCE-ABUSE INTERACTIVE TEACHING SEMINAR

Approximately half of the freshman/sophomore students now take an IAT in substance abuse. It has been offered 5 times yearly for the past 3 years, 1989–1991, with a waiting list almost every time the course is given. Over 180 students have completed the course. We have varied the number of students in each seminar from 8 to 16; groups of 12 to 14 seem, on balance, to be the most effective way to reach the most students. Groups meet for 2 hours weekly over an 8-week period, some beginning as early as the first week of their freshman year, to explore issues and topics pertaining to aspects of the four major areas of substance abuse: treatment, research, prevention/education, and law enforcement. Another focus of this course is to help students understand the interaction of health problems and societal problems; therefore, social policy issues involving these four areas are emphasized.

The course exposes students to many community resources and brings their medical training out of the isolation of the university. To obtain the information for their presentations in the seminar, students, in teams of two, make three field/site visits to various university and community facilities. The teams then present their assigned topics and lead the group in a discussion of the issues.

Our primary goals for the IAT are simple—to let the students know that substance abuse is a treatable illness; that their attitudes about substance abuse will affect their ability to provide effective diagnosis, intervention, and treatment (4–7); and that they must critically examine and challenge teaching to the contrary. To accomplish these goals, the students participate in the following activities.

Twelve-Step Visits

Students, in teams of two, visit a 12-step program (Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, Al-anon, Adult Children of Alcoholics, Overeaters Anonymous, etc.) for one of their three site visits. One factor in the underdiagnosis of substance abuse is the reluctance of physicians to examine their own and their colleagues’ drug-using behaviors. Frequently physicians believe that only skid row-type individuals really have a substance-abuse problem. To change this belief, all students attend these 12-step meetings with a “recovery teacher,” a physician or other health professional who has himself or herself been “in recovery” from substance abuse for at least 2 years (8). The recovery teacher briefs the students prior to the meeting, accompanies them to the meeting, and afterward discusses with them what they have experienced. Impressions are shared, and the different 12-step programs are compared and contrasted during the IAT session entitled “Twelve-Step Day.”

Prevention/Education, Law Enforcement, and Treatment Site Visits

Sites for the students’ second field trip include the Los Angeles Police Department’s prevention/education program Drug Abuse Resistance Education in the city schools, the police Drug Recognition Evaluation Unit at the city jail, a walkalong with a street homeless outreach team, a detoxification center, an adolescent residential facility, a methadone maintenance program, a drug diversion program, etc. The students prepare reports on what they have learned about such prevention/education, law enforcement, and treatment from the resource professionals they see and the substance abusers they interview at each site.
Debates, Reports, and Role-plays

For their third presentation, students are involved in a debate, a report, or a role-play. Students may select issues to debate, such as the disease concept of alcoholism, the ethics of random urine testing among medical students and house staff (the Johns Hopkins model [9]), and the social policies of “zero tolerance” versus drug legalization, including needle exchange programs.

Other students select topics for prepared reports, including an overview of treatment modalities, the psychological dynamics of 12-step programs, drug abuse as a family disease, the impaired physician, and theories of prevention/education. Other reports have addressed fetal alcohol syndrome, the addicted newborn, genetic implications of alcoholism, AIDS and drug abuse, the biological and psychological effects of the different classes of psychotropic drugs, and the addictive features of nicotine.

Students have also created their own topics for reports: for example, some have contacted the state medical board, the hospital’s medical ethicist, and the hospital attorney. Others have appeared before the hospital credentials committee. One group of students surveyed their entire class about their drug attitudes by ethnic background. Another team made a videotape for their urine-testing debate. Each year, after the course, several students participate in the Betty Ford Center’s Professional in Residence week-long experiential teaching program for physicians and medical students.

We have used some nontraditional teaching techniques in an attempt to bring affect into the learning situation and to have an impact on students’ attitudes. Role-playing has been used when topics of early diagnosis and intervention are presented. For the section on early diagnosis, a “programmed patient” actor who has studied a case history of a drug abuse patient is interviewed in turn by each student (10). An internist facilitator “freezes” the patient, suggests new avenues of inquiry to the interviewer, and gives feedback to the students. In the intervention segment, students play the roles of family members and friends of the “programmed patient” while a professional interventionist leads them in a home intervention in which the classroom serves as the patient’s living room. (An interventionist is a professional who specializes in motivating the addicted patient to get help, even if the patient has been unwilling to do so, using family and friends to exert group pressure [11].)

Materials for all debates, reports, and role-plays come primarily from each student team’s meeting with a resource professional who has special expertise in the student’s chosen area of interest. Over 60 resource professionals and recovery teachers, from a variety of departments at UCLA and the Medical Center as well as from the community, have enthusiastically participated to date.

The students also explore their attitudes toward substance abusers through the use of audiovisual materials such as the Project CORK tapes (12,13). Videotapes, including many on current events, are used extensively (14). Each session begins with a general discussion called “This Week in Drug Abuse” in which the students present what they have learned that week from the mass media. Particularly lively discussions followed such events as John Tower’s physician telling the media that his patient did not have a drinking problem because his liver function tests were normal and Pete Rose’s gambling “addiction” being put forward as a defense against his ban from baseball. In addition, at each session the instructors pose a “Question of the Week” on a relevant substance-abuse issue.

Evaluation of the Substance-Abuse IAT

Attitudes about substance abusers seem to be a critical element in the physician’s approach to the evaluation, early diagnosis,
and treatment of such patients. In the IAT seminar we attempt to provide a non-judgmental forum for expression of these attitudes. For example, one major goal in the seminar is to present the idea that alcoholism and other drug dependencies are diseases seen by physicians in all fields of medicine and therefore all medical students should be knowledgeable about them. We hypothesized that the students’ exposure in the IAT to addicted/recovering patients, community recovery programs, 12-step meetings, and resource professionals would help them gain perspective on the breadth and depth of substance abuse, and that as they discussed these experiences students would integrate or discard prior negative stereotypes and attitudes.

METHODS

In order to assess the effect of this self-learning seminar on the beginning medical students’ attitudes, we administered the 50-item Substance Abuse Attitude Survey (SAAS), developed by Chappel and Veach at the University of Nevada-Reno (15), to the students at the beginning and end of each IAT seminar. The SAAS items deal with attitudes about various treatment, prevention/education, and law enforcement aspects of substance abuse. Items are listed in Table 1. The SAAS has been administered to a variety of populations, including medical students, physicians, and physicians in recovery (16).

Responses to each item were rated on a Likert scale on which 1 = strongly disagree, 2 = disagree, 3 = uncertain, 4 = agree, and 5 = strongly agree. The tests were administered to all medical students taking the substance-abuse IAT on the first (pretest) and last (posttest) sessions of each 8-week seminar from 1989 through 1991. The data analyzed included 141 sets of pretests and posttests, the total number available from the approximately 180 students who enrolled in the seminar during this time. (The SAAS data from the first three IAT seminars were lost.) Two-tailed t-tests were used to assess pre- to posttest shifts in the mean ranking on each SAAS attitude question. On questions that did not show such a shift, chi-square was used to measure changes in the distribution of scores on each item across subjects.

RESULTS

Fifteen of the 50 statements were found to show a significant \( P < 0.05 \) difference between mean pretest and posttest responses (Table 1), and the direction of these response shifts reflected the goals of the IAT seminar. For example, there was more student disagreement on the posttest that alcoholism is associated with a weak will (#11). A better understanding of the relapsing nature of the disease was indicated by significantly more student disagreement with the statement that a previous addict or alcoholic needs no further contact with a physician (#49). Similarly, there was more disagreement that a relapsed alcoholic cannot be treated (#40) and also more disagreement that most alcoholic and drug-dependent persons are unpleasant patients (#35).

Perhaps because of their exposure to patients as well as to resource professionals, students believed more strongly at posttest that lifelong abstinence is a necessary goal of recovery from alcoholism (#27) and that recovering substance abusers can never be social users (#37). They were also more likely to agree that group therapy (#34) and paraprofessional counselors (#38) are effective and important aids to recovery.

Students also disagreed on the posttest that angry confrontation is necessary (#17); this may have been in response to their participation in an intervention with a programmed patient actor. Perhaps because there is frequent discussion about role models, particularly in the opening segment of each session ("This Week in Drug Abuse"), there was significantly more agreement that
### TABLE 1. Comparison of Substance Abuse Attitude Survey items before and after interactive teaching seminar

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Mean Score</th>
<th></th>
<th>% Uncertain</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>$t^*$</td>
<td>$P$</td>
<td>Pre</td>
</tr>
<tr>
<td>1. Alcohol is an effective social relaxant.</td>
<td>3.3</td>
<td>3.3</td>
<td>0.22</td>
<td>13.5</td>
<td>10.6</td>
</tr>
<tr>
<td>2. Marijuana should be legalized.</td>
<td>2.2</td>
<td>2.0</td>
<td>1.59</td>
<td>24.1</td>
<td>14.2</td>
</tr>
<tr>
<td>3. Any drug can be safely used by a person who is mentally healthy.</td>
<td>1.6</td>
<td>1.6</td>
<td>-0.08</td>
<td>5.0</td>
<td>5.7</td>
</tr>
<tr>
<td>4. Almost anyone would turn to drugs if his/her problems were great enough.</td>
<td>1.9</td>
<td>2.2</td>
<td>-2.11</td>
<td>&lt;0.05</td>
<td>11.3</td>
</tr>
<tr>
<td>5. Alcohol is a food, not a drug.</td>
<td>1.4</td>
<td>1.3</td>
<td>2.36</td>
<td>&lt;0.05</td>
<td>2.1</td>
</tr>
<tr>
<td>6. Physicians are an important source of drugs for most users.</td>
<td>2.9</td>
<td>3.1</td>
<td>-1.35</td>
<td>29.1</td>
<td>18.4</td>
</tr>
<tr>
<td>7. Marijuana use leads to mental illness.</td>
<td>2.8</td>
<td>2.4</td>
<td>3.36</td>
<td>&lt;0.01</td>
<td>44.0</td>
</tr>
<tr>
<td>8. Heroin is so addicting that no one can really recover once he/she becomes an addict.</td>
<td>2.6</td>
<td>2.4</td>
<td>1.57</td>
<td>31.2</td>
<td>10.6</td>
</tr>
<tr>
<td>9. Smoking leads to marijuana use, which in turn leads to hard drugs.</td>
<td>2.1</td>
<td>2.4</td>
<td>-2.58</td>
<td>&lt;0.01</td>
<td>14.2</td>
</tr>
<tr>
<td>10. Clergymen should not drink in public.</td>
<td>2.8</td>
<td>3.3</td>
<td>-3.29</td>
<td>&lt;0.01</td>
<td>15.6</td>
</tr>
<tr>
<td>11. Alcoholism is associated with a weak will.</td>
<td>2.2</td>
<td>1.9</td>
<td>2.78</td>
<td>&lt;0.01</td>
<td>14.2</td>
</tr>
<tr>
<td>12. All heroin use leads to addiction.</td>
<td>2.9</td>
<td>3.0</td>
<td>-1.25</td>
<td>35.5</td>
<td>18.4</td>
</tr>
<tr>
<td>13. Daily use of one marijuana cigarette is not necessarily harmful.</td>
<td>2.5</td>
<td>2.5</td>
<td>-0.64</td>
<td>29.1</td>
<td>14.2</td>
</tr>
<tr>
<td>14. Physicians should not smoke tobacco in front of their patients.</td>
<td>4.2</td>
<td>4.4</td>
<td>-1.82</td>
<td>4.3</td>
<td>3.5</td>
</tr>
<tr>
<td>15. People who use marijuana usually do not respect authority.</td>
<td>2.4</td>
<td>2.3</td>
<td>0.66</td>
<td>21.3</td>
<td>21.3</td>
</tr>
<tr>
<td>16. The laws governing the use of marijuana and heroin should be the same.</td>
<td>2.8</td>
<td>2.7</td>
<td>0.27</td>
<td>20.6</td>
<td>14.9</td>
</tr>
<tr>
<td>17. Angry confrontation is necessary in the treatment of alcoholics or drug addicts.</td>
<td>2.2</td>
<td>1.9</td>
<td>3.03</td>
<td>&lt;0.01</td>
<td>20.6</td>
</tr>
<tr>
<td>18. Using any hard drug shortens one's life span.</td>
<td>3.7</td>
<td>3.5</td>
<td>1.55</td>
<td>29.8</td>
<td>24.1</td>
</tr>
<tr>
<td>19. Tobacco should not be smoked in the rooms where nonsmokers are present.</td>
<td>4.3</td>
<td>4.4</td>
<td>-0.83</td>
<td>2.8</td>
<td>1.4</td>
</tr>
<tr>
<td>20. Weekend users of drugs will progress to drug abuse.</td>
<td>2.9</td>
<td>3.0</td>
<td>-1.32</td>
<td>31.9</td>
<td>24.1</td>
</tr>
<tr>
<td>21. Tobacco smoking should be allowed in high schools.</td>
<td>1.7</td>
<td>1.7</td>
<td>-0.52</td>
<td>5.0</td>
<td>4.3</td>
</tr>
<tr>
<td>22. Anyone who is clean-shaven with short hair probably doesn't use illegal drugs.</td>
<td>1.3</td>
<td>1.3</td>
<td>0.00</td>
<td>0.7</td>
<td>1.4</td>
</tr>
<tr>
<td>23. Family involvement is a very important part of the treatment of alcoholism or drug addiction.</td>
<td>4.7</td>
<td>4.7</td>
<td>0.19</td>
<td>1.4</td>
<td>2.1</td>
</tr>
<tr>
<td>24. Alcohol is so dangerous that it could destroy the youth of our country if it weren't controlled by law.</td>
<td>3.1</td>
<td>3.3</td>
<td>-1.77</td>
<td>24.1</td>
<td>22.7</td>
</tr>
<tr>
<td>25. A physician who has been addicted to narcotics should not be allowed to practice medicine again.</td>
<td>2.2</td>
<td>2.2</td>
<td>0.20</td>
<td>12.8</td>
<td>9.2</td>
</tr>
<tr>
<td>26. Recreational drug use precedes drug abuse.</td>
<td>3.6</td>
<td>3.8</td>
<td>-2.02</td>
<td>&lt;0.05</td>
<td>15.6</td>
</tr>
<tr>
<td>27. Lifelong abstinence is a necessary goal in the treatment of alcoholism.</td>
<td>3.9</td>
<td>4.4</td>
<td>-3.88</td>
<td>&lt;0.01</td>
<td>14.9</td>
</tr>
<tr>
<td>28. Drug addiction is a treatable illness.</td>
<td>4.3</td>
<td>4.3</td>
<td>-0.93</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>29. Alcoholism is a treatable illness.</td>
<td>4.2</td>
<td>4.3</td>
<td>-1.54</td>
<td>6.4</td>
<td>3.5</td>
</tr>
</tbody>
</table>
TABLE 1. Comparison of Substance Abuse Attitude Survey items before and after interactive teaching seminar—continued

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Mean Score</th>
<th>Pre</th>
<th>Post</th>
<th>t</th>
<th>P</th>
<th>% Uncertain</th>
<th>Pre</th>
<th>Post</th>
<th>$\chi^2$</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. Street pushers are the initial source of drugs for young people.</td>
<td>2.6</td>
<td>2.4</td>
<td>0.98</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Personal use of drugs should be legal in the confines of one's own home.</td>
<td>2.3</td>
<td>2.3</td>
<td>-0.24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. People who dress in hippie-style clothing usually use psychedelic drugs.</td>
<td>1.9</td>
<td>1.8</td>
<td>0.38</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. A hospital is the best place to treat an alcoholic or drug addict.</td>
<td>2.4</td>
<td>2.3</td>
<td>1.35</td>
<td></td>
<td></td>
<td>29.8</td>
<td>14.9</td>
<td>11.96</td>
<td>&lt;0.05</td>
<td></td>
</tr>
<tr>
<td>34. Group therapy is very important in the treatment of alcoholism or drug addiction.</td>
<td>4.1</td>
<td>4.4</td>
<td>-2.90</td>
<td>&lt;0.01</td>
<td></td>
<td>10.6</td>
<td>3.5</td>
<td>17.16</td>
<td>&lt;0.01</td>
<td></td>
</tr>
<tr>
<td>35. Most alcohol- and drug-dependent persons are unpleasant to work with as patients.</td>
<td>2.7</td>
<td>2.4</td>
<td>2.54</td>
<td>&lt;0.05</td>
<td></td>
<td>40.4</td>
<td>27.7</td>
<td>9.55</td>
<td>&lt;0.05</td>
<td></td>
</tr>
<tr>
<td>36. It can be normal for a teenager to experiment with drugs.</td>
<td>3.7</td>
<td>3.6</td>
<td>1.03</td>
<td></td>
<td></td>
<td>11.3</td>
<td>9.9</td>
<td>2.37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Once a person becomes drug free through treatment, he/she can never become a social user.</td>
<td>3.4</td>
<td>3.9</td>
<td>-3.80</td>
<td>&lt;0.01</td>
<td></td>
<td>22.0</td>
<td>8.5</td>
<td>20.27</td>
<td>&lt;0.01</td>
<td></td>
</tr>
<tr>
<td>38. Paraprofessional counselors can provide effective treatment for alcohol or drug abusers.</td>
<td>3.8</td>
<td>4.1</td>
<td>-4.18</td>
<td>&lt;0.01</td>
<td></td>
<td>23.4</td>
<td>9.2</td>
<td>18.55</td>
<td>&lt;0.01</td>
<td></td>
</tr>
<tr>
<td>39. Long-term outpatient treatment is necessary for the treatment of drug addiction.</td>
<td>3.8</td>
<td>3.8</td>
<td>-0.07</td>
<td></td>
<td></td>
<td>22.7</td>
<td>7.8</td>
<td>31.12</td>
<td>&lt;0.01</td>
<td></td>
</tr>
<tr>
<td>40. An alcohol- or drug-dependent person who has relapsed several times probably cannot be treated.</td>
<td>2.2</td>
<td>2.0</td>
<td>2.05</td>
<td>&lt;0.05</td>
<td></td>
<td>17.0</td>
<td>10.6</td>
<td>7.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41. Marijuana use among teenagers can be healthy experimentation.</td>
<td>2.5</td>
<td>2.6</td>
<td>-0.42</td>
<td></td>
<td></td>
<td>19.9</td>
<td>17.7</td>
<td>6.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. Urine drug screening can be an important part of drug abuse treatment.</td>
<td>3.6</td>
<td>3.6</td>
<td>0.26</td>
<td></td>
<td></td>
<td>27.0</td>
<td>12.8</td>
<td>20.17</td>
<td>&lt;0.01</td>
<td></td>
</tr>
<tr>
<td>43. Physicians who diagnose alcoholism early improve the chance of treatment success.</td>
<td>4.0</td>
<td>4.2</td>
<td>-1.88</td>
<td></td>
<td></td>
<td>14.9</td>
<td>9.9</td>
<td>9.69</td>
<td>&lt;0.05</td>
<td></td>
</tr>
<tr>
<td>44. Alcohol and drug abusers should be treated only by specialists in that field.</td>
<td>3.0</td>
<td>2.9</td>
<td>0.35</td>
<td></td>
<td></td>
<td>25.5</td>
<td>13.5</td>
<td>10.47</td>
<td>&lt;0.05</td>
<td></td>
</tr>
<tr>
<td>45. The best way for a physician to treat an alcohol- or drug-dependent patient is to refer him/her to a good treatment program.</td>
<td>3.5</td>
<td>3.6</td>
<td>-1.07</td>
<td></td>
<td></td>
<td>29.1</td>
<td>18.4</td>
<td>7.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46. Persons convicted of sale of illicit drugs should not be eligible for parole.</td>
<td>2.7</td>
<td>2.7</td>
<td>-0.53</td>
<td></td>
<td></td>
<td>22.7</td>
<td>25.5</td>
<td>2.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>47. Chronic alcoholics who refuse treatment should be legally committed to long-term treatment.</td>
<td>2.7</td>
<td>2.7</td>
<td>-0.06</td>
<td></td>
<td></td>
<td>27.0</td>
<td>25.5</td>
<td>3.33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>48. An alcohol- or drug-dependent person cannot be helped until he/she has hit &quot;rock bottom.&quot;</td>
<td>2.1</td>
<td>2.0</td>
<td>1.67</td>
<td></td>
<td></td>
<td>15.6</td>
<td>6.4</td>
<td>9.31</td>
<td>&lt;0.05</td>
<td></td>
</tr>
<tr>
<td>49. Once an alcohol- or drug-dependent patient is abstinent and off all medication, no further contact with a physician is necessary.</td>
<td>1.8</td>
<td>1.6</td>
<td>2.09</td>
<td>&lt;0.05</td>
<td></td>
<td>6.4</td>
<td>2.1</td>
<td>7.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50. Parents should teach their children how to use alcohol.</td>
<td>3.3</td>
<td>3.5</td>
<td>-1.22</td>
<td></td>
<td></td>
<td>13.5</td>
<td>13.5</td>
<td>5.09</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*df = 280; **df = 4.0.
clergymen should not drink in public (#10). Students also increasingly saw alcohol as a drug (versus a food) (#5), believed that anyone could become drug dependent (#4), that smoking leads to marijuana and then to hard drug use (#9), that recreational drug use precedes drug abuse (#26), and that marijuana does not lead to mental illness (#7).

Each item was also analyzed with chi-square tests to measure changes between pre- and posttests in the distribution of responses (Table 1). Although most of the items that showed significant mean differences by t-test also had significant distribution changes by chi-square, 11 items showed a significant difference only in the chi-square test ($P < 0.05$), with no change in the mean response. For 10 of the latter, the principal change occurred in the number of “uncertain” responses. Students on the posttest had become more opinionated about substance abuse, changing their previous “uncertain” answers to either agreement or disagreement with an item without changing the mean response to that item.

Most responses with significant reductions in uncertainty involved items about treatment. For example, the IAT experience includes visits to a variety of community and hospital-based treatment centers for teenagers, adults, and the homeless. The number of “uncertain” responses dropped from 30% to 15% to item #33, “A hospital is the best place to treat an alcoholic or drug addict,” whereas the mean showed continuing posttest disagreement with the statement. Similarly, students showed less uncertainty in their responses regarding long-term outpatient therapy as a necessary part of treatment (#39), with most students continuing to agree with this statement.

**DISCUSSION**

Our study found that the substance-abuse IAT did change the attitudes of students on about one-third of the SAAS items and decreased students’ uncertainty about substance-abuse issues on several other items. However, some items that dealt directly with key issues did not show a change in mean score or response distribution following the IAT. Some of the desired attitudes were already in place when the medical students began the class. Because the students chose this class from a selection of up to 25 IAT seminars, it is possible that those choosing it were already sophisticated about substance abuse, as suggested by other studies that have used the SAAS to assess medical students’ attitudes (17). We would need further data to assess whether students who did not take the substance-abuse IAT seminar had different preexisting attitudes from those who did.

**Evaluations**

The students also evaluated in writing their own performance and the course at the end of the last session. These write-ups highlight some of the nonquantitative teaching aspects of the IAT seminar that we believe are worth sharing.

**Grades:** The students are always relieved when we announce that, although UCLA has a very competitive grading system, grades will not be a major emphasis in the IAT; they are told that by actively participating in class and making their site visits/reports/debates they will all receive “A”s. Typical student evaluation comments about this include: “Simply, a wonderful experience, made more enjoyable by the fact that there was no pressure for getting an ‘A’—something that’s quite unique at UCLA.”

**Handouts:** We hand out brief, relevant articles from the lay press to illustrate various points about substance abuse. We also distribute the Michigan Alcoholism Screening Test and the FOY and CAGE screening tests (acronyms are based on keywords in the questionnaires) as well as medical assessments of patients with drug problems. Stu-
students seem appreciative of these handouts, but some write evaluation comments like, "The handouts were fine; I hope to read them some day."

Audiovisuals: The audiovisual (VCR) segments are well regarded. Samples of the nearly uniformly favorable student comments include: "The incorporation of audiovisual 'shows' is a great teaching tool"; "Too few audiovisuals—I loved them." As an introduction to reports or debates, we show brief initial opening segments of some "Geraldo" episodes because they are so outrageously overstated. One student wrote that after the course "All the students now have a new addiction, to 'Geraldo'." Especially popular have been his segments on the impaired physician, drug legalization, "coca-ladies" (white upper-class users), steroids, drug lawyers, female drug smugglers, drugs in the workplace, drug education classes held in the morgue (for drunk drivers), and children who have turned in their parents for drugs. In contrast to "canned" educational tapes, these current-events videos stimulate lively discussions.

Reports, Debates, and Discussions: A valuable by-product of the students' presentations has been the development of their ability to self-critique and to organize their thoughts. Many students entering medical school have little experience in presenting a report or making a site visit; time is devoted in each IAT to how to do these tasks. A consistent theme in the students' self-evaluations is that the reports they had to prepare and present were among the most valuable experiences in this IAT: "The debates were great; when one is forced to argue an issue one learns as much as possible"; "I worked very hard [on the reports] but I learned so very much."

Students early suggested that we enforce a strict time limit of 7 to 10 minutes on their presentations so that they would not ramble, and the use of a timer has been an extremely effective learning tool. The most vivid example is one student whose report on the history of cocaine use and abuse was terminated by the timer when the student had just reached 1903, the year the Coca-Cola company removed cocaine from its drink.

The student-led discussions following their presentations are usually lively and well regarded. Student comments included: "Class discussion often got heated, and much was always learned"; "The discussions forced me to consider my own beliefs and what I would do in given situations—in just that, it was 'worth its weight' by prodding me to think"; "Provocative and informative at the same time"; "The mixture of presentations and discussions was fantastic."

The Need to Know: Students often want absolutes from the faculty—"What is the answer? Is alcoholism a disease? Is drug legalization desirable?", and so on. As moderators, we feel that silence is often important, but we do often help the students reach some closure on an issue by adding our opinions. For us to successfully walk this fine line involves a different, less directive teaching than that done in traditional lectures or seminars. However, there are pitfalls; one student wrote that the class and the instructors seemed too antidrug, making him too uncomfortable to share what he felt was positive about illegal drug use.

Students also often want to know what is happening with drug use in different cultures and in different countries. At UCLA we have a very diverse group of medical students, and it is fascinating to listen to them share the attitudes about drugs with which they have been raised and the drug practices in some of their countries of origin.

Humor: We emphasize humor, especially through the audiovisuals. Substance abuse is such a serious and often tragic subject that without some humor it can quickly become
overwhelming. Students liked this: "The audiovisuals added humor to some topics and expressed the seriousness of others."

**Actors:** The programmed-patient segment was introduced in the 1990-91 academic year. It has been particularly well received by the students because they like becoming actively involved in the role-play situations as interviewers taking a drug history and as concerned family members doing an "intervention." Student comments included: "The best segment of the course"; "[The actor] deserves an Academy Award"; "It's hard to believe he's an actor."

**The Personal Nature of the IAT:** Student comments about the milieu of and emotions generated by the IAT were unexpected: "I felt liked"; "Makes you feel like they care about what you're doing"; "They were interested in the students"; "I became too emotional during my debate and my 12-step report, but I learned so much"; "We are constantly being told that by the end of the year we won't care about people as much as about diseases; maybe if we have [more] classes like these we won't change."

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**The Negative Side**

There are "negatives" in teaching this course: the issue of burnout of the resource professionals and recovery teachers is all too real. These volunteers are usually very enthusiastic; however, most are busy practitioners, and careful coordination of effort is needed to ensure that we do not overuse the same people. The IAT is a very labor-intensive way to teach students, and teacher resources for this course are also crucial. To keep the recovery teachers and resource professionals actively involved, we solicit extensive evaluation comments from the students about each of them, and we send the applicable comments to each individual teacher. These comments are usually favorable, and students often describe the resource professionals and recovery teachers as role models.

The administrative complexities involved for the students, with their busy classroom schedules, in linking up with the resource professionals in the field are considerable. Students frequently have difficulty reaching the resource personnel far enough in advance; they then often wait until the last minute to meet with the resource professional as their report time approaches. We try vigorously, but not always successfully, to encourage the students to schedule their site visits and meetings well in advance.

In an attempt to meet the student demand for the course, we have tried to run two courses simultaneously, one for the freshmen and one for the sophomores. However, this has caused major logistical problems for us, and we are now experimenting with different ways to meet this demand. We feel strongly that this initial substance-abuse teaching should occur early in training, during the basic science years, before exposure to faculty and house staff with negative attitudes toward these difficult, provocative, and often manipulative patients.

In summary, the IAT seminar on substance abuse has been an exciting learning experience for students and faculty alike. We would like to present the course to all medical students, as well as be able to respond to requests to expand and adapt the model to other departments within the medical center. We are interested in emphasizing the issue of medical students' well-being in general, and especially prevention/education about student impairment from substance abuse.

Other goals for the future include the following:

1. Sharing our expertise with other medical schools and assisting them with the development of similar programs.
2. Developing a relevant substance-abuse curriculum over the four years of medical training that continues to empha-
size attitudes about, as well as knowledge of, substance abuse.
3. Stimulating interest in addiction medicine so that, regardless of advanced specialty training, physicians will continue to develop an awareness of substance abuse as a concomitant condition in the patients they treat. This will likely involve retraining for both house staff and faculty.

References
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9. Moses H: Johns Hopkins Hospital is first to start random drug testing of M.D.’s. American Medical News, February 23, 1989
Book Forum

Seymour L. Halleck, M.D.
Editor

Psychotropic Drugs: Fast Facts
By Jerrold S. Maxmen, M.D.
New York, Norton Professional Books
$19.95, 304 pages

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Dr. Bakewell is a professor in the Department of Psychiatry, University of North Carolina School of Medicine.

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New York, Praeger
$47.95, 221 pages

Reviewed by Jill J. Rowan, Ph.D.

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**Handbook of Family Therapy, Volume 2**
Edited by Alan S. Gurman, Ph.D., and David P. Kniskern, Psy.D.
$65.00, 715 pages

*Reviewed by Andrew Kent, M.D.*

This volume describes and discusses the development and practice of various models of family therapy. It is a well-written and comprehensive reference that offers the reader a clear presentation of the dominant conceptual and clinical influences on the field of family therapy. In addition, it provides practical applications of these therapeutic models to specific clinical issues such as sexual dysfunction and divorce. I would recommend it to those who seek to update their knowledge.

**Solving Problems in Couples and Family Therapy: Techniques and Tactics**
By Robert Sherman, Ed.D., Paul Oresky, M.S., A.C.M.F.D., and Yvonne Rountree, Ph.D.
$38.50, 339 pages

*Reviewed by Lloyd Price, M.D.*

In this rather condensed volume, the authors offer a conceptual framework for treatment as well as an abundance of techniques and tactics for addressing many common problems and issues that confront the therapist working with couples and families. The book is well written, although somewhat “overindexed.” Its techniques are both useful and innovative, although the section on physical and sexual abuse fails to present accurately one’s obligation to report suspected child abuse. This work would be useful for the experienced therapist seeking to expand his or her knowledge of strategies and techniques in this complex area.
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Educational Abstracts

Dorthea Juul, Ph.D.
Abstract Editor


Weinholtz and his colleagues report on two studies of clinical teaching by attending physicians. In the first they looked for relationships between specific behaviors and student ratings of teaching effectiveness, and in the second they conducted an experiment to determine whether feedback affected teaching style.

In the earlier study, 41 attending physicians, all of whom were interns, were observed for 4 to 5 days each during their attending rounds, which usually lasted 1½ to 3 hours. Trained raters recorded the amount of time spent on making didactic (prepared) presentations, asking probing questions, illustrative teaching (e.g., using chalkboard, X-ray viewer), talking with patients, examination of patients by attending or other team members, patient presentations and discussion, and listening during presentations and discussions. Team members—medical students, interns, and residents—rated various aspects of the attendings’ teaching performance, including an overall rating of effectiveness.

Correlation analyses indicated that the different groups of learners had somewhat different views about what was effective teaching and that some behaviors were rated positively in one setting but not in another. For example, asking probing questions was positively correlated with several ratings by medical students and residents when it occurred in conference rooms but correlated negatively when it happened in the hallway or in front of patients.

Despite these variations, the authors conclude that increasing the amount of time devoted to didactic presentations, asking probing questions, and illustrative teaching would improve ratings of teaching effectiveness. They also suggest that time spent teaching in the hallway should be minimized and that time spent at the bedside is likely to be viewed positively only if specific physical findings are emphasized and students are not quizzed in front of patients. Team members also did not like the attendings to spend too much time listening or to give negative evaluations publicly.

In the second study, 25 internists were observed for 1 week by trained raters who recorded amount of time allocated to 9 teaching behaviors. A teaching effectiveness rating form was filled out by the medical students, interns, and residents on the ward teams.

The 13 attendings who were randomly assigned to the intervention group then met individually with an instructional consultant, who reviewed the observations and rating data and made 1 to 5 specific recommendations for changes in teaching. Both the
intervention and control groups were observed again for a second week and rated by team members.

More of the physicians in the intervention group than in the control group increased the percentage of time allocated to the behaviors targeted by the consultation. However, there were no differences between the learners' ratings for the intervention and control groups, and the ratings for both groups improved between the first and second observations. The attending physicians felt that participating in the study had been valuable.

The authors conclude that although this instructional intervention led to changes in behavior, this did not affect learners' ratings of teaching effectiveness. They suggest that larger scale studies are needed to fully explore clinical teaching.

Edwards JC, Kissling GE, Plauche WC, Marier RL: Evaluation of a teaching skills improvement program for residents, in Research in Medical Education: Proceedings of the Twenty-Sixth Annual Conference. Washington, DC, Association of American Medical Colleges, 1987, pp. 89-95


Edwards and her colleagues also focused on teaching skills, but they were interested in residents rather than attendings. The first study presents data collected to evaluate a half-day workshop on teaching skills. Over a 4-year period, 145 first-year residents from 13 specialties participated. There were a few residents who were unable to attend and served as a control group.

Residents rated their teaching skills before and 3 to 4 months after the workshop. Medical students rated the residents at the end of each third-year clerkship throughout the 4-year period, and these ratings were divided into pre- and post-workshop ratings.

Residents rated their teaching skills significantly higher after the workshop than before, and medical students rated those residents who had attended significantly higher than those who had not on knowledge, organization, demonstration of skills, and overall teaching effectiveness.

The authors conclude that the teaching-skills workshop for residents was effective, and they suggest that improved teaching skills will facilitate the residents' own learning and serve them well in their future careers as well as increase the satisfaction, and hence cooperation, of medical students in patient-care activities.

In the second study, which was designed to determine the effectiveness of a program to improve teaching skills, 18 house staff in medicine, family medicine, and obstetrics-gynecology participated. The experimental group (n = 12) received instruction, critique, and feedback about their teaching skills during the first 2 years of residency. The teaching behaviors of interest were communicating objectives, directing case presentations, formulating differential diagnoses, expanding the case, managing the case, giving feedback, improving the learning climate, and demonstrating good overall teaching.

Both the experimental and control groups were evaluated three times: in the first year, before the instructional program; in the second year, during the instructional program; and in the third year, 6 months after the instructional program. On each occasion, trained raters evaluated videotaped teaching performances.

Before instruction, there were no significant differences between the experimental and control groups. During instruction, the
treatment group was rated significantly better on differential diagnosis, expanding the case, and overall teaching quality. After instruction, the only significant difference between the two groups was on communicating objectives.

The authors conclude that although the instructional program was effective in the short run, the residents' teaching skills declined after the program ended, suggesting the need for ongoing reinforcement to maintain these skills.

**Stritter FT, Bland CJ, Youngblood PL:** Determining essential faculty competencies. Teaching and Learning in Medicine 1991; 3:232-238

Stritter, Bland, and Youngblood report on a study to identify nonclinical competencies necessary for success in academic family medicine. A task-analysis strategy was used in which exemplar faculty rated competencies derived from a review of the literature in family medicine, general medical education, and general higher education.

The exemplar faculty were identified by medical education directors in schools of medicine and by department chairs and residency program directors in family medicine. Seventy-four tenure-track and 91 non-tenure-track family medical faculty and 55 family medicine preceptors participated, along with 56 tenure-track faculty from other primary-care specialties (e.g., internal medicine, pediatrics).

These four groups of faculty rated 211 competencies on the basis of how essential they were for success in faculty roles in their setting. The competencies were divided among five categories: research, teaching, administration, writing, and professional academic skills.

The majority of competencies were considered highly desirable or essential by all four faculty groups, although there were some differences among the faculty types. Although teaching and writing were rated high by all groups, the tenure-track faculty rated the research competencies higher than did those not in the tenure track. The physicians from other primary-care specialties rated administration lower than those in family medicine did, and academic skills were rated lower by the preceptors than by the other three groups.

The authors conclude that similar skills are considered important for faculty within and outside family medicine and suggest that these competencies can provide objectives for faculty development programs, which may need to be tailored to the needs and interests of different types of faculty.
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