Academic Psychiatry

Salutes the

1993 AAP/
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We look forward to their active participation in the AAP Annual Meeting to be held March 10–13, 1993, at the Hawthorn Suites Hotel, Charleston, South Carolina; their ongoing commitment to the pursuit of excellence in psychiatric education; and their future involvement in AAP.
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EDITORIAL

1  A Time of Transition
   Jonathan F. Borus, M.D., William H. Sledge, M.D.

SPECIAL ARTICLES

3  Teaching and Learning Psychiatry
   Jonathan F. Borus, M.D.

12  Order and Chaos: Subspecialization and American Psychiatry
    James H. Shore, M.D.

REGULAR ARTICLES

21  Learning Priorities of Staff, Residents, and Students for a Third-Year Psychiatric Clerkship
    Peggy E. Chatham-Showalter, M.D., Edward K. Silberman, M.D.,
    Robert E. Hales, M.D.

26  The Role and Function of Residents' Organizations in Psychiatry Education
    James Lock, M.D., Ph.D., Brian Kleis, M.D., Thomas Strouse, M.D.,
    Sandra Jacobson, M.D., Joel Yager, M.D., Mark Servis, M.D.

32  Medication Backup in Psychiatry Residency Programs
    Michelle Riba, M.D., Richard Seth Goldberg, M.D., Allan Tasman, M.D.

NEW IDEA

36  Teaching Consultation Psychiatry Through Computerized Case Simulation
    John S. Jachna, M.D., Seth M. Powsner, M.D., Patrick J. McIntyre,
    Robert Byck, M.D.

Q AND A

43  Frequently Asked Questions About the American Board of Psychiatry and Neurology
    Stephen C. Scheiber, M.D.
BOOK FORUM

45  Shame and Pride: Affect, Sex and the Birth of the Self, by Donald L. Nathanson  
    Reviewed by Craig L. Donnelly, M.D.

    Reviewed by Thomas J. Oglesby, M.D.

47  To Paint the Stars: The Life and Mind of Vincent van Gogh (videotape)  
    Reviewed by Rif S. El-Mallakh, M.D.

48  Paradox and the Family System, by Camillo Lorieda, M.D., and Gaspare Vella, M.D.  
    Reviewed by Stephen H. Dinwiddie, M.D.

48  Existential-Dialectical Marital Therapy: Breaking the Secret Code of Marriage,  
    by Israel W. Charny, Ph.D.  
    Reviewed by Michael F. Cleary, M.D.

48  The Chemically Dependent: Phases of Treatment and Recovery, edited by  
    Barbara C. Wallace, Ph.D.  
    Reviewed by Philip B. Dooskin, M.D.

48  The Human Dimension of Depression: A Practical Guide to Diagnosis,  
    Understanding, and Treatment, by Martin Kantor, M.D.  
    Reviewed by Brian Ladds, M.D.

EDUCATIONAL ABSTRACTS

Abstracted by Dorthea Juul, Ph.D.

49  Self-assessment programs and their implications for health professions training

49  Educating Medical Students: Assessing Change in Medical Education—The Road to  
    Implementation (ACME-TRI)

50  Teaching and evaluation of physical examination skills on the surgical clerkship

51  Does competence of general practitioners predict their performance? Comparison  
    between examination setting and actual practice
LETTERS

52 The Journal Club in Psychiatric Residency Training
   Ole J. Thienhaus, M.D., Lawson R. Wulsin, M.D.

53 Recruitment for Psychiatric Residency
   Richard Balon, M.D.

54 In Reply
   Jerald Kay, M.D., David Bienenfeld, M.D.

ANNOUNCEMENTS

55 Correction to Figure 1, Winter 1992 issue, page 181

56 Psychiatric Education at the APA Meeting

58 Information for Contributors
Editorial

A Time of Transition

Jonathan F. Borus, M.D.
William H. Sledge, M.D.

The beginning of volume 17 marks a major leadership transition for the journal. Dr. William H. Sledge, who has been deputy editor during the journal's formative first four years as Academic Psychiatry, has completed his term, and Dr. Phillip R. Slavney, Professor of Psychiatry and Director for Psychiatric Education at Johns Hopkins, with this issue has assumed the role of deputy editor. I'm delighted to welcome Phillip and look forward to working collaboratively with him to continue improving the journal.

Will Sledge, Professor and Vice Chairman for Education in the Department of Psychiatry at Yale, has played a critical role in the rejuvenation of Academic Psychiatry. A full partner in the leadership team, he has worked closely with me on all journal policies and innovations over the last four years. As former president of the American Association of Directors of Psychiatric Residency Training, he has a broad knowledge of psychiatric education that has added immeasurable depth to this journal's efforts. His detailed reviews and integrative comments to authors have been crucial in shaping many of the articles we have published. He also took the lead in organizing our expert reviewer panel and in working with Dr. Juul to develop the Educational Abstracts section.

Will's wit, keen intelligence, hard work, and wisdom will be sorely missed in the day-to-day workings of the journal. I am consoled by the knowledge that he will remain a member of the Academic Psychiatry family as a reviewer and advisor to the journal. I wish to express my indebtedness and that of the psychiatric education community to Will for his contributions to the development of Academic Psychiatry. —J.F.B.

Parting is such sweet sorrow, according to a well-known lover who was accused of being overcommitted. And so it is with me now as I bid farewell to my duties as deputy editor of Academic Psychiatry. In contrast to Juliet's anxious farewell, however, I hope mine will benefit all concerned. I joined Jon Borus in this noble venture in a time of duress and uncertainty almost four years ago. There was no chance to reflect or to consider if the job made sense or if the resources were appropriate or even if it was something that we wanted to do. It was a job that had to be done and we did it. Working with Jon and the APPI Journals staff has been a grand time for me, and I want to pay homage to them and their generosity and expertise.

Dr. Borus is editor and Dr. Sledge is former deputy editor of Academic Psychiatry. Copyright © 1993 Academic Psychiatry.
Being associated with this group was a fine learning experience and one that I enjoyed immensely. However, with the untimely death of my secretary, who was enormously skilled and herself devoted to the enterprise of Academic Psychiatry, and the budget constraints that made it impossible to replace her, it became clear to me that I would not be able to give the editorial task the attention and time necessary to hold up my end of the effort to continue the trajectory of excellence the journal has established. Happily, the governing bodies of Academic Psychiatry accepted our recommendation of Phillip Slavney, M.D., as my replacement. Phillip has been a particularly sensitive reviewer who possesses the literary and editing skills to raise the journal’s standards even higher. With him in place, I can move on with ease.

But before I am done with the last manuscript, I want to acknowledge those who made this work fulfilling and interesting. First, I want to thank the authors who bravely and with trust (mostly) sent the products of their minds to us for review and comment, especially those who persisted in the face of some substantial requirements that we placed on them. The authors are the backbone of any journal and must be nurtured and supported both to keep the copy coming and to continue to develop their writing skills. If the authors are the backbone, the reviewers are our arms and legs, for the journal will go nowhere without an effective peer review process. Editors can do only so much; the expertise, standards, and feedback of the peer review panel are the limits and opportunities of the intellectual potential of any scholarly journal. It is my experience that peer review in many psychiatric journals is a casual and unenlightening process. I am pleased and proud of the “teaching reviews” that most of our peer reviewers have given us over the last four years. I want to thank the Academic Psychiatry governing bodies that allowed me to do this job, and I want to express my appreciation for the good will and professionalism of the APPI staff. And finally, I want to remind the readers of what a treasure we have in Jon Borus, who devotes enormous effort and expertise to an enterprise whose participants do not always know and appreciate that effort and the results forthcoming from it.

So as I leave this post, I call upon my fellow readers to reflect upon the elements of this journal and its success and to consider ways in which we can all help the process be even more effective by supporting more demonstratively those who make it happen and by doing more ourselves to make it happen even better. The help we can provide is to write more and encourage others to write, do comprehensive and timely reviews, get libraries to subscribe, and find ways to express appreciation. Farewell and thanks.

—W.H.S.
Order and Chaos

Subspecialization and American Psychiatry

James H. Shore, M.D.

Psychiatric subspecialties have emerged rapidly during the past decade. This article discusses significant influences in nonpsychiatric medicine and psychiatry that led to these developments. The process for new subspecialty recognition, certification, and accreditation is outlined. The status of the major psychiatric subspecialties is reviewed. The impact of the changing recruitment into psychiatry is discussed for subspecialization, the psychiatric generalist, and psychiatric educational resources.

The 1980s were a remarkable decade in American psychiatry, with increasing pressure from many sources toward subspecialization. The revolution in neuroscience and the knowledge explosion in psychiatry and nonpsychiatric medicine propelled the field toward an ever-increasing subspecialty focus. New aspects of practice have developed with increased competition, including interdisciplinary competition, economic incentives with the growth of proprietary hospitals, managed care, and multiplying certification opportunities. In an effort to improve the quality of postgraduate education, many national groups advocate increasing specificity of psychiatric residency curricula, reinforcing the trend toward subspecialization. Also, economic pressures on medical students, primarily indebtedness, contribute to subspecialization because the highest reimbursement in American medicine is received by physicians who are most specialized and technically oriented. Finally, pressures from the federal government, state licensing boards, and hospital credentialing committees contribute to an increasing specificity of practice with an expectation of certification and recertification throughout professional life.

MEDICAL SPECIALIZATION

The debate on specialization in American medicine began in the nineteenth century and was noted by Storer (1) in his 1866 address as president of the American Medical Association. Storer expressed alarm over the implications of specialization:

A growing disposition is apparent in a portion of the profession to direct their undivided attention to some one department, to the exclusion of others; to confine their researches to the derangements of one organ or system of organs; to stand aloof from the rest of their brethren; to disclaim the title of general practitioner, and to assume that of specialist . . .

So many ungentlemanly, unwarrantable means are not unfrequently employed by the unscrupulous specialist to advance personal ends, that many physicians, utterly disgusted, will not for a moment listen to any reference which may be made to this

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subject: their track has been crossed, they feel aggrieved. (pp. 56, 57)

However, in the conclusion of his address Storer also discussed advantages of specialization, with obstetrics as his example:

Thus the obstetrical societies existing in our larger cities are unquestionably producing a most desirable influence upon this branch of the profession, not merely by collecting and publishing the numerous important cases which from time to time occur, but by bringing together gentlemen possessing similar tastes, pursuing the same studies, anxious to accomplish the same end—the elevation and advancement of their favorite pursuit. (p. 64)

In the mid-nineteenth century, the AMA recognized a trend toward specialization by organizing the presentation of articles at its annual meetings into specialty areas. Six sections were presented at the 1859 annual meeting: 1) anatomy and physiology; 2) chemistry and materia medica; 3) practical medicine and obstetrics; 4) surgery; 5) meteorology, medical topography, and epidemic diseases; and 6) medical jurisprudence and hygiene (2). These six groups included both basic science and clinical medicine, with the emergence of practical medicine, obstetrics, and surgery as clinical specialties. Psychiatry’s place in the AMA was yet to be defined.

One of the earliest modern specialties was ophthalmology. The development of modern ophthalmology is of special interest because, like much of twentieth-century medicine, it originated in a technological development: the invention of the opthalmoscope by Helmholtz in 1850. Advances in the field led to the creation of the American Ophthalmological Society in 1864. In 1917 the ophthalmologists founded the first group of the American Board of Medical Specialties (ABMS), called the American Board of Ophthalmic Examinations (2). In 1844 the medical administrators of the public asylums had founded the Association of Medical Superintendents. This group eventually became the American Psychiatric Association. Almost a century later, in 1935, psychiatric leaders founded the American Board of Psychiatry and Neurology (ABPN), the fifth member of the ABMS.

Starr (3) outlines three structural factors that contributed heavily to the growth of specialization in American medicine. First, he notes that the system for certifying medical specialists that developed in the 1930s did not include regulation of the size or distribution of those specialties, which is still true today. Second, the affiliation of physicians with expanded hospitals during World War II was a strong incentive to set up training programs for specialists. This created more openings for specialty training than there were American medical graduates to fill them. The third factor was government subsidies. Health insurance created high returns for specialty practice. There was no provision within the system for reducing specialists’ income as their numbers grew; thus, the expanded programs continued to be a strong incentive for physicians to undertake specialty training.

There were additional incentives toward specialization. In World War II, specialists received a higher rank, and after the War the Department of Veterans Affairs created salary incentives for certified specialists. Residents in the new specialties were used to expand the hospital work force and performed many clinical services and on-call backup. A strong trend developed for the specialist to receive a higher income that was linked to improved insurance coverage for hospital treatment vs. ambulatory care. Specialization was influenced by larger medical school facilities and larger graduating classes with an accompanying growth in graduate medical education programs. Total residency positions increased from 5,000 in 1940 to 12,000 in 1947 and from 25,000 in 1955 to 90,000 in 1990.

The ABMS is organized medicine’s central authority for all officially recognized
specialties and their boards. It is composed of 23 member boards including the ABPN (4). Table 1 lists the boards, founding dates, special (subspecialty) certificates, and type of examination (5). There are 24 areas of general certification and 62 subspecialty certificates. In addition, in 1988 the Office of Technology Assessment reported a total of 70 independent medical boards not affiliated with the ABMS. Whereas the ABMS certifies 64% of physicians practicing in the United States, the number certified by these independent boards is much smaller (6). According to the Association of American Medical Colleges, 97% of current graduates plan at least 3-7 years in graduate medical education training and intend to become certified. Within the last decade the number of certified psychiatrists has risen dramatically and is reported to be approximately 70% (7). In addition, since 1989 the ABPN has added geriatric and addiction psychiatry plus clinical neurophysiology as new psychiatric subspecialties. A proposal for forensic psychiatry is under review by the ABMS.

THE PSYCHIATRIC SUBSPECIALIZATION PROCESS

There are several national organizations that play a crucial role in the subspecialization process (8). These are the American Psychiatric Association (APA), the ABPN with the ABMS, the Psychiatry Residency Review Committee (RRC) with the Accreditation Council for Graduate Medical Education.

<table>
<thead>
<tr>
<th>Board</th>
<th>Founding Dates</th>
<th>Special Certificates</th>
<th>Written Exam</th>
<th>Oral Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy and immunology</td>
<td>1971</td>
<td>1</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>1941</td>
<td>2</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Colon and rectal surgery</td>
<td>1949</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Dermatology</td>
<td>1932</td>
<td>2</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>1979</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Family practice</td>
<td>1969</td>
<td>2</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>1936</td>
<td>13</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Neurological surgery</td>
<td>1940</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Nuclear medicine</td>
<td>1971</td>
<td>—</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Obstetrics/gynecology</td>
<td>1930</td>
<td>4</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1917</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>1935</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>1924</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pathology</td>
<td>1936</td>
<td>11</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1933</td>
<td>13</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Physical medicine and rehabilitation</td>
<td>1947</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>1941</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventive medicine</td>
<td>1949</td>
<td>1</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Psychiatry and neurology</td>
<td>1935</td>
<td>3 (6)*</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Radiology</td>
<td>1935</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Surgery</td>
<td>1937</td>
<td>5</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Thoracic surgery</td>
<td>1970</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Urology</td>
<td>1935</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Current and pending American Board of Psychiatry and Neurology special certificates: current = child and adolescent psychiatry, geriatric psychiatry, clinical neurophysiology; pending = addiction psychiatry, forensic psychiatry, child neurology.
(ACGME), and the relevant subspecialty societies. A general process has developed in psychiatry that leads to the formal identification of a new psychiatric subspecialty. This process begins when a subspecialty society makes a proposal to receive formal subspecialty recognition from the APA. The APA Commission on Subspecialization is psychiatry's starting point for consideration of initial proposals. If the APA review leads to approval, the ABPN and ABMS are then requested to evaluate the subspecialty and develop a certification process. Finally, the ACGME has its Psychiatry RRC develop and ratify the special training requirements for accreditation of subspecialty education programs.

For subspecialty recognition the ABMS requires documentation of the professional and scientific status of the special field with four guidelines (5):

1. A body of scientific medical knowledge underlying the area that is in large part distinct from, or more detailed than, that of other areas in which certification is offered.
2. A group of physicians concentrating their practice in the proposed area.
3. National societies, the principal interest of which is in the proposed area.
4. Identification of medical school and hospital departments, divisions, or other units in which the principal educational effort is devoted to the area proposed for special certification.

Through the ABMS, certification can be granted to a subspecialty for either "special" or "added" qualifications. An ABMS member board may issue certificates to designate special qualifications in selected areas of the specialty field represented by that board and to reflect that a candidate has completed full-time, formal, postresidency training. A certification of special qualifications is intended to apply primarily to diplomates of a primary board who have completed 2 additional years of postresidency subspecialty training. Child and adolescent psychiatry is an example of a subspecialty granted special qualifications. Boards may accept for examination and special certification applicants other than their own diplomates if they qualify. A certification of added qualifications is an addition to the primary specialty certificate to reflect that a candidate has completed additional full-time, formal, postresidency training of 1 year. There are several distinctions between special qualifications and added qualifications. For special qualifications, diplomates from other boards may qualify to sit for such an examination. For added qualifications, only diplomates of that board qualify to sit for that examination. For recertification, diplomates with special qualifications for a subspecialty are not required to maintain certification in the primary specialty to retain their special qualification status. However, those diplomates with time-limited added qualification certificates who fail to be recertified in their primary specialty lose their added qualifications certification status when their primary certificate expires.

At the next stage of development the ACGME requires six criteria (9) for subspecialty training accreditation:

1. The subspecialty area must have evolved to the extent that the projected number of programs to be accredited will be sufficient to ensure that accreditation is a cost-effective method of quality control. Normally, applications from at least 25 programs should be anticipated.
2. The programs must be for training in a clinical field, not just in one or more techniques.
3. The duration of training must be a minimum of 1 full-time year or its equivalent devoted to clinical rotations. Research should be encouraged but may not be a major emphasis in the year of clinical training.
4. A clear and detailed explanation of how the accreditation of training programs in the subspecialty area will affect programs of the primary specialty must be provided. Potential impact on other disciplines should also be clarified.

5. Documentation must be provided of communication between the RRC and the relevant board concerning the subspecialty area. This documentation must clearly indicate the board’s recommendation concerning the subspecialty.

6. A detailed justification/impact statement is required.

There is now a projected timetable for the subspecialty approval of geriatric, addiction, and forensic psychiatry through these review processes. The timetable is outlined in Table 2 and includes the required steps of subspecialty recognition by the APA, certification by the ABPN and ABMS, and training accreditation by the ACGME and its Psychiatry RRC. Child psychiatry has been recognized by the ABPN since 1959 for special qualifications. In 1989, geriatric psychiatry was given APA approval for added qualifications with ABPN and ABMS approval following in 1989 and 1990, respectively. The first geriatric psychiatry certification examination was given in 1991. In 1990 addiction psychiatry was recognized by the APA. The ABPN proposal for addiction psychiatry was approved by the ABPN and ABMS in 1991. Forensic psychiatry was approved by the APA and ABPN in 1991 with an application to ABMS pending. In addition, clinical neurophysiology (10) was given ABPN and ABMS approval in 1990 for subspecialty recognition; both neurologists and psychiatrists are eligible if they qualify with appropriate training and practice experience.

Advantages and disadvantages of psychiatric subspecialization have been widely debated and are outlined in Table 3. Yager and Langsley (11) have presented a similar list of subspecialization influences and have strongly supported greater subspecialization within psychiatry (12,13). In addition, they proposed five ways of categorizing subspecialization, including functional subspecialization, employer subspecialization, treatment site subspecialization, knowledge/treatment/procedure subspecialization, and patient subspecialization.

Various classifications of psychiatric subspecialists have included lists from 10 to 100 subspecialties. Table 4 lists 10 subspecialties, drawn largely from the Directory of Psychiatry Residency Training Programs (14), that include the subspecialization areas of addictions, administrative/community psychiatry, child and adolescent psychiatry, clinical neurophysiology, consultation-liaison psychiatry, forensic psychiatry, geriatric psychiatry, psychoanalysis, psychopharmacology, and psychiatric research. For each of these subspecialties the current

<table>
<thead>
<tr>
<th>TABLE 2</th>
<th>Psychiatry subspecialty approval timetable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>APA</td>
</tr>
</tbody>
</table>

Note: APA = American Psychiatric Association; ABPN = American Board of Psychiatry and Neurology; ABMS = American Board of Medical Specialties; ACGME/RRC = Accreditation Council for Graduate Medical Education/Psychiatry Residency Review Committee.

<table>
<thead>
<tr>
<th>TABLE 3</th>
<th>Influences of psychiatric subspecialization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantages</td>
<td>Improved patient care</td>
</tr>
<tr>
<td></td>
<td>Increased knowledge base</td>
</tr>
<tr>
<td></td>
<td>Improved residency education</td>
</tr>
<tr>
<td></td>
<td>Improved subspecialist competitiveness</td>
</tr>
<tr>
<td>Disadvantages</td>
<td>Fragmentation of patient care</td>
</tr>
<tr>
<td></td>
<td>Fragmentation of general psychiatry</td>
</tr>
<tr>
<td></td>
<td>Limitations of practice privileges</td>
</tr>
<tr>
<td></td>
<td>Diminished importance of the generalist</td>
</tr>
</tbody>
</table>
or potential sponsor of the certification examination, the accreditation process for training programs, and the number of training programs currently listed in the directory is designated.

NEWLY APPROVED PSYCHIATRIC SUBSPECIALTIES

Geriatric Psychiatry

A recent survey about geriatric psychiatry conducted by the APA identified approximately 2,000 members who considered geriatrics to be their primary subspecialty. In addition to the 2,000 psychiatrists who considered themselves primarily geriatric psychiatrists, approximately 5,000 stated that they were "very interested" in working with the elderly. There are 45 listed postresidency geriatric psychiatry training programs that in aggregate enroll 30–50 trainees annually with fellowship stipends ranging from $24,000 to $36,000 per year. The first ABPN certification examination for added qualifications in geriatric psychiatry was administered in the spring of 1991. A total of 660 candidates took the exam; 490 were certified for a 74% pass rate. For a 5-year interval from 1991 to 1996, applicants for the added qualifications certification examination will meet eligibility requirements through a grandfathering rule. To qualify they must devote at least 25% of practice to the subspecialty. After 1996, candidates must have completed a 1-year, ACGME-approved geriatric psychiatric training program. The requirement for accredited training, after the 5-year grandfather interval, completes the process of subspecialty recognition for geriatric psychiatry.

Addiction Psychiatry

In an APA membership survey, Miller and Frances (15) reported that 4,600 psychiatrists chose addiction disorders as an area of interest. This group was sent a follow-up survey to which 1,705 (37%) responded. Ten percent of these psychiatrists indicated that they spend more than 70% of practice time with substance abusers. Sixteen percent spend 31%–70% and 74% spend 30% or less of this practice time with substance abusers. The most common factor cited for their interest in alcoholism and drug abuse was patient and community needs (82%); the second was training (41%). However, life

<table>
<thead>
<tr>
<th>TABLE 4. Subspecialties of psychiatry</th>
</tr>
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<td>Subspecialty</td>
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<td>Research</td>
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Note: ABPN = American Board of Psychiatry and Neurology; APA = American Psychiatric Association; RRC = Psychiatry Residency Review Committee; APsaA = American Psychoanalytic Association.


\(^b^{American Board of Medical Specialties approval pending.}
events and practical experience were listed as the most common categories of training (75%), apparently from job experience and/or the "college of hard knocks." Forty percent reported active teaching about addictions during residency, and 36% reported a residency rotation on a substance abuse service. There are 25 training programs in addiction psychiatry involving approximately 60 trainees with an average annual stipend of $39,000.

Forensic Psychiatry

Certification in forensic psychiatry had been independently established by the American Board of Forensic Psychiatry. In the past decade, this independent board certified over 225 diplomates with a combined written and oral examination. The American Academy of Law and Psychiatry, in conjunction with the American Academy of Forensic Sciences, established an independent accreditation council of forensic psychiatry fellowship programs. In 1989, this council accredited the first 10 programs for 1 year of postresidency fellowship. There are currently 45-50 positions available in 28 forensic fellowship programs with accreditation outside of the ACGME. In 1990, 32 positions were filled with a range in annual stipends from $22,000 to $68,000. In 1990, these independent forensic subspecialty societies formally requested that the certification and accreditation functions be assumed by the ABPN and the Psychiatry RRC.

DISCUSSION

The trend toward subspecialization and the declining number of medical students entering psychiatry combine to focus attention on work force issues and the number of available psychiatrists for general and subspecialty practice. The total number of U.S. medical graduates matched to psychiatric residents grew from 489 in 1981 to 745 in 1988, an increase of 34% (16,17). In 1988, 4.7% of all U.S. medical students were entering psychiatry through the National Residency Matching Program (NRMP). However, by 1992 the results of the NRMP showed a decline to 526 U.S. graduates matched to psychiatry. This was a 29% decline from 1988, with only 3.7% of 1992 U.S. medical graduates entering psychiatry. This means that the 1996 psychiatry residency graduating class may produce 200 fewer psychiatrists than the 1992 graduating class. The ability of general psychiatry and each subspecialty to continue to recruit at current levels is a major uncertainty affecting psychiatry's work force planning. In 1996, on the basis of the 1992 match plus trainees entering outside the match, there will be approximately 700-750 new residency graduates. If the optimistic estimates of the subspecialty organizations are accurate, 200 will enter child and adolescent psychiatry, 30-50 will enter geriatric psychiatry, 30-50 will enter addiction psychiatry, and 30-50 will enter forensic psychiatry. These subspecialty training projections represent up to 50% of the annual graduating class by 1996. This is a dramatic change for a medical specialty that has considered itself a generalist field (18) and a rapid evolution to subspecialization over a short period of time.

There are wide-ranging implications and unanswered questions raised by the momentum of psychiatric subspecialization. For example, what is the impact of subspecialization on the education of general psychiatrists and the curricula of general residency training programs? Another pressing question is, who will pay for the new subspecialty programs? Their cost projections and salary ranges vary widely and are influenced by rapidly changing reimbursement patterns and federal requirements for graduate medical education. Postresidency training program costs will include not only resident/fellow salaries of $24,000-$68,000 but also an additional 33%-100% of this salary base for faculty, support personnel, and other educational costs.
Do current policies for subspecialty recognition follow a consistent process? Because of the effective advocacy from subspecialty societies, has psychiatry developed a process of subspecialty approval without comprehensive oversight? How can psychiatry best balance the vested interest of these multiple psychiatric subspecialty organizations and their practitioners with the best interest of patients and the resources available to maintain existing and develop new educational programs? With a provincial point of view, is each organization proceeding independently or are these efforts sufficiently integrated and coordinated to ensure the most effective outcome?

In my opinion, the positive contributions of psychiatric subspecialization to date have significantly outweighed the negative influences. Subspecialties have been major contributors to psychiatry's expanding knowledge base and have benefited the education of all psychiatry residents and psychiatric generalists. Although economic incentives may threaten the general psychiatrist, these pressures are substantially from outside our field and have added momentum to psychiatric subspecialization. In fact, psychiatry has been much slower to respond to these changes than other medical specialties. For example, internal medicine and pediatrics each have 13 separately designated subspecialties under the ABMS and their boards.

The process within psychiatry for subspecialty recognition has been both orderly and chaotic, as reflected in this article's title. The orderly aspect is the described process of review and approval for a new subspecialty from recognition, to certification, to accreditation. However, even before the recruitment crisis of 1992, the chaotic component was the uncertainty of psychiatry's future work force and its potential rapid evolution toward a subspecialty-dominated profession. Psychiatry's experience in the 1992 NRMP match has sharply emphasized this issue and stimulated calls for a renewed national recruitment initiative to propose solutions to this crisis. An increased recruitment before 1996 would resolve the chaos and allow the field to preserve major roles for both psychiatric generalists and subspecialists. However, without an increased work force there will be an inevitable collision of several forces as the recognized and emerging subspecialties compete with the general field for the smaller pool of residency graduates.

At present the answer to many of these questions is uncertain. As psychiatric subspecialism proceeds, it is critical to develop a view that is broader than the focused perspective of each subspecialty organization. The field is proceeding at a pace that will change psychiatry permanently within the decade. Psychiatry has progressed rapidly from a focus on psychoanalysis to community psychiatry, clinical phenomenology and nosology, the neurosciences, and now to subspecialization. This is the critical time for us all to carefully reflect on these changes and on subspecialization's impact on psychiatry's future.

This article was given as the annual Shein Lecture for the American Association of Directors of Psychiatric Residency Training, January 17, 1991, in Tucson, Arizona. Dr. Shore's experience as a member of several national organizations has contributed to his viewpoint on these issues. The organizations are the APA, AADPRT, AACDP, ABPN, RRC, and ACGME. Opinions in this article are solely his and do not represent any official position of these groups.

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Regular Articles

Learning Priorities of Staff, Residents, and Students for a Third-Year Psychiatric Clerkship

Peggy E. Chatham-Showalter, M.D.
Edward K. Silberman, M.D.
Robert E. Hales, M.D.

Psychiatric clerkships combine classroom instruction with patient care. The different learning experiences in those two settings prompted the authors to survey 86 third-year medical student clerks, 44 staff psychiatrists, and 15 PGY-2 psychiatric residents about the importance of 31 skill and knowledge areas as learning goals for clerks. All groups of respondents included the following five items (16.2%) among the most important: performing a mental status examination, becoming comfortable with psychiatric patients, evaluating suicidality, developing interview skills, and suspecting drug and alcohol problems. The importance placed by staff on aspects of the doctor-patient relationship was not apparent to students, who perceived psychiatric diagnosis as receiving higher priority than staff intended. The implications of these findings for curriculum planning are discussed.

Appropriate educational objectives for medical students in psychiatry clerkships have been the subject of debate, and opinions on this topic have evolved over the years. Goals may reflect both formal departmental objectives and each instructor’s personal objectives. In 1961, Romano (1) published a widely quoted set of objectives for the psychiatric education of medical students. He moved psychiatric education away from classic psychiatric theories toward topics that would be most useful for a nonpsychiatric physician to learn. In 1977 Johnson et al. (2) compared the opinions of second-year medical students, staff psychiatrists, and nonpsychiatric physicians about what was important for medical students to learn. The highest rated items tended to be general and subjective doctoring skills rather than specialized psychiatric knowledge. These high-rated items included talking to patients about personal problems; appreciating the dynamics of the doctor-patient relationship.

This study was done at the Departments of Psychiatry of Walter Reed Army Medical Center and the Uniformed Services University of the Health Sciences, Washington, DC. Dr. Chatham-Showalter is currently a consultation-liaison psychiatrist at Lehigh Valley Hospital, Allentown, Pennsylvania, Dr. Silberman is director of resident education at Jefferson Medical College, Philadelphia, Pennsylvania, and Dr. Hales is chairman, Department of Psychiatry, California Pacific Medical Center, San Francisco. Address reprint requests to Dr. Chatham-Showalter, Lehigh Valley Hospital Department of Psychiatry, 1243 South Cedar Crest Boulevard, Suite 2800, Allentown, PA 18103-6296.

The opinions or assertions contained herein are private views of the authors and are not to be construed as official or as reflecting the views of the Department of the Army, the Department of Defense, or the U.S. Government. This work was compiled as part of their official duties and is, therefore, in the public domain.
patient relationship; understanding emotional aspects of chronically ill or dying patients; knowing physiologic concomitants of emotional stress; being familiar with common psychopharmacologic medications; and knowing how and when to refer a patient to a psychiatrist.

Teaching toward such goals is achieved through both didactic and clinical/experiential formats: clerkships combine didactic sessions with patient care in a variety of settings. Classroom didactics include lectures, case conferences, and seminars. Good clinical experiential teaching emphasizes thinking out loud, showing students how problems are solved, modeling attitudes and outlooks, interacting with others, and giving and getting feedback and criticism (3). Teaching priorities and emphases can be expected to differ depending on the learning setting and the teacher. In our program, as in many academic hospitals, residents tend to do the bulk of clinical/experiential teaching of medical student clerks, whereas staff members tend to do the bulk of classroom didactics.

In this study we examined what staff, PGY-2 residents, and third-year medical student clerks reported as important for clerks to learn. We then attempted to determine whether staff’s reports of what they considered important were reflected in what the clerks perceived about their teaching by the staff.

METHODS

The participants in this study were the 86 third-year medical student psychiatry clerks, 15 PGY-2 residents, and 44 staff psychiatrists at Walter Reed Army Medical Center (WRAMC) in the 1987-1988 academic year. The staff group was defined as WRAMC full-time or affiliated military and civilian psychiatrists as well as PGY-4 residents. Clerks spent their 6-week rotation on either the inpatient or the consultation-liaison service. Each week all clerks attended two 1-hour interviewing seminars and 3 hours of lectures with staff. They also spent 2 hours per week individually with a staff preceptor reviewing case write-ups and formulations.

The questionnaire contained 31 skill and knowledge areas identified from the literature (1,2) as important for medical students to learn during a psychiatry clerkship. Each item could be rated as 5—very important, 4—important, 3—neither important nor unimportant, 2—unimportant, or 1—very unimportant. This method is similar to that used in Johnson’s survey (2).

An “Importance” form was given to each participant to rate each item as to the “importance it has for a medical student to learn regardless of future specialty during his/her third-year psychiatry clerkship.” The clerks were surveyed at the start and finish of their rotations because their opinions were expected to change based on their clerkship experience. Staff and PGY-2 residents were surveyed just once because their opinions were expected to be more fixed, although this presumption is open to question. A “Perception” form was given to each clerk at the end of the rotation to rate each item as to the “overall importance it was actually given by staff.”

Within each participant group, the items with a mean rating ≥ 4.5 were defined as the most important items for that participant group. Fisher’s exact tests were used to compare five pairs of participant groups. The cells of the $2 \times 2$ tables contained the number of items ≥ 4.5 and those < 4.5, which divided the items into those considered most important and all other items. The clerk prerotation and postrotation groups were compared; each clerk group was compared with staff; the PGY-2 residents’ group was compared with staff; and clerks’ perception of staff was compared with the staff’s own report. These multiple comparisons are a potentially confounding issue. If the respondents do have the same range of ratings, then our test, with an alpha level of 0.5, would be expected to
give about 8 false positives from our 155 comparisons. We have no way to predict which, if any, of our preliminary results reported below would not be replicable because of this confounding effect.

RESULTS

Of 86 medical students who rotated through the department during the study period, 87% completed the “Importance” form at the beginning and 80% completed the “Importance” and the “Perception” forms at the end of their rotation. Of 44 staff members, 75% completed the “Importance” form. All 15 of the PGY-2 residents completed the “Importance” form. Each group’s mean rating of importance per item is shown in Table 1. Eleven items of the 31 study items (25.4%) were rated ≥ 4.5 by at least one group, which represented the group’s opinion of the most important items for a third-year clerk to learn.

The staff group included 7 of the 31 items (22.5%) among the most important skill or knowledge areas for third-year clerks to learn: performing a mental status evaluation, evaluating suicidality, developing interview skills, developing communication skills, suspecting alcohol and drug problems, feeling comfortable with psychiatric patients, and knowing medical causes of psychiatric symptoms. Prerotation clerks rated 10 of the 31 items (32.3%) ≥ 4.5. They differed from staff by including empathy, feeling comfortable as a physician, evaluating dangerousness, and drug causes of psychiatric symptoms among the most important and by omitting medical causes of psychiatric symptoms (P ≤ 0.01).

Clerks had a significant change in opinion after their rotation (P ≤ 0.01). They rated nine items ≥ 4.5 and became more like staff in their responses; they differed from them only by continuing to include feeling comfortable as a physician and evaluating dangerousness among the most important (P ≤ 0.01). It is noteworthy that clerks rated assessing a patient for commitment relatively low both before and after the rotation. PGY-2 residents included the fewest items among the most important. They rated five of the 31 (16.2%) items ≥ 4.5 and differed from staff by excluding medical causes of psychiatric symptoms and developing communication skills from the most important items (P ≤ 0.01).

Clerks perceived that staff held six areas as among the most important: performing a mental status examination, evaluating suicidality, developing interview skills, suspecting drug and alcohol problems, diagnosing psychiatric disorders, and generating a differential diagnosis. The clerks’ perception showed differences from the staff’s own report (P ≤ 0.02). Clerks did not perceive staff’s opinion that feeling comfortable with psychiatric patients, developing communication skills, and knowing medical causes of psychiatric symptoms were among the most important areas. Clerks perceived staff as holding diagnosing psychiatric disorders and generating a differential diagnosis among the most important, but staff did not rate them as such.

DISCUSSION

Our survey revealed good general agreement between attending staff, residents, and medical students in learning priorities for a third-year psychiatric clerkship. All groups placed basic psychiatric skills needed by most physicians ahead of specialized psychiatric knowledge. The learning priorities among our group of respondents are similar to those reported by Johnson (2), who also found an emphasis on generally applicable, rather than highly specialized, psychiatric skills and knowledge.

This consensus on learning priorities can lead to an examination of the content and format of psychiatric clerkships. It appears to be important that classroom and clinical settings afford clerks ample opportunity for observing and practicing with super-
vision the skills of performing a mental status evaluation, evaluating suicidality, developing interview skills, developing communication skills, suspecting alcohol and drug problems, feeling comfortable with psychiatric patients, and knowing medical causes of psychiatric symptoms.

Providing clinical emphasis and modeling of these skills may require specific teaching techniques that do not come naturally to all clinicians. The PGY-2 residents were the most restrictive in rating items as highly important to teach. If this finding were to prove reliable, the limited number of items so rated might stem from these residents' early stage as psychiatric teachers. If residents felt inad-

<table>
<thead>
<tr>
<th>Area</th>
<th>Staff (n = 33)</th>
<th>Clerks Before Rotation (n = 75)</th>
<th>Clerks After Rotation (n = 69)</th>
<th>PGY-2 (n = 15)</th>
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<tbody>
<tr>
<td><strong>Most important (mean rating ≥ 4.5)</strong></td>
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<td>Performing a mental status evaluation</td>
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<td>Feeling comfortable with psychiatric patients</td>
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<td>Developing interview skills</td>
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<td>Knowing medical causes of psychiatric symptoms</td>
<td>4.63</td>
<td>4.44a</td>
<td>4.59a</td>
<td>4.46d</td>
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<td>Developing communication skills</td>
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<td>4.13d</td>
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<td>Evaluating suicidality</td>
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<td>Developing empathy</td>
<td>4.48</td>
<td>4.53b</td>
<td>4.39b</td>
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<tr>
<td>Knowing drugs that cause psychiatric symptoms</td>
<td>4.45</td>
<td>4.61b</td>
<td>4.46b</td>
<td>4.20</td>
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<tr>
<td>Evaluating dangerousness</td>
<td>4.24</td>
<td>4.58c</td>
<td>4.65c</td>
<td>4.46</td>
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<tr>
<td>Feeling comfortable as a physician</td>
<td>4.15</td>
<td>4.57c</td>
<td>4.50c</td>
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<td><strong>Intermediate importance (3.5 &lt; mean rating &lt; 4.5)</strong></td>
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<tr>
<td>Having a multifactorial perspective</td>
<td>4.48</td>
<td>4.38</td>
<td>4.34</td>
<td>4.06</td>
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<tr>
<td>Diagnosing psychiatric disorders</td>
<td>4.42</td>
<td>4.06</td>
<td>4.17</td>
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<tr>
<td>Treating drug and alcohol problems</td>
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<td>4.38</td>
<td>4.32</td>
<td>4.06</td>
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<tr>
<td>Knowing benefits and limits of psychiatric consults</td>
<td>4.36</td>
<td>4.21</td>
<td>4.01</td>
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<td>Generating a differential diagnosis</td>
<td>4.33</td>
<td>4.42</td>
<td>4.17</td>
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<tr>
<td>Identifying psychosocial factors</td>
<td>4.15</td>
<td>4.02</td>
<td>4.23</td>
<td>3.86</td>
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<tr>
<td>Developing critical objectivity</td>
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<td>4.45</td>
<td>4.32</td>
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<td>Working with dying patients</td>
<td>4.03</td>
<td>4.45</td>
<td>4.19</td>
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<tr>
<td>Using psychotropic medication</td>
<td>3.97</td>
<td>3.78</td>
<td>4.07</td>
<td>4.06</td>
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<td>Working with a treatment team</td>
<td>3.93</td>
<td>4.38</td>
<td>4.32</td>
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<tr>
<td>Evaluating sexual dysfunction</td>
<td>3.60</td>
<td>4.12</td>
<td>3.96</td>
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<td>Identifying psychodynamic factors</td>
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<td>4.19</td>
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<td>Knowing the value of psychiatry as a career choice</td>
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<td>3.54</td>
<td>3.65</td>
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<tr>
<td><strong>Least important (mean rating ≤ 3.5)</strong></td>
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<tr>
<td>Managing family problems</td>
<td>3.45</td>
<td>4.02</td>
<td>3.78</td>
<td>2.93</td>
</tr>
<tr>
<td>Knowing therapies of other mental health providers</td>
<td>3.36</td>
<td>3.96</td>
<td>3.98</td>
<td>3.33</td>
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<tr>
<td>Assessing a patient for commitment</td>
<td>3.21</td>
<td>3.74</td>
<td>4.01</td>
<td>2.93</td>
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<td>Working within the economic limits</td>
<td>2.97</td>
<td>3.84</td>
<td>3.56</td>
<td>3.46</td>
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<tr>
<td>Using touch therapeutically</td>
<td>2.60</td>
<td>3.62</td>
<td>3.52</td>
<td>1.93</td>
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<tr>
<td>Conducting individual psychotherapy</td>
<td>2.57</td>
<td>2.88</td>
<td>3.01</td>
<td>2.20</td>
</tr>
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</table>

Note: Rating scale: 5—very important; 4—important; 3—neither important nor unimportant; 2—unimportant; 1—very unimportant.

*aClerks differed from staff before rotation only (P < 0.01); item gained importance.

*bClerks differed from staff before rotation only (P < 0.01); item lost importance.

*Clerks differed from staff before and after rotation (P < 0.01).

*PGY-2 differed from staff (P < 0.01).
equate or too busy to teach beyond a narrow range of topics, efforts could follow to support residents’ roles as teachers (4), including instruction in how to teach (5).

Senior clinical staff should be best equipped to teach student clinicians these skills, yet in our institution and others, they often have limited contact with clerks (6). Our study found evidence of the influence of staff on students in that the students’ learning priorities became more like those of staff by the end of the clerkship. In our setting, staff gave lectures and led interviewing seminars where they could model behaviors and interactions with patients. It appears, however, that staff conveyed to students more emphasis than they intended on the importance of learning specific diagnostic rather than interpersonal skills.

This initial survey of priorities and clerk perceptions at one medical school and teaching hospital opens further avenues for study and discussion. Expansion of the range of possible objectives can add the areas of neuroscience, human immunodeficiency virus, homelessness, and other emerging topics to surveys of students, residents, and staff at other sites. Our study focused on the learning goals of students and teachers rather than on objective measures of what students actually learned. Thus, we do not know how the personal priorities of students and teachers might have related to actual acquisition of knowledge and skills during the clerkship. This question could indicate a useful area for future study: there may be interactions between the type of teacher (resident or staff) and the type of setting (classroom or clinical) that influence learning in psychiatric clerkships.

The authors thank Dr. Joseph M. Rothberg, Ph.D., Research Mathematician at Walter Reed Army Institute of Research, for his assistance during this project. This work was presented in part at the 142nd annual meeting of the American Psychiatric Association, San Francisco, May 6–11, 1989.

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The Role and Function of Residents' Organizations in Psychiatry Education

James Lock, M.D., Ph.D., Brian Kleis, M.D.
Thomas Strouse, M.D., Sandra Jacobson, M.D.
Joel Yager, M.D., Mark Servis, M.D.

Psychiatry residents' organizations have been poorly studied and variously portrayed as facilitative or regressive. A telephone survey of 19 residency programs of differing sizes in all major geographic regions revealed that 89% had some form of residents' organization. The groups are characterized by a wide range of structures, and they undertake a variety of tasks. The most common tasks are support, problem solving, and ventilating dissatisfaction. Problems frequently faced by such groups include changing resident constituencies, personality conflicts, authorization disputes, and representation and consensus problems. Strengths of such groups include their ability to help foster a sense of group identity; to provide a safe place to ventilate, work on problems, and fashion a consensus for the residents' input to the institution; and to offer training opportunities for future psychiatric managers.

Residents' organizations are established groups of residents within psychiatry training programs in which residents formulate and express their own opinions and interact with faculty administrators. These organizations are of interest and value to most training programs because they provide opportunities for the program director and faculty to gain access to resident problems and issues. They can also provide a vehicle through which program administrators can delegate relevant tasks to resident groups. Finally, they can present interesting opportunities for residents to undertake administrative training and leadership in team-building, cooperative work, and dealing with complex institutions.

The first article to discuss a residency organization was a 1973 review of the Menninger Clinic program's resident organization written by faculty at the institution (1). This report of a single residents' organization has obvious limitations, but its observations warrant consideration. Two negative points were emphasized: 1) the group was viewed as primarily selfishly motivated in pursuing salaries and benefits while ignoring or not appreciating the larger issues in social and academic psychiatry, and 2) the authors concluded that persons taking leadership roles in this organization had difficulty establishing their professional...
identities as psychiatrists. An alternative, more positive view of such organizations appears in Pichot's 1988 description of the residents' organization developed at Eisenhower Army Medical Center (2). Pichot concludes that such organizations provide an opportunity for group cohesion and enhance the junior residents' opportunities for identification and role modeling of more senior residents. This arrangement avoids the complicating dynamic issues associated with authority relationships when such identifications are with faculty members. He also pointed out the leadership training opportunities provided by such resident group administrative experiences (3,4). The ongoing need for residents' organizations is suggested by more recent articles that report house staff experiences of stress were subjectively ameliorated when the residents had more control of their environment (5) and that institutions often inhibit and discourage the development of systems that lessen house officers' stress and dysfunction (6).

Because there is little in the recent literature beyond the above two program descriptions about residents' organizations, we decided to conduct a survey of training programs throughout the country to explore the prevalence, roles, structure, functions, advantages, and problems of residents' organizations in psychiatry training programs.

METHODS

A representative sample of 20 residency programs was derived from a list of accredited U.S. psychiatry residencies (7). All listed programs were divided into five regions (Northeast, Southeast, Southwest, West, Northwest); each set of regional programs was then divided into four different groups by residency program size (PGY-1-4 classes in the ranges of 1-20, 21-35, 36-45, or > 45 residents). These divisions by location and size produced 20 program categories, and one program name was drawn from each category to provide a 20-program sample for our study.

A survey instrument was designed to identify basic structural and functional elements of residents' organizations (see Appendix A). Such organizations were defined as resident-run groups, although leadership and membership might include some non-residents. Structure was defined as the presence of any of the following: regular meetings, written authorization, and procedures for continued existence (e.g., elections). Functional aspects included any work identified as under the auspices of the organization. Highly evolved tasks were those requiring ongoing work, planning, and representation (e.g., planning social events, mediating resident and institutional needs, attempts to achieve resident consensus, dispute resolution, planning educational events). Less highly evolved tasks were those that could occur immediately and met basic emotional and physical needs for the resident group (e.g., support, food, venting dissatisfaction). The survey instrument was used as the basis of telephone interviews conducted in November 1990 by the four resident authors with the chief resident of each identified program. All chief residents were asked the same battery of questions, and each interview lasted approximately 30 minutes.

RESULTS

Nineteen of 20 programs selected were surveyed. The one program not surveyed, a medium-sized (21-35) residents' organization in the Northeast, was inaccessible because the chief resident could not be reached after multiple attempts. Seventeen programs had some form of residents' organization, whereas the two smallest residencies did not. Most organizations had been functioning for more than 5 years (range = 8 months to > 20 years). Only two chief residents knew how or why such organizations originated in their institutions.
Participation in residents’ organizations included residents from PGY-1–4 classes in 15 of the 17 programs. The two exceptions did not have PGY-1’s in their programs. Seven of 17 organizations included the residency program director. Regular participation by staff or faculty was rare in other programs, although such persons often came by invitation. All 17 groups reported the regular participation of the chief resident. The organizations met as a group from one to four times per month: four times per month was most common (seven programs), followed by two times per month (six programs) and once per month (four programs).

The leadership of the organizations varied widely. Most commonly, officers were elected from among the house staff (seven programs). The training directors provided leadership in three programs, whereas self-selected leaders (one program) and faculty facilitators (one program) were the leaders in other residents’ organizations. Programs often used more than one process to choose their leaders.

Authorization of these organizations rested for the most part on historical precedent, but five programs said that they had some form of written authorization (i.e., by-laws or a constitution). Implicit authorization of the residents’ organization was present in most programs through the department’s allocation of resources and time to the organization and its responsiveness to the group’s concerns. Specific support by program directors and department chairs was identified in approximately one-third of the programs surveyed.

Tasks undertaken by these residents’ organizations included all of those initially considered in the survey. The most commonly reported functions were support, problem-solving, and venting dissatisfaction. Dispute resolution among residents themselves was undertaken by only two organizations. Most work attempted by these organizations was accomplished within the group itself during the meeting time frame. Additional work was accomplished by individual assignment outside the group meeting time and by subcommittees meeting at alternative times.

Chief residents were offered an opportunity to comment on their subjective impressions of the residents’ organization at their institution. The most commonly identified benefits of such groups included the following: 1) opportunities for residents to get support for stresses in the work environment through dialogue, ventilation, and nurturance of each other, 2) mechanisms to increase effective communication with residency directors, 3) facilitation of early problem identification, and 4) mechanisms to prevent faculty splitting of residents into “good” and “bad” groups by generating a consensus among them on controversial issues in the residency.

Although no data on the percentage of residents who belonged to these organizations were collected, difficulties in such groups identified by the chief residents included ongoing problems with attendance and representation. Without adequate attendance, resident consensus was difficult to achieve. Too often, resident representatives to departmental committees failed to check with their resident constituency and based their decisions instead on personal preferences. It was also difficult to get the groups to actually do the work once a task had been identified. Lack of a clear administrative structure was seen as an impediment to designating responsibility for ongoing work. Chief residents also candidly noted that many times the group could degenerate into “complaining and whiny” forums. Interpersonal dynamics of competition, envy, and personal dislike often interfered with the achievement of consensus and the accomplishment of work.

These limitations aside, residents’ organizations were reported to have accomplished many specific tasks. A partial list of these includes 1) setting up a support team for residents whose patients committed
suicide, 2) mediation of a hospital request for extra on-call responsibility for house staff, 3) setting up a psychopharmacology journal club, 4) organizing a graduation dinner/dance, 5) obtaining an improved call room, 6) setting up a day-call system, 7) initiating work to improve residents’ safety, and 8) helping to persuade administration to hire a social worker to work in the emergency room at night.

DISCUSSION

The results of our survey suggest that there is a wide array of possible structures and activities of residents’ organizations. Most residents’ groups involve residents from all years of training and the chief resident. Most value the groups for the support they offer to residents, although some also often accomplish tasks that improve the residents’ lot in more material ways. Such resident groups are present in most of the programs surveyed, but their respective degrees of formal organization vary greatly.

The roles and functions that the residents’ organizations undertake seem to provide an ongoing vehicle for residents to develop skills in working in groups and organizations cooperatively with colleagues, as well as continually giving a voice to the needs and wishes of residents at their training institution.

From an institutional perspective, such organizations help meet practical and programmatic needs. The data suggest that most institutions provide at least tacit support for such groups through allocation of resources and time, and through recognition of the messages conveyed by such groups. The presence of the program director at a certain percentage of these groups may indicate an institutional need to keep an eye on or attempt to control such groups; conversely, in a safe and nurturant milieu, it might be an important vehicle for an open exchange of information between residents and their program director.

Institutions may, at times, take divergent perspectives on residents’ organizations (1,2). When such organizations are not working well, a negative institutional perspective may emphasize a regressive side to such groups, and the faculty may see them as consisting of immature individuals who use the group to cope with intrapsychic deficits or conflicts with authority. Viewed from such a perspective, these groups are seen as petulant, demanding, complaining, and bickering. A more positive institutional perspective views such organizations as consisting mostly of mature colleagues who represent an additional resource for the institution. This perspective sees the supportive and ventilating aspects of the group serving as an emotional and conceptual filter, thereby helping to clarify, refine, specify, and articulate needs, problems, and potential solutions. This formulation also allows the institutions to use the residents’ organization as a resource with particular skills, expertise, and interests.

One of the ongoing challenges for residents’ organizations is to maintain themselves as organized groups over time. One major impediment is the nature of the constituency of these groups—an ever-changing resident population in which the most experienced members graduate each year. Further, as membership changes, the tenor of the group may change based on the temperaments of the new leaders and members. Since in most programs residents are also competing with one another for limited resources and rewards, the emergence of competition, envy, and selfishness makes the group’s work even more difficult (8).

Although all such residents’ organizations face these problems, several tactics may help overcome them. Within the residency group itself, it is generally helpful to define the main purposes or tasks of the group consistently and clearly. In most institutions this can be done informally. These also can be documented in a set of bylaws as has been done in several programs (2).
formal structures provide the group with a reference for its purposes and functions that is consistent over time. The bylaws provide a sense of identity that can be maintained in the face of the inevitable changes that residency classes undergo by attrition and addition. They can also provide methods to help residents appropriately accept and assign tasks. But formalized structures, especially in institutions with a small number of residents, may promote unnecessary bureaucracy that can inhibit communication and work. They also may serve as smoke screens that provide a group pseudoidentity that never truly represents or works for residents’ causes or issues. This problem may arise especially when activity in such organizations is viewed by the other residents as a way to identify with and get noticed by higher-ups or to rebel against such authorities. Resentment by the resident body as a whole and collapse of a meaningful organizational process are likely to follow. Unfortunately, sometimes institutions respond to such nonrepresentative but vociferous groups, thereby usually worsening the situation. To summarize, the inevitable tension between too much and not enough structure appears to require continuous fine-tuning for both formally and informally structured groups.

Residency program directors can do much to foster and facilitate the workings of residents’ organizations. The best encouragement is programmatic responsiveness to such groups’ requests and suggestions. Even if the problems cannot be solved, the willingness to negotiate with the entire residency group through the residents’ organization, rather than solely with individual residents, authorizes the organization’s functioning as a meaningful body. Cutting side deals has the opposite effect and undermines the authority of the residents’ organization. To help these organizations maintain their identity, it is useful to give them something tangible to own and manage, such as a social function budget, secretarial resources, or an event to plan. Such assets give the group not only responsibility but also resources to manage. Again, these assets must truly belong to the organization, otherwise the authority remains outside the group.

One of the most powerful reasons to support residents’ organizations is that they can offer opportunities for excellent training and experience in administration and management. These resident groups promote an experiential understanding of institutional dynamics, conflicts, and limitations by encouraging residents to work in a group, manage limited resources, mediate conflicts, and accomplish specific tasks and goals. All these experiences will serve them well in future administrative roles.

References
APPENDIX A. Survey form: the role of residents' organizations in psychiatric residencies

<table>
<thead>
<tr>
<th>Interviewer: __________________________</th>
<th>Date: __________</th>
<th>Informant: __________</th>
</tr>
</thead>
</table>

1. Number of Residents: _______ (PGY-1–PGY-4 only)

2. Is there a resident-run residents’ organization that has responsibility for making decisions for residents or for representing residents to others? yes/no
   (If there is more than one group, fill this out twice.)

3. How many years has it existed? _______

4. How was it established? _____________________________________________________

5. Who participates in this organization? (Check all that apply)
   - PGY-1 residents (Interns)
   - PGY-2 residents
   - PGY-3 residents
   - PGY-4 residents
   - fellows
   - chief resident
   - __________

   ___ residency program director
   ___ (or representative)
   ___ nonphysician staff
   ___ faculty
   ___ department chair
   ___ other ________________

6. Who leads this organization? (Check all that apply)
   - elected officer(s)
   - program chief resident
   - appointed officer(s)
   - training director
   - executive committee
   - other: ________________

   Appointed by: _____________________________________________________________

7. How often does the organization meet?
   - daily
   - weekly
   - monthly
   - __________ other: ________________

8. Is there a formal, written definition of the function of the organization? yes/no
   (If so, please mail it to us.)

9. Who authorizes the organization? (Check all that apply)
   - residents
   - chief resident
   - residency program director
   - faculty
   - department chair

10. What are the mechanisms of ongoing authorization? (Check all that apply)
    - elections
    - by-laws
    - consensus
    - appointments
    - policy or decree
    - from outside the resident group
    - self-authorization
    - other: ______________________

11. What are the functions of the organization? (Check all that apply, then rank:
     A = most important; B = moderately important; C = least important.)
     - nurturance
     - support
     - protection (e.g., work hours, harassment)
     - problem-solving
     - dispute resolution
     - planning socials
     - venting dissatisfaction
     - mediating resident and institutional needs
     - means for institution to communicate with residents
     - planning educational events

12. How is work accomplished?
    - by committees
    - by the governance group as a whole
    - other: ______________________

13. Additional comments on the benefits or difficulties of such organizations:
Special Articles

Teaching and Learning Psychiatry

Jonathan F. Borus, M.D.

This article reviews the teaching-learning process in psychiatry. It describes eight attributes of a successful teacher, suggests ways that psychiatrists may improve their teaching skills, and delineates four stages (exposure, incorporation, integration, and mastery) of the learning process that have implications for how and what we teach. Methods to evaluate teaching rigorously so that it can be academically rewarded are described. At a time when the place of the psychiatric teacher in the academic medical center is precarious and often discouraging, the author discusses sources of support from students, fellow faculty, and national colleagues that can help sustain teaching in, and teachers of, psychiatry.

Academic psychiatry has several elements: teaching and learning, research, clinical care, and administration. All are necessary, and none can profitably stand alone. This article will focus on psychiatric education and specifically discuss the teaching-learning process in psychiatry, the evaluation of teaching and its rewards, the precarious position of psychiatric teachers in today’s academic medical center, why we teach, and potential sources of support for our teaching. For simplicity’s sake I will use male pronouns throughout this article with the full recognition that in psychiatry today a large number of our most talented teachers, students, and colleagues are women (1).

TEACHERS AND THE LEARNING PROCESS

To some in medicine, the term psychiatric educator is an oxymoron, an absurd linkage of incongruous terms. It has been reasonably asked, “Do we really need paid psychiatric teachers?” After all, very few psychiatrists have any formal preparation for teaching, and teaching ranks far below research or even administration in the eyes of academe and well below clinical excellence in the eyes of both our profession and the public. Except for the brief period of National Institute of Mental Health (NIMH) support for the Career Teacher initiative, no one has seemed willing to pay for excellence in teaching psychiatry. And isn’t it said that the best teaching is what one learns from the patient with “hands on” (in our case, “ears on”) self-education? In a time of fiscal belt tightening and decreased availability of resources for medical education (2,3), do we need designated, paid psychiatric educators or should we return to the apprenticeship training mode of the past in which practicing clinicians donated their time to supervise and teach by example the next generation of psychiatrists? Although part-time voluntary faculty are invaluable, I submit that we have progressed far beyond the point where apprenticeship is sufficient, and in these complex, rapidly changing, and troubled times we must reinvest in teaching if our specialty is to survive.

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To the question "Are psychiatric teachers born or made?" the obvious answer is "both." Any good teacher must have the following eight attributes: he must be able to identify and rally with his learners; start where they are (not where he is and hopes they will end up); present his ideas clearly and succinctly; help the learner separate the important from the trivial; pull diverse ideas together; present material with a dramatic flair; acknowledge the uncertainty of what he knows; and invite others to express their ideas and further explore an area. Some of these attributes are clearly hard-wired into personality, but others can be taught. Unfortunately, most of us as learners have encountered the know-it-all pedant, the self-involved expert who starts far above his students and cannot tune in to their needs, the researcher so lost in the esoteric minutiae of his data that he never surfaces for air to relate to the class, the dull obsessive who drones on and on without separating the wheat from the chaff, and the narcissist who cannot acknowledge that he doesn't have all the answers; all of the above are constitutionally unfit to be teachers.

However, there is much to be learned about teaching that is all too rarely taught to psychiatrists. We wouldn't send our six-year-old into a first-grade classroom with a teacher who had never had any professional training in how to teach, yet we regularly entrust the teaching of medical students to residents without such teaching preparation, and the training of both students and residents to faculty without any formal educational background. I am not suggesting that all academic psychiatrists get M.Ed.'s; however, there is a body of knowledge about education that is relevant to psychiatry.

Teaching Techniques and Skills

First, there are specific educational techniques and skills that can be taught. Giving a good lecture is not an accident but involves a learnable format and skill. A lecture has a structure that organizes the facts, presents them logically, and reinforces them in ways they can most easily be taken in and then integrated with prior knowledge (4). Similarly, leading a seminar requires more than knowledge of one's topic; it also requires a plan for how to balance inquiry with specific content, an open discussion with the making of focused points, and so forth. Clinical supervision likewise requires clearly identified goals and two-way feedback to improve the process (5). Real teachers call this a "lesson plan." I think of such a plan as the road map that makes the teacher specify where his learners are starting from, where he wants them to end up, and how they are going to get there in the time allotted for their "trip" together. Just the fact that one should have such a plan is news to many psychiatric teachers who assume that their knowledge of course content is sufficient.

How can psychiatrists obtain basic knowledge about how to teach? We could take adult education theory and practice courses at our local universities. We could also talk with and directly observe the expert teachers in our own departments to find out how they prepare and deliver their teaching. Another source is a series of readable handbooks on medical teaching developed at the University of Utah that outline some of the basics for residents and medical faculty thrust into teaching roles with little preparation (4,6-8). Unfortunately, the Educational Development for Psychiatric Educators project, a program sponsored by NIMH and the American Psychiatric Association that organized conferences around the country to teach academic psychiatrists teaching techniques and skills, has been a casualty of NIMH funding cutbacks. Colleagues and I recently described a resident-initiated program at the Massachusetts General Hospital (MGH), designed to teach residents how to teach, that incorporated seminars on different types of teaching skills into the PGY-2, -3, and -4 psychiatry residency curriculum (9).
Learning Processes and Sequences

The teacher also has to learn about the process of learning itself. He must first understand that the most effective teaching methods will vary with the needs of the learner. Our experience as clinicians has taught us to empathize with our patients, to understand their feelings and perspectives, and we should recognize a similar need for an alliance with our students around the learning task. A corollary of the above is that different people learn in different ways and sequences. This is a difficult lesson for the teacher, who usually assumes that the student will learn best in the manner that the teacher does and therefore tailors his teaching as if he were the learner.

Students learn aurally, visually, by discussion (verbally), by participation, and by "doing." I am a visual and verbal learner; that is, I learn best by reading material, thinking about it, and then discussing it with others in a seminar format. I have great difficulty as an aural learner and retain little from a lecture unless I write it down and then read the notes. The didactic part of the residency training program I directed for almost 15 years at the MGH was patterned on my learning style. It featured a full schedule of weekly Core Academic Seminars running throughout the three residency years, in which residents read from the literature before the seminar and then joined in a discussion with the seminar leader. Although this mode of teaching was generally well accepted, it took me a while to realize that it may not be the way all residents learn best. Every year or two a resident would tell me that he didn't get much out of the seminars and only learned from his direct work with patients. I used to see this as anti-intellectual resistance, but learned to understand it as perhaps reflecting a different, "doing" learning style; I did, however, expect a resident who chose not to participate in the core seminars to master the same material using his alternative way of learning.

Another thing the teacher should know is that different students learn in different sequences. I learn best deductively, reasoning from the general to the specific and fitting specific cases into the previously learned frame. I also teach this way, describing and discussing principles first, then presenting examples that either fit into, or heuristically vary from, that framework. Other teachers swear by inductive learning, asking the student to move from the single case or article to build his own frame. The important thing to realize is that the best sequence, like the best teaching/learning method, will vary with the learner.

Stages of Learning

Given that people learn in different ways, there are stages of learning that have heuristic value. Although Piaget not only thought of it earlier but also said it better (10), I believe that there are four stages of learning, all necessary but often confused with each other.

The first stage is exposure to knowledge, which is too often taken as the sole attribute of the learning process. This belief is attested to by our usual requirements that students or residents complete a certain course of study, sit through a certain lecture series, or have a specified number of hours of supervision, as if exposure ensured mastery. Although exposure is a required ingredient, it in no way guarantees that any learning has occurred.

The second stage of learning is the incorporation ("assimilation" is Piaget's term) of the new knowledge or skills to which one has been exposed. Taking in the new data is a necessary, but again not sufficient, step for useful learning. This stage is often aided by repetition of information or experience and its reinforcement by multimodal exposure. For example, such multimodal exposure in a lecture may include the verbal presentation, written words on slides, and affect-laden cartoons, all to encourage the learner
to take in what is being taught.

Third, there must be some integration of the new knowledge with past ideas and concepts, a "working through" of the new information to find its place among competing ideas. Piaget's term for this is "accommodation," the rearranging of existent knowledge to include the new material so that one can make sense of it. This is facilitated by discussion with others of newly incorporated ideas; through problem-solving tasks that require bringing together the new knowledge with other, potentially conflicting, concepts; and by opportunities or requirements to integrate disparate ideas learned at different times or from different teachers. For example, studying for Board exams requires, often for the first time, that the psychiatrist integrate all he has learned about schizophrenia in various clinical settings and throughout different phases of training, including epidemiology; descriptive and dynamic psychopathology; biological, social, and psychological etiologic hypotheses; and the varying pharmacologic, psychologic, social welfare, and medical aspects of comprehensive treatment. Similarly, preparation for teaching and writing for publication requires such synthetic integration of old and new knowledge.

Although it can be considered a part of the integration/accommodation stage, I have added a final stage of learning that I call mastery of the skill or knowledge, which requires reinforcement through regular use. Through use, new knowledge not only becomes mastered but also leads to seeking out further information that may confirm or be at odds with what one has mastered. Knowledge that is either not useful or rarely used is not likely to be retained, and any teacher should question the wisdom or necessity of teaching it in the first place.

These stages of learning are clearly relevant to how and what we teach. We can require students to be exposed to anything, but the incorporation, integration, and mastery tasks depend on the relevance, interest, and usefulness of the material to the learner. One way to have multimodal reinforcing exposure, which demands incorporation and integration and provides opportunities for mastery through use, is the case- or problem-based teaching method, well developed in business schools and just taking hold in medical schools and teaching hospitals (11,12). It bases learning on small-group problem solving of model "cases," which require that the learners seek out and integrate the relevant basic science and clinical knowledge necessary to understand a specific person's medical dilemma.

Evaluation of and Rewards for Teaching

Can teaching be rigorously evaluated and, if so, adequately rewarded? I am confident that both are possible, although neither is routinely done. Medical school deans often say that they highly value teaching and think it the core of the school, but feel it cannot be evaluated as rigorously as research production and therefore can never have the standing that the latter has in promotion decisions. I believe, however, that we already have the criteria and tools for rigorous evaluation of teaching (13).

A first criterion of teaching effectiveness is whether students learn the expected material or skills. Although the teacher alone cannot produce this learning, his ability to ally with the students and facilitate their learning should be mirrored in the improved test scores of his students. Second, we should ask our students to evaluate the helpfulness of our teaching efforts as one valid criterion of teaching skill. The students are the consumers of our teaching, and if we don't satisfy their needs, what are we teaching for? Third, we can peer review teaching just as we peer review journal articles. As an editor and reviewer of manuscripts, I see my job as evaluating both the quality of the science and its readability, i.e., how well it communicates its points to the reading audience. The same criteria can be applied to teaching,
with fellow faculty sitting in on lectures, seminars, and supervisory sessions directly or via videotape and evaluating the quality of the teaching against defined standards of content and process. There is subjectivity in such evaluation, but no more so than in the review of journal articles (14), which are the accepted currency of academic achievement, rewarded by promotion and grants in our medical schools. Finally, teaching innovations and materials (teaching videotapes, interactive computer or videodisk materials, innovative curricula, novel programs to aid the professional development of the learner, etc.) can be reviewed by a panel of expert judges and evaluated for their originality, quality, and contribution to the field.

However, it is an Alice in Wonderland world we live in when we are told that teaching is the first task, the heart of the medical school, but that doing it well will not bring advancement in academia. One reason for this paradox is that researchers, rather than teachers, bring in large grants with 50–100% overhead payments and also spread the name of the school or hospital throughout the country via their publications and presentations. Psychiatric teachers, on the other hand, rarely bring in outside funds since the decline a decade ago in NIMH support for training, and those training grants that have survived have only an 8% overhead. Second, a teacher’s excellence is usually only known and appreciated locally. Elvin Semrad (15) was not a prolific writer and therefore not well known nationally; in Boston, however, he was a legend revered by the generation of students he taught at the Massachusetts Mental Health Center.

So, although teaching excellence can be evaluated, and such evaluation used as an important criterion for academic reward, it may well take an uprising of students, demanding that their learning and the teaching that facilitates it be valued, to make this happen. As tuitions rise and the number of applicants for medical school positions goes down, some bright dean may get the idea that he can draw the best students by announcing not that he has the best researchers (who usually have little to do with undergraduate medical students) but that he has the best teachers. At other schools, some bright students, dissatisfied with the level of teaching they are receiving for their hefty tuitions and the huge debt they are incurring to get a medical education (16,17) and finding their school’s “big names” sequestered in labs or “on the road” to speak elsewhere, may forcefully bring the importance of teaching to their dean’s attention. The need for such realizations is becoming more urgent as small group, case-based, teacher-intensive learning takes hold in U.S. medical schools; some schools have recently responded by initiating “teacher-clinician” promotion ladders on a par with “clinical investigator” paths to promotion (18).

**PSYCHIATRIC TEACHERS AS AN ENDANGERED SPECIES**

Teachers are not very highly regarded in many academic medical centers in which research and clinical care are the highest priorities. With prospective payment formulas, all hospitals are preoccupied with improving the efficiency of their clinical care and keeping their beds both full and rapidly “turning over,” activities that many hospital administrators feel are inhibited by teaching programs. With federal government cutbacks in funding for medical education, the fiscal base of teaching hospitals is in jeopardy (2,3). Psychiatric faculties, which grew in the 1960s and ’70s with earmarked NIMH monies, have already been hard hit by the curtailment of NIMH training support. Today, with all of the specialties vying for a shrinking pool of hospital training monies, psychiatry is endangered; because we don’t bring in the money that the procedure-oriented specialists do, when funds get tight we are unlikely to be near the top of the priority list of departments whose training programs get bailed out by the
Psychiatric teachers are also endangered within our own departments (19). Time is always limited, and academic psychiatrists have to do several things to earn a living, mixing clinical, administrative, and research responsibilities with teaching to support themselves. Devoting time to teaching takes time away from more academically rewarding research or more monetarily rewarded clinical endeavors. With the explosion in psychobiological research, much of which demands bench laboratory skills and/or full-time attention to stay competitive for grants, many teachers feel they are left out of these cutting-edge areas and have become "second-class citizens" in their department next to the full-time researchers. Others who teach as part of their clinical staff roles find the increasing tempo of clinical work in today’s teaching hospitals, with increased paperwork, cost pressures, and rapid patient turnover, draining them of time and energy to devote to either teaching or research. Because very few teachers receive salaries just to teach, the other things necessary to earn our keep often overshadow and intrude on our capacity to strive for excellence in teaching. When we add to all this the reality that teaching often is not considered "hard enough" to be rewarded with academic promotion, life as a teacher of psychiatry today is difficult and at times discouraging.

**SUPPORT FOR TEACHING FROM COLLEAGUES**

So why do psychiatrists teach? For me, the rewards of teaching are fourfold: the clarity I gain by having to pull together diverse ideas into a comprehensible whole in order to teach the material to a novice (I learn more when I have to integrate and synthesize a topic to teach it than in any other way); the pleasure in figuring out how to best present materials to stimulate my students to learn; the excitement of discussing interesting issues with students and going beyond what I knew when I started (that is, learning from my students as they learn from me); and finally, the privilege to have a hand in facilitating the development of the next generation of psychiatrists.

What can sustain our teaching is the support, collaboration, and stimulation we can get from our colleagues, fellow teachers and students at our home institutions and around the country. One reason we teach is to create colleagues by helping our students understand and appreciate our work. This does not mean that our purpose in teaching is to narcissistically clone ourselves, but we do try to stimulate an excitement and interest in our area of expertise to ensure its continued development. If you’re good at it, teaching is very reinforcing because your students appreciate your efforts to facilitate their learning, and, although they rarely say it to your face, they respect you for it.

However, one of the saddest aspects of the modern medical center is that many of us remain isolated from our faculty colleagues. We get so caught up in the pressures of our daily duties that we don’t take full advantage of opportunities to get together with fellow faculty to share research ideas, learn what they teach to others near and far, or discuss the developmental aspects of an academic career. It is important that we make the time (and it always requires not doing something else important) to take advantage of the fraternity of scholars that composes our department to decrease our isolation and reinforce our sense of purpose and worth. Another reason we must actively seek each other out is to avoid teaching burnout. An important preventative may be the periodic, deliberate exchange of teaching assignments with a colleague. After you’ve taught the same materials for a period of time, it can become rote and you stop learning as you teach. There comes a time when every teacher should follow the adage "If it ain’t broke, break it!" to keep his teaching alive.

It is important for academic psychia-
trists to know that there are also national
groups of colleagues from whom to learn
and with whom to share. For example, I have
found the annual meeting of the Association
for Academic Psychiatry the high point of
my academic year for the last 17 years. Its
informal format and collegial tone has
helped me develop many new ideas to
improve my teaching and share with others
some of the innovations of my training pro-
gram (20–23). Just as important, I have made
lasting friends interested in teaching who
face issues similar to mine in their academic
roles. It helps to have such a national refer-
ence group to put the experiences in your
department into perspective, to see how dif-
ferently issues are approached and taught
elsewhere than “the way we have always
done it here,” and to discuss the triumphs
and travails of your academic career without
concern for the internal competitiveness that
is an inherent part of every department (24).
Other specialized national groups, such as
the American Association of Directors of
Psychiatric Residency Training and the Asso-
ciation of Directors of Medical Student Ed-
ucation in Psychiatry, are also important
sources of perspective, encouragement, and
support for teaching.

A final national source of such collegial-
ity is the group of peers who write and read
about educational issues in psychiatry. The
American Journal of Psychiatry and Academic
Medicine are receptive to papers describing
well evaluated, innovative teaching pro-
grams. An exciting recent development is
the rejuvenation of this journal, Academic
Psychiatry, as a vehicle for academic psychi-
atrists to share ideas, findings, and programs
with colleagues nationally.

THE FUTURE AND
ACADEMIC PSYCHIATRY

Psychiatry and medicine are changing dra-
matically as organized/managed care sys-
tems become the predominant modes of
practice and the solo private practitioner be-
comes a rarity (25). Academic psychiatry
also will have to change to adapt to this
revolution in health care, and we should
expect to be kept increasingly busy, juggling
many balls to keep the academic enterprise
going.

Why, in these difficult times of organi-
zational constraints and limited funding,
should bright young psychiatrists go into
academics? One reason is that as psychi-
atrists find themselves working under multi-
ple constraints as employees of organized
medical care systems, academic organiza-
tions, even with all their hassles and bureau-
cracy, may be some of the best places to
work. Our lives are more interesting than
most in medicine because they allow us the
synergistic, although exhausting, opportu-
nity to live a four-ring circus life as we bal-
ance research, teaching, administrative, and
clinical care activities. We have benefits not
available in some other practice settings,
such as retirement programs, group health
insurance plans, and sabbatical time, and a
few even have the security of academic ten-
ure. Most important, we are constantly stim-
ulated to learn in order to teach and keep
ahead of our bright students. It is just this
opportunity for continued stimulation and
learning that may be missing in other areas
of the managed care psychiatry of the future.

If academic psychiatry is to have a fu-
ture, present faculty have the responsibility
to reach out to the best of the next generation
and tell them what we do and why we do it.
We must devote some of our precious time
to facilitating their career development, pro-
viding them the inspiration, support, and
“good enough” academic mentoring that we
received at earlier stages of our careers.
There are specific ways we can help young
psychiatrists make the difficult transition to
teaching and academics. First, we can dis-
cuss the different stages of an academic ca-
reer and openly share our experiences (26).
Second, we should describe “survival stra-
tegies” for making it within academia that we
have used and observed (27). Third, we
should invite our junior colleagues to join in our research, teaching, and writing, so that they can both learn the "right ways" to do them and get started on the path toward professional rewards. Finally, we should invite them into our organizations as colleagues, first through the numerous fellowship opportunities for residents, then through personally facilitating junior faculty's joining and getting to know others with similar interests in these organizations. Despite the tough sledding ahead, I believe the future of academic psychiatry in general, and the crucial role of teachers in particular, is still bright. Medical schools and psychiatry departments are realizing that they must reward and sustain the excellent teachers whose recruitment efforts will determine the futures of the schools and the specialty. I am encouraged that our best residents continue to make the sacrifices necessary to embark on academic careers in the face of many tantalizing opportunities in the private sector. At national meetings of colleagues I am reinvigorated by the bright junior faculty who find ways to make their teaching vital as they struggle to define a viably rewarding path through the maze of obstacles facing young academics today. It leaves me confident that whatever the future structure of medicine, we will have psychiatric teachers capable of sustaining excellence and passing it on to future generations.

This article was presented as the Outstanding Psychiatric Educator Lecture at the 1992 meeting of the Association for Academic Psychiatry in San Antonio, TX. It was adapted from a longer paper presented as a Distinguished Psychiatrist Lecture at the 1987 meeting of the American Psychiatric Association in Chicago.

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Medication Backup in Psychiatry Residency Programs

Michelle Riba, M.D.
Richard Seth Goldberg, M.D.
Allan Tasman, M.D.

All directors of U.S. adult psychiatry residency training programs (N = 202) were surveyed in 1988 about the practice of medication backup by trainees in their programs. Medication backup was defined as "the provision of medications by psychiatrists to patients receiving psychotherapy from nonphysicians." Of 110 respondents, 94 of the programs (85%) had residents providing medication backup, the majority in the PGY-3 and -4 years. The university hospital inpatient service and the community mental health center outpatient clinic were the most common sites. Supervision was the most prevalent training method (84 programs), followed by lectures and seminars (45). Sixty-four program directors viewed medication backup as a useful and important function for the psychiatrist; 48 raised ethical concerns. Results point to the need for further investigation into the practice of medication backup in residency training.

In many psychiatry residency training programs, residents provide psychotropic medication to patients who are being seen for psychotherapy by therapists who are not physicians. Some common terms for this practice are "medication backup," "medication check," and "medication coverage," but neither the definition nor the scope of this practice has been well defined for psychiatric residents or for practicing psychiatrists (1-4). There is scant information on guidelines for training, legal or ethical criteria, or methods of appropriate supervision for residents providing medication backup (5,6). In one of the few studies on the subject, McNutt et al. (7) proposed guidelines based on interdisciplinary dilemmas faced by trainees, staff, and patients in the outpatient psychiatry department of a New York teaching hospital. These guidelines focused on responsibilities of the medication backup psychiatrists in such areas as managing psychiatric emergencies, medication side effects, and quality of care. Our study was undertaken to better understand the prevalence of the practice of medication backup in the adult psychiatry residency training setting.

METHODS

In November 1988, a 10-question, 3-page survey and cover letter were sent to all 202 directors of U.S. adult psychiatry training...
programs listed in the 1988 Directory of Psychiatry Residency Training Programs (8). The questionnaire was designed to be brief yet informative. A stamped, self-addressed envelope was enclosed with the survey to increase rate of response. At the beginning of the survey, “medication backup” was defined as the provision of medication by psychiatrists to patients receiving psychotherapy from nonphysicians. The questionnaire sought information in the following categories: 1) prevalence of the practice, 2) settings of care, 3) training and supervisory methods employed, and 4) attitudes of training directors. Respondents were also given space to provide comments and to give their name and institution. Because of financial and time constraints, no attempt was made to solicit information from nonresponders.

RESULTS

From the 202 U.S. programs, 110 residency training directors (“directors”) returned the survey, a response rate of 54%. All responses were usable, but not all questions were answered by each respondent. The respondents represented a wide variety of types of programs (Table 1). Respondents and nonrespondents did not differ by type of program or university/medical school affiliation, although larger programs (40 or more residents) were somewhat over-represented among the respondents.

Of the 110 responding programs, 94 (85%) require their residents to provide medication backup. Sixty-four directors (58%) think medication backup is a useful and important function for psychiatrists, and 67 (60%) view it as a useful part of psychiatric training. Forty-six (41%) feel that the topic warrants further study; 32 (29%) think that it requires special training; and 48 (43%) feel that it raises serious ethical questions. Nineteen directors (17%) view medication backup as primarily a service obligation.

Sixty-four directors (58%) believe that residents find medication backup a useful and important function for psychiatrists, and 62 directors (56%) believe that residents see medication backup as an important part of their training (Table 2). The directors noted that attending psychiatrists also provide medication backup in their staff roles in 82 programs (74%) and in their private practices in 50 programs (45%).

The 94 program directors who do require their residents to provide medication backup were asked additional questions about this function in their programs. The directors said the residents may provide medication backup in more than one year of training. Residents provide this service in PGY-4 in 71 programs (75%); in PGY-3 in 85 programs (90%); in PGY-2 in 44 programs (46%); and in PGY-1 in 7 programs (7%).

Residents provide medication backup in both the inpatient and outpatient settings, with the university hospital the most common inpatient setting (22 programs, 23%) and the community mental health center the most common outpatient setting (51 programs, 54%). In the outpatient setting, residents see their medication backup patients at least once a month in 75 programs (79%).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total</th>
<th>Responders</th>
<th>Nonresponders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freestanding or private</td>
<td>21</td>
<td>11 52%</td>
<td>10 47%</td>
</tr>
<tr>
<td>Affiliated or operated by university/medical school</td>
<td>178</td>
<td>94 52%</td>
<td>84 47%</td>
</tr>
<tr>
<td>40 or more residents in program</td>
<td>29</td>
<td>17 59%</td>
<td>12 41%</td>
</tr>
</tbody>
</table>

Note: Characteristics as described in the 1988 Directory of Psychiatry Residency Training Programs (8).
In 4 programs, residents see their medication backup patients less than once a month; and in 3 programs, patients are seen only initially by residents. In the last group, presumably, patients would be followed by other psychiatrists if medication were necessary for ongoing care. Twelve of the 94 directors who said residents provide medication backup in their programs did not answer the question regarding frequency of visits.

In the 94 programs in which residents provide medication backup, 92 of the directors answered a question about the format of such treatment. In 21 programs (22%) residents see medication backup patients exclusively in individual sessions; in another 71 programs (76%) patients are treated either in medication groups alone or in a combination of medication group and individual sessions.

When asked about training and supervision for the backup task required of their residents, 84 directors (89%) report that most resident education about medication backup is derived from supervision; 45 directors (48%) report providing lectures and seminars; and 12 (13%) provide written materials. Nine directors (10%) admitted providing no training in medication backup even though residents must provide this service. Eighty-seven program directors responded to a question about how long medication backup had been part of their program. Forty-seven (54%) said that it had been part of the program for more than 10 years, and 40 (46%) had required this task for 1 to 10 years.

**DISCUSSION**

The results of this study illustrate three interesting and potentially important issues related to the practice of medication backup in psychiatric residency training programs. First, residents are routinely asked to perform a function for which there are no generally agreed-upon standards for the frequency or format of care. Second, residency training directors are not clear about what constitutes adequate training in medication backup. Although 12% of the program directors say that they provide their residents with written materials on this subject, we have found almost nothing in the literature specifically about the medication backup task. This raises our suspicion that programs do not offer distinct training on medication backup—a view consistent with Vasilie and Gutheil's conclusion in 1979 (2) that there was little formal education and training of residents on the "medical backup phenomenon." Some of the respondents who did answer affirmatively about providing lectures wrote that instruction is based on the usual psychopharmacology curriculum, implying

<table>
<thead>
<tr>
<th>TABLE 2. Survey of respondents' personal attitudes and opinions of residents' attitudes toward medication backup</th>
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</thead>
<tbody>
<tr>
<td><strong>Directors think these are residents' attitudes</strong></td>
</tr>
<tr>
<td><strong>n</strong></td>
</tr>
<tr>
<td>Medication backup is a useful and important function for psychiatrists</td>
</tr>
<tr>
<td>is a useful and important part of psychiatric training</td>
</tr>
<tr>
<td>requires more study</td>
</tr>
<tr>
<td>requires special training</td>
</tr>
<tr>
<td>raises serious ethical questions</td>
</tr>
<tr>
<td>is contraindicated in certain patients</td>
</tr>
<tr>
<td>is primarily a service obligation</td>
</tr>
</tbody>
</table>

*Note: Number of respondents = 110. Some directors gave more than one response.*
that there is little special educational input on this subject.

Third, at the same time that over 85% of the responding program directors have their residents perform this function, 43% of the directors report having serious ethical questions about it. Some directors (30%) also believe residents find this practice ethically questionable. One director wrote, "This issue is a loaded gun"—a sentiment similar to those of practicing psychiatrists in Connecticut in our earlier study (4), who noted both ethical and liability concerns about providing medication backup.

Several limitations to this study must be acknowledged. Even though our questionnaire provided a definition of medication backup, this concept has not been generally well defined, and all respondents may not have been commenting on the same task. Next, although we noted no significant differences in program types between responders and nonresponders, our response rate was only 54%. Finally, we did not specifically ask about the role and relationship of case managers to residents and patients. This may be important in trying to determine the differences between medication backup in a community mental health center and other outpatient or inpatient settings.

Our results suggest that further studies of medication backup in residency are needed. An important next step will be to survey psychiatric trainees directly. This should provide a clearer picture of this practice and residents' preparation for it. Further study should also explore more specifically the frequency at which residents see medication backup patients, the length of such sessions, communication strategies used with the nonmedical therapist, and consequences for trainees who do not wish to provide this type of care. Economic, clinical, and political forces that encourage the practice of medication backup in residency programs also need to be explored. Finally, the effect on patient care and ways to optimize residency training for the medication backup task must be studied.

This work was presented in part at the annual meeting of the American Association of Directors of Psychiatric Residency Training, San Diego, CA, January 1989.

References

New Idea

Teaching Consultation Psychiatry Through Computerized Case Simulation

John S. Jachna, M.D.
Seth M. Powsner, M.D.
Patrick J. McIntyre
Robert Byck, M.D.

The PsyConsult Adventure Simulation program presents a case simulation of consultation in a general hospital. Exploring this computerized case helps trainees prepare for the complexities of consultation that they will face on the hospital wards. The simulation provides a distinctive approach, modeling the process of an actual consultation and allowing trainees to explore on their own initiative. It presents general techniques of psychiatric consultation as well as specifics of diagnosis and treatment. The program demonstrates the feasibility of using case simulation with a personal computer system as a supplement to bedside teaching of consultation psychiatry.

Computer-assisted instruction is developing as a useful supplement to existing teaching techniques (1,2). Evidence is building that well-constructed programs can be effective adjuncts to teaching. Recent efforts have created software in a variety of fields offering new types of learning experiences that augment traditional methods (1,3,4). Case simulations are particularly effective because they present standardized patient encounters and allow trainees to try various approaches without the consequences of errors during patient care. Audiovisual features take these programs far beyond the more primitive question-and-answer educational software. Ideally, simulation software transforms the presentation of medical facts into an interactive exploration of medical knowledge. It challenges trainees to go beyond memorization to understanding and using concepts.

Teaching psychiatric consultation in a general hospital presents a unique educational opportunity and a distinct educational challenge. The consultation setting for providing psychiatric care is one in which many trainees have little experience. They must learn to obtain medical, psychological, and social information about a patient. Simultaneously, they must try to integrate and understand the information within the dual contexts of the hospital and the patient's life. Finally, they must acquire the psychiatric knowledge needed for appropriate diagnosis and treatment. Trainees submerged in this process can feel lost in a strange, puzzling world.

To assist them, the paradigm of computer adventure game programs, familiar to many trainees, can be converted to educa-
tional ends. These programs were originally designed to simulate imaginary worlds with many possible paths, a variety of traps and challenges, some helpful characters, and a goal such as buried treasure. The fantasy setting can be changed to the setting of the hospital, with many wards, numerous staff and patients, and the goal of an accurate evaluation. An adventure format has been used in the medical education program “Bugs and Drugs” (5), which teaches antibiotic use.

THE SIMULATION PROGRAM

The PsyConsult Adventure Simulation program has been designed to introduce medical students and residents to consultation psychiatry. It was developed using HyperCard™ for the Macintosh personal microcomputer and can be used on a standard Macintosh computer running the HyperCard program. It includes 87 individual scenes and over 25 characters. For effective use, the simulation requires a hard disk drive. (Copies of the program are available on written request from Dr. Jachna; please enclose $5 to cover the costs of disks and shipping.)

Of the variety of possible simulation approaches, the PsyConsult Adventure Simulation uses a state-based model akin to ones used in acid-base or pulmonary physiology simulations (6). Just as acid-base simulations keep track of electrolyte concentrations, the simulation keeps track of interactions the trainees have had with staff and patients, how long each conversation has lasted, what information has been discussed, and similar details. These are the relevant aspects of the “state” of an interview. Based on the trainees’ actions, the simulation adjusts corresponding state variables. It may appear to have much in common with traditional branching-path simulations of clinical case management, but that is an artifact of the non-numeric information. Unlike the fixed sequence of events in a branching-path simulation, which does not allow the trainees to return to the same place and try again, PsyConsult allows trainees to return to a scene as often as needed, as part of an infinitely convoluted path. Only the beginning and end are fixed: start and finish at the office for rounds. A random factor in some responses provides variety. All the elements of the simulation are independent, so trainees can examine them closely, peruse them casually, ignore them, or even miss them entirely, depending on the way they explore.

Simulation Design

The Yale-New Haven Hospital psychiatric consultation service takes a focused, problem-oriented approach based on the belief that a request for consultation is a request for help with a specific problem. The request may be imprecisely stated, so the first task is to determine the true basis for the request. The consultant should then be able to apply specialty expertise to recommend a specific solution to the problem. This approach places a premium on getting the facts of a case promptly and accurately. Computer adventure simulation is a rich medium, one that can blend subtle issues of the philosophy of consultation with diagnostic criteria and drug dosages. This is an appealing opportunity for a service trying to convey not just the facts, but also a style of consultation.

The case used in the PsyConsult simulation is an amalgam of several cases seen by our service. The trainee is asked to see a veteran who was badly burned in a fire. He has a history of alcohol abuse, and the staff is concerned about recent depression and agitation. Issues include the effect of medical illness on the presentation of psychiatric symptoms; the nature of psychological reactions to disabling illness; and the appropriate use of social services, chaplains, and substance abuse counselors. While using the program, trainees can learn criteria for diagnosis of alcoholism, depression, and post-traumatic stress disorder, and correct
dosages of narcotics and benzodiazepines.

On another level, the simulation deals with stylistic aspects of consultation. It rewards a respectful approach to patients and staff with more informative dialogue. Timely consultations are rewarded with higher scores, so trainees must decide when to make decisions with limited data. A meandering tour through the hospital will be penalized if it makes trainees late for rounds. Focused consultations are rewarded. These responses are meant to convey the service’s philosophy without being pedantic.

Conceptually, the case can be divided into several steps. The simulation starts at the door of the consultation service office. The trainees must cope with mundane details such as getting into the office, meeting the secretary, and finding out that a doctor wants a patient seen. They must then determine the nature of the request and locate the assigned patient within the hospital. The implicit message is that mastery of the details of consultation is necessary in order to have a chance to progress to mastery of the consultation itself. Also, this approach allows trainees to learn the mechanics of using the simulation before they reach central aspects of the case.

After obtaining the case assignment and leaving the office, trainees choose their own path through the simulated hospital, gathering information and trying to avoid pitfalls of poor consultation technique. The patient and staff must be properly addressed to obtain information, and the trainees must gauge the appropriate depth of questioning. The information must be corroborated by others, including nurses, doctors, family, and friends. The trainees may simply “run into” these people while exploring or may need to locate them in the hospital or by phone. Each can provide information that can be useful, immaterial, or even misleading, depending on the trainee’s approach. For example, simply relying on the initial report of alcohol abuse can result in an inaccurate perception of the simulated patient. If the trainees have spoken to the patient’s brother and obtained other clues, they will be able to place this history in its proper context. Among the other information sources available are the hospital chart, medication record, vital signs record, old chart, laboratory computer, and hospital formulary.

The trainees “walk through” this simulated hospital environment scene by scene. A combination of graphic images, text descriptions, dialogue, and sound effects adds to the realism (Figures 1 and 2). In each scene, trainees use the mouse to signal their moves, usually by clicking on an object in the scene and triggering a response. For example, clicking on a doorknob opens a door and causes the trainees to enter a new room. Selecting a telephone causes a call to be placed. Trainees receive immediate responses, with rewards for correct choices and penalties for inappropriate actions. Figure 1 provides a sample scene of the simulated office.

The graphic images provide more information than purely text-based interactions and allow more natural simulation. Interactions with the patient, staff, or friends are represented by an illustration of the person, occasionally accompanied by simple animation and text of the dialogue. This text- graphic approach requires only a desktop personal computer, with no need for additional equipment such as a videodisk. (Although a videodisk can offer more detail, it still permits only a fixed set of choices.) The simple hardware needs of the PsyConsult program allow it to be used in a variety of settings.

To make the simulation realistic, the program monitors factors such as effort expended and time elapsed. If too many extraneous selections are made, the trainees will be unable to arrive at rounds on time. The program stops the simulation and provides an explanation if this occurs or if the trainee makes a particularly egregious error. Less serious errors have less serious conse-
FIGURE 1. Clicking on the secretary's desk moves the trainees toward her. Other possibilities may appear in the upper right, like the option here for the trainees to leave the office. Text at the bottom of the screen provides background. Symbols in the lower right of each scene allow the trainees to consult a hospital map, monitor factors such as time, "page" the chief resident to ask for hints, or "go home," quitting the simulation.

FIGURE 2. The trainees "talk" to the character by selecting a choice at the right of the screen. The full text of each of the possible statements or questions can be read at the bottom of the screen.
quences. The simulation strives to provide the trainees with prompt feedback and a sense of the actual challenges presented by the consultation process. Humor helps hold the trainees’ attention.

In the PsyConsult Adventure Simulation, scenes simulating conversation with staff or patients allow trainees to choose among a set of possible statements or responses (see Figure 2). Providing a set of responses limits creativity, but it avoids the need to guess what choices the computer will understand and avoids most typing. Each character’s attitude changes based on prior interactions. As trainees progress into the simulation, the choices become more subtle and the information elicited depends more heavily on the trainees’ style of interaction.

The patient interview scene presents a more involved “conversation.” The trainees can ask about history of present illness, past history, social history, and mental status examination. The patient provides an initial reply in each category. The trainees have the option of asking for supplementary information. Clearly, this provides much less subtlety of detail than live patient interviews or even videotaped interviews. There has been a conscious effort to minimize the details of individual interviews and emphasize the need to identify and integrate information from the range of available sources. The focus of this program is on teaching the process of hospital consultation rather than on teaching the acknowledged intricacies of patient interview, which may be better introduced by other methods.

The final scene is the presentation of rounds. The trainees select, from a panel of statements, those that best fit their impressions of the case. The statements are offered in groups covering the patient’s presentation, diagnosis, and appropriate treatment. The program reviews the trainee’s selections and reports a specific critique of each. It then reports a total score and the time needed to complete the consultation. As the program ends, it awards and prints a personalized certificate based on the score.

Evaluation

To assess the program’s effectiveness, five groups of third-year medical students (a total of 38, ranging from 2 to 10 students per group) were allowed to use the simulation in the seminar series on consultation psychiatry. All groups were first asked to answer a set of 10 multiple-choice, single answer questions. Five covered general issues in consultation psychiatry. The other five related to specific points that are covered in the simulation but are not part of the final “rounds” presentation of the simulation. These included questions about medication issues, such as the importance of adequate pain relief, and issues of obtaining clinical information, such as knowing the type of information one could likely expect to obtain from a head nurse.

The trainees were provided with a basic introduction to the use of the program, then completed the simulation together. Interaction and discussion among the students about the case was encouraged. One member of the group was selected to make the final choices when the group was in conflict with no clear majority opinion. After they completed the case, the students were re-tested on these questions.

The trainees’ answers generally became more accurate after use of the simulation, especially in the questions related to the simulated case (Table 1). On paired t-tests, the degree of improvement in both case-related questions and general psychiatric questions, and the difference in improvement between the two types of questions were all significant at the 0.05 level or better. Only one group of trainees was an exception to this general trend of improvement. Notably, this group was the only one unable to present the case accurately, having missed some important aspects of the case in their initial use of the simulation. The other four groups were
able to identify the important issues involved and—after much debate at times—accurately present the case. The response of the student groups and individual residents to the simulation was quite positive. They commented on the simulation's realism and the interest generated in the material by this approach. Attendance at subsequent seminars in the series improved after this program was introduced as the initial session for each group.

**DISCUSSION**

As used in our teaching seminars, the PsyConsult Adventure Simulation is a springboard for group discussion of issues involved in psychiatric consultation and an opportunity to make trainees aware of subjects for further study. With a single case available for use, the simulation does not cover a complete course of study, but it does offer an introduction to some issues and situations commonly encountered in consultation. The case-based approach increases students' interest and engages them in exploration of the subject. This exploration can then be continued in conjunction with other parts of the curriculum.

Bedside teaching will continue to be essential for training in consultation psychiatry. A review of the results of a consultation does not always give a clear picture of the groundwork needed to produce the final product. Once trainees gain experience, they eventually become familiar with the techniques needed to provide effective consultation. During orientation, however, these can be difficult skills to appreciate. This program allows for a safe, simulated interaction with the patient and staff in a variety of hospital settings. It does this without expensive video equipment. Through its distinctive format, the trainees have an opportunity to try different approaches to the consultation in a free-form exploration of a simulated hospital. They can gradually learn the most rapid and accurate route to the crucial facts about the case. The immediate feedback guides trainees toward proper technique. These lessons about the facts and philosophy of our consultation service are applicable in actual consultations and are presented in a way that resembles real experience. The PsyConsult Adventure Simulation demonstrates a case-related presentation of facts and techniques of general hospital consultation, captured in an enjoyable, educational manner.

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**TABLE 1. Quiz performance by 38 students before and after using simulation in class**

<table>
<thead>
<tr>
<th></th>
<th>Five questions related to case</th>
<th>Five questions on general psychiatry</th>
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</thead>
<tbody>
<tr>
<td>Total correct/190 (%)</td>
<td>127 (67%)</td>
<td>149 (78%)</td>
</tr>
<tr>
<td>Before</td>
<td>153 (81%)</td>
<td>163 (86%)</td>
</tr>
<tr>
<td>Change in number correct (%)</td>
<td>26 (14%)</td>
<td>14 (8%)</td>
</tr>
<tr>
<td>Significance (P) level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within question type</td>
<td>0.005</td>
<td>0.025</td>
</tr>
<tr>
<td>Between question types</td>
<td></td>
<td></td>
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</tbody>
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*Note: The quiz consisted of 10 multiple-choice questions. Five related to specific issues addressed in the simulation. Five related to general psychiatric issues. Significance levels of the change in score before and after the simulation were calculated using two-tailed paired t-tests for each of the 38 students' scores in both question categories.*
References

Q and A

Questions and Answers
About Psychiatric Education

Frequently Asked Questions
About the American Board
of Psychiatry and Neurology

[Editor’s Note: In this new section, noted psychiatric educators respond to questions frequently asked about their areas of expertise.]

Stephen C. Scheiber, M.D.

Q: What are the minimum training requirements for psychiatry needed to apply for the American Board of Psychiatry and Neurology (ABPN) examination?
A: It is necessary to complete a PGY-1 that includes a minimum of 4 months of primary care and 2 months of neurology, followed by PGY-2, -3, and -4 of residency training in psychiatry. Also, it is necessary to have an unlimited license to practice. It is not possible to take the Part I examination until the year after completion of residency training.

Q: Will the ABPN accept a rotation in emergency medicine as 1 of the 4 months of primary care training?
A: Yes, 1 month, but no more, of the required 4 months in internal medicine, family practice, and/or pediatrics can be fulfilled by an emergency medicine rotation, so long as the experience is predominantly with medical evaluation and treatment as opposed to performing surgical procedures.

Q: What is the ABPN's policy on maternity leave, vacation time, or leave time?
A: The ABPN adopted the policy that leave or vacation time may not be used to reduce the amount of required residency training or to make up deficiencies in training. The ABPN does not have a policy regarding the amount of leave or vacation time allowed; each program may develop individual leave or vacation time in accordance with its overall institutional policies.

Q: How can training directors in psychiatry receive data regarding the ABPN performance of graduates of their program?
A: The performance of graduates on examinations for certification by the ABPN may be obtained by the training director by writing to the ABPN office. All requests must be submitted in writing by the program director or by the chairman each time the information is desired.

Q: When does the ABPN cease issuing lifetime certificates?
A: Effective October 1, 1994, all individuals achieving ABPN certification by the ABPN, Inc., in psychiatry, neurology, neurology with special qualification in child neurology, and child and adolescent psychiatry will be issued 10-year time-limited certificates. Physicians who become board certified before
that time will receive lifetime certificates. The first recertification examination will be given no later than January 1, 2000.

The certificates of added qualifications, beginning with geriatric psychiatry and followed by clinical neurophysiology and addiction psychiatry, are valid for 10 years from the date of issue.

Q: Where is the information published regarding the pass rates on ABPN examinations?
A: The pass/fail percentages and updates on the policies of the ABPN are published in the August issue of the American Journal of Psychiatry and the August issue of Neurology.

Q: What are the minimum requirements of training for child and adolescent psychiatry?
A: Applicants seeking certification in child and adolescent psychiatry must meet the following requirements: an approved PGY-1 for psychiatry, 2 years of residency training in psychiatry in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada, and 2 years of ACGME-approved residency training in a child and adolescent program.

Q: What is the earliest that a Part I application can be submitted by a resident in child psychiatry?
A: An application may be submitted for examination in psychiatry after successful completion of the PGY-1 plus 2 years of residency training in psychiatry and 1 year of residency training in child and adolescent psychiatry.

Q: When can a fully trained psychiatrist apply for the ABPN written examination?
A: Applications are available by contacting the ABPN office. They are due in the ABPN office the September 1 prior to the date of the Part I examination. The Part I examination is currently held in the spring. (The ABPN will hold two written examinations in 1994, one in the spring and one in the fall. Beginning in 1995, the Part I examination will be given only in the fall, and the examinations for added qualifications will continue to be held in the spring.) The next Part I examination will be given on March 30, 1993. There is no limit on the number of times an applicant can apply for the Part I examination.

Documentation must include an unlimited license in addition to a certificate or a letter from the training director verifying successful completion of residency training. Documentation must include the exact dates of training.

If the candidate did not complete a categorical year in internal medicine, family practice, pediatrics, surgery, or OB-GYN, he or she must submit a letter from the program director detailing the PGY-1. This must include the exact length and content of rotations.

Q: When are the added qualification examinations planned for board-certified psychiatrists?
A: The first examination for certification in added qualifications in addiction psychiatry will be held March 30, 1993. The application deadline was September 1, 1992.

The next examination for certification in added qualifications in geriatric psychiatry and in clinical neurophysiology will be held in the spring of 1994. The application deadline is September 1, 1993.

Dr. Scheiber is executive vice president of the American Board of Psychiatry and Neurology, Inc., 500 Lake Cook Road, Suite 335, Deerfield, IL 60015.

The author acknowledges the assistance of the following people in preparing these questions and answers: Pat Janda, credentials coordinator; Patti Difino, child and adolescent psychiatry coordinator; Jackie Posternak, Part I coordinator; Maria Alonzi, Part II coordinator; Lyn Maddox assistant director of administration; and Jean Ferrone.
Book Forum

Shame and Pride: Affect, Sex and the Birth of the Self
By Donald L. Nathanson
New York, W.W. Norton, 1992
ISBN 0-393-03097-0, 480 pages, $24.95

Reviewed by Craig L. Donnelly, M.D.

Einstein once remarked, "Explanations in science should be as simple as possible, and no simpler." Donald L. Nathanson, in his book Shame and Pride: Affect, Sex and the Birth of the Self, has just such a taste for necessary complexity and offers a richly constructed treatise on affect theory to explain the relevance of shame in human experience.

The book promises much, and delivers. Dedicated to Silvan Tomkins, an experimental psychologist who developed his theory of affect nearly 40 years ago and is not widely known outside of affect theory and psychological testing circles, it is an explicit attempt to bring Tomkins's theory into the prominence in contemporary social and psychological thought that Nathanson believes it deserves. The book begins with rather simple premises: "Affect makes good things better and bad things worse... Affect is the engine that drives us." Moreover, affect is a built-in biologically determined amplifier of our internal and external experiences, no less important in evolutionary terms than the development of intelligence.

Nathanson briefly reviews the history of emotion theory, beginning with Darwin's The Expression of Emotions in Man and Animals. He critically reviews the James-Lange hypothesis, Freud's drive theory, the Jung-Hillman theory, and other energy transformation theories before segueing into his and Tomkins's theory. In it, affect is defined as the innate and strictly biological portion of emotion, triggered by a specific stimulus that releases a pattern of biological events.

With a nod to the ethologists Tinbergen and Lorenz, Nathanson tells us, "Affect theory states simply that the affects are triggered by meaning free alterations in biological systems, that they cause changes to occur at sites all over the body, and that we learn to appraise these changes with growing sophistication as we grow older." It is the myriad forms of the evocation and appraisal of affect, and our reactions to it, that are the basis for the remainder of the book.

Although Nathanson attempts to weave in explanations of the biological mechanisms involved in triggering and expressing affect through the use of pictures of babies' facial expressions, other empirical findings, and clinical anecdotes, his theory rests largely on conjecture and empirical data without firmer ties to the scientific literature in brain and behavioral physiology. His explanations are nevertheless thought-provoking and appeal to informed common sense in the way that Paul MacLean's ontological theory of the triune brain has an explanatory appeal for neurobiologists.

Much attention is given to explicating Tomkins's affect theory as a framework for the introduction of the nine innate affects: interest-excitement, enjoyment-joy, surprise-startle, fear-terror, distress-anguish, anger-rage, "dismell," disgust, and shame-humiliation. The book takes time to gain momentum in the early going, but with the theory outlined and the nomenclature defined, Nathanson then casts a wide net in demonstrating the range and explanatory utility of affect theory in human experience. Topics such as true love, shame, pride, the use of pornography to control humiliation, classic drive-based psychoanalysis, Bowlby's attachment theory, masochism, the comedy of Buddy Hackett, and the current violence of inner-city culture in America are pursued from the fresh perspective of an
affect-based interpretation. Nathanson invites the reader to rethink contemporary psychiatry's equally weighted triad of emotion, cognition, and behavior as the basis for organizing thinking about human being. He suggests, using examples from Greek mythology, popular culture, and computer modeling, that affect cannot be so easily isolated from thinking and behaving. Indeed, as the "engine that drives us," it shapes our most private internal experiences as well as our most complex social interactions. From the personal to the political, from the sexual to the societal, it is affect that provides the motive force to existence.

Some of the most original and enjoyable material in the book is to be found in the chapters on sexuality. Although falling short of providing, as the chapter title suggests, "A New Theory of Sexuality," Nathanson's discussion of the differences in sexual drive and arousal mechanisms in men and women is inclusive and insightful. His excursions into the developmental patterns of male versus female arousal and their ties to the affective states of shame, excitement, and fear highlight intrinsic differences in the experience of maleness and femaleness. The function of rape fantasies in men and women and the counter-shaming strategies invoked by homosexuals to preserve self-esteem in a homophobic culture are examples of the topics that Nathanson explores in his discussion of inhibited and uninhibited enjoyment of sexual arousal. Vivid and true to life, his examples spare the clinical jargon and meta-psychology found in much of the contemporary literature on human sexuality.

I found this book delightful on both reading and rereading. Although it is about many things, at bottom this is a book about shame. It is a virtual compendium of the phenomenology of shame in human experience. The book has clear relevance for psychotherapists and researchers in affect theory. For the professional psychotherapist it has the informational value of a textbook but the readability of a novel. Its wittiness, lack of jargon, and vivid applicability to real life make it highly accessible to the psychologically minded casual reader. I can highly recommend this book for those who seek to understand the power and influence of shame in our intrapsychic and interpersonal lives and in the broader context of our social existence.

Dr. Donnelly is executive chief resident, Department of Psychiatry, Duke University Medical Center, Durham, NC.

Psychiatric Ethics, 2nd Edition
Edited by Sidney Bloch and Paul Chodoff, M.D.
New York, Oxford University Press
556 pages, $120.00 hardcover,
$55.00 paperback
Reviewed by Thomas J. Oglesby, M.D.

For its second edition, the already popular Psychiatric Ethics has been revised and updated with six new chapters and nine new contributors. Fortunately, the core of gifted writers remains, and the new contributions, especially Paul Brown’s "Ethical Aspects of Drug Treatment," are excellent. Although bibliographies are included and the content is didactic, the best chapters read like well-crafted essays.

In their introduction, the editors challenge the readers' "denial" that routine psychotherapeutic decisions are ethically neutral and carry no political or social consequences. They warn that the "civil liberties approach" to mental illness, which is our present response, could destroy psychotherapy itself. This section emphasizes the practical daily need to examine more closely the contemporary ethical issues that guide our behavior as psychiatrists.

The reader is offered a basic course in ethics, quickly immersed in theoretical topics, and then presented concrete clinical examples of contemporary problems. The volume succeeds in describing and suggest-
affect-based interpretation. Nathanson invites the reader to rethink contemporary psychiatry's equally weighted triad of emotion, cognition, and behavior as the basis for organizing thinking about human being. He suggests, using examples from Greek mythology, popular culture, and computer modeling, that affect cannot be so easily isolated from thinking and behaving. Indeed, as the "engine that drives us," it shapes our most private internal experiences as well as our most complex social interactions. From the personal to the political, from the sexual to the societal, it is affect that provides the motive force to existence.

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The format, using many experts from various subspecialties (geriatric, forensics, etc.), results in an inevitable variation in writing styles and levels. Fortunately, even the weakest chapters are superior to most contemporary textbooks.

Although of interest as a reference to all psychiatrists, this volume will be especially useful to those who serve on the ethics committees of their community hospitals and local American Psychiatric Association chapters. In addition, it is an essential tool for the directors of psychiatry residency programs. It is at present the most complete and authoritative text available in this subject area.

Dr. Oglesby is chief medical officer, Medical Services of Circuit Court of Baltimore City, Baltimore, Maryland.

To Paint the Stars: The Life and Mind of Vincent van Gogh (videotape)
Coordinating Producer: Richard Jed Wyatt, M.D.; Executive Producer and Writer: Kay Redfield Jamison, Ph.D.; Producer: Benjamin Brady Magliano; Director: Alan Skog
Washington, D.C., Manic-Depressive Foundation, 1991, 60 minutes, $28.95

Reviewed by Rif S. El-Mallakh, M.D.

Dr. Richard Jed Wyatt and Kay Redfield Jamison have combined their extraordinary efforts and talents toward the production of a four-part series of documentary programs aimed at increased understanding of bipolar illness. Unlike most such documentaries, however, this series is unique in that it places the scientific issues of genetics, pathophysiology, and treatment within the fascinating framework of artistic endeavor. Each of the four programs deals with a different aspect of artistic ability: music, visual arts, literature, and the performing arts. The first ("Moods and Music") and this, the second installment, are available; the third and fourth are still in production. The general format is to focus on the life and work of one or more accomplished artists who also happen to be afflicted by bipolar illness. The programs use the presentation of the art to stimulate the curiosity and capture the attention of the viewers and then subtly educate them about the scientific, human, and ethical aspects of bipolar illness.

Efrem Zimbalist, Jr., hosts the program, and British writer and broadcaster John Julius Norwich is the voice of Vincent van Gogh. Singer-songwriter Don McLean performs his well-known song "Vincent" and another song specifically written for this program. The show features more than 150 of van Gogh's paintings from 35 private collections and museums throughout the world. Commentary is provided by leading art historians (J. Carter Brown of the National Gallery of Art, Susan Stein of the Metropolitan Museum of Art, and others) and clinical scientists (Raymond DePaulo, Jr., M.D.; Lewis Judd, M.D.; Judy Rappaport, M.D.; Janice Stevens, M.D.; Richard Wyatt, M.D.; and others).

The programs are enjoyable and educational. The format is ideal for junior medical students and the lay public, but it can also provide new insight for more advanced students and residents.

Dr. El-Mallakh is director of the Mood Disorders Research Programs, Department of Psychiatry and Behavioral Sciences, University of Louisville School of Medicine, Louisville, KY. Partial support for this writing came from a University of Louisville Instructional Development Mini-grant.
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Mini-Reviews

Paradox and the Family System
By Camillo Lorieda, M.D.,
and Gaspare Vella, M.D.
New York, Brunner/Mazel
222 pages, $27.95
Reviewed by Stephen H. Dinwiddie, M.D.

In this book, the authors attempt to place the practice of paradoxical psychotherapy on a foundation of mathematical logic. By reviewing advances since the time of Whitehead and Russell's Principia Mathematica, the authors make a good case that paradoxical interventions are more logically complex than is often realized; they are less convincing, however, when relating these insights to clinical practice. This book may intrigue professionals who use paradox or want to learn more about it, but it seems of marginal relevance to the practice of most forensic clinicians.

Existential-Dialectical Marital Therapy: Breaking the Secret Code of Marriage
By Israel W. Charny, Ph.D.
New York, Brunner/Mazel
281 pages, $34.95
Reviewed by Michael F. Cleary, M.D.

This volume describes a form of marital therapy that combines an existential approach to couple relationships with a dialectical concept of human experience, in the interest of growth and improved decision making. The text, which is liberally illustrated with clinical examples and vignettes, is recommended highly for content, style, and readability. The focus is primarily on couple relationships, but many insights also applicable to individual psychotherapy are presented.

The Chemically Dependent: Phases of Treatment and Recovery
Edited by Barbara C. Wallace, Ph.D.
New York, Brunner/Mazel
346 pages, $45.00
Reviewed by Philip B. Dooskin, M.D.

Addressing theoretical and practical issues in the treatment of chemically dependent individuals, this book presents an overview of various treatment modalities, theoretical perspectives, and research issues. I can comfortably recommend this volume as an excellent text for those who are conversant with psychoanalytic, cognitive, and biologic principles and who are working with the chemically dependent or are interested in a broader understanding of this patient group.

The Human Dimension of Depression: A Practical Guide to Diagnosis, Understanding, and Treatment
By Martin Kantor, M.D.
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Various aspects of what the author refers to as “depressive” people are discussed in this volume, including their internal experiences, their mode of relating, and ways to “handle” them. It is very outdated in its approach and fails to even mention DSM-III-R. Some professionals may find some interesting psychodynamic insights in this book, but it is not highly recommended.
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Educational Abstracts

Dorthea Juul, Ph.D.
Abstract Editor


Gordon searched the literature from 1970 through 1990 and found 11 articles that met his two criteria, based on a previous literature review, for a successful self-assessment program. These criteria were 1) learners had to be involved in collecting and interpreting data about their performance and 2) learners had to reconcile their self-evaluations with those from credible external evaluators.

Eight of the studies involved health professions training, and three took place in other teaching environments. The learners' cognitive and affective responses to the programs are described. The impact on performance standards, ethical issues, resource requirements, and transfer of training are also discussed.

Although the introduction of self-assessment often produced initial feelings of disorientation and discomfort, it eventually resulted in "more mature, collegial, and productive learning environments" (p. 677). The early negative feelings were related to mastering skills not usually called for in conventional educational settings and having to engage in frank discussions of one's strengths and weaknesses with supervisors. Positive cognitive benefits included improvements in knowledge, performance, and self-analysis of performance. In most of these studies faculty retained control of final grades.

The author describes these programs as pioneering and acknowledges that certain ethical issues—for example, how to deal with a dishonest individual who attempts to cheat the system or with an individual who is too self-critical—are not resolved. Nor are the issues of resource requirements (although these do not appear to be excessive) or the transfer of the skills to other work settings.

Gordon argues that successful self-assessment programs can fundamentally alter the teacher-student relationship to one of "mutually strong alliance, motivation, and performance" (p. 678). He believes that these outcomes are particularly significant for health professions education and are deserving of further research and development.

Educating Medical Students: Assessing Change in Medical Education—The Road to Implementation (ACME-TRI). Washington, DC, Association of American Medical Colleges, 1992

Faculty members involved in undergraduate medical education should find it enlightening, albeit somewhat discouraging, to read this report recently published by the Association of American Medical Colleges (AAMC). Developed by a committee of medical educators, it addresses the issue of why the major shortcomings in medical education that have been identified since the 1930s have for the most part gone uncorrected.

In 1990 a survey was sent to the deans of the 143 allopathic schools in the United States and Canada. Twelve recommendations were drawn from three recent reports on medical education, and the respondents were asked to describe how their institutions had responded to each topic, the constraints or opportunities shaping that response, and the major difficulties in implementing the change.

Because too few of the 84 respondents
addressed one of the recommendations (to establish centers for information management), the final report has 11 topics organized into 5 sections: 1) organization of the program and management of the curriculum; 2) faculty development; 3) evaluation of students’ achievement; 4) educational strategies; and 5) information transmission and management. For each topic, the report describes the spirit of the recommendation, approaches to implementation, constraints and difficulties, insights gained, and necessary strategies for change.

As an example, one of the recommendations in the faculty development section is to make the teaching of medical students important. The perceived difficulty of measuring the quality of faculty accomplishment in this area, especially for promotion and tenure, is discussed, along with the need for mechanisms that will allow for academic recognition of teaching.

The report provides a summary of the schools’ views of reasons for lack of change in medical school education. The reasons include faculty inertia; lack of leadership and oversight of the educational program; limited resources and no defined budget for medical student education; and a perception that change will not necessarily result in improvement.

Strategies that schools, the AAMC, and other national organizations can use to move ahead are proposed, but the report makes this point:

By any standard in higher education, the teaching loads of faculty members in medical schools are low and the schools’ resources are ample. The major reason that faculty members think there are not enough resources to devote to educational change is because the institutional priorities of the academic medical culture do not give students’ education a high priority. . . . Meaningful change can occur only when everyone who is responsible agrees that medical students’ education is critically important and works together to improve it. (p. 51)

The report can be obtained from Irene Nicolaidis at the AAMC (202-828-0589).


The study compared the physical examination skills of third-year medical students at the beginning and end of their surgery clerkship with performance at the end of a second-year introductory clinical medicine course. A 38-item checklist was developed from the one used in the second-year course; it included those items considered to be essential components of surgical teaching (chest, abdomen, groin, and external genitalia).

The 67 students were observed and evaluated by the clerkship director or a trained nurse instructor and given immediate feedback during the first week of the 6-week clerkship. They were retested at the end using the same format.

Scores from the clerkship were compared with the 90% performance level that was required for successful completion of the second-year course. Performance on all subtests as well as on the total physical examination had decreased significantly by the third year. For example, the mean total score was 68%, compared with the 90% standard that had been met in the second year. By the sixth week performance had improved significantly, returning to the previous year’s level for the total examination and all subtests except the hernia (groin) subtest. The effect of specific rotation was looked at, and there were no differences in performance across the academic year.

The authors conclude that skills that were mastered in the second year had deteriorated by the third year, and routine clerkship experiences did not correct these deficiencies. This study serves as a reminder
that ongoing evaluation and feedback may be necessary to foster the retention and maturation of a skill.


Rethans and his colleagues undertook this study to compare what Dutch physicians did in a test situation with what they did in their practices. They defined the former as competence (what a doctor is capable of doing) and the latter as performance (what he or she actually does). They invited the 442 general practitioners from their province to participate, and 137 (31%) agreed to do so; 34 of these comprised the final sample.

The researchers selected four clinical cases for which there were published Dutch primary care standards. They were tension headache, acute diarrhea, shoulder pain, and checkup for a patient with non–insulin-dependent diabetes. Although the cases were common in general practice, they were also thought to present a diagnostic challenge.

Three standardized patients (SPs) were trained to portray each case and to score the physicians’ performance. The clinicians saw 4 patients in their practices over a period of 4 months beginning at least 1 year after they agreed to participate in the study. In none of these 156 visits was the physician able to detect the SP. Five months later the physicians came to the medical school and were given the same 4 cases, but portrayed by a different SP than the one seen in their practices.

Several outcome variables were computed, including number of obligatory (necessary), intermediate (not essential but not harmful), and superfluous actions per case and across cases; an efficiency score (ratio between obligatory and total scores); duration of each case (time); and an efficiency–time score (ratio between efficiency and time scores). These variables were computed for both the practice visits (performance) and the test situation (competence).

Competence scores were significantly higher than performance scores for the obligatory, intermediate, superfluous, and total scores. For example, across all 4 cases there were 68 obligatory actions. On the practice assessment, a mean of 37 (55%) were done, and in the test situation 49 (72%) were done. On the other hand, the performance efficiency scores were significantly higher than the competence efficiency scores. Most of the correlations between the competence and performance action scores and efficiency scores were not significantly different from zero.

The physicians spent significantly more time on the 4 cases in the test setting where no limit was set (mean of 56 minutes) compared with the practice setting (mean of 39 minutes). The correlation between time spent in practice and on the test was 0.49. For the efficiency–time scores, performance was significantly better in practice than on the test. The correlation between the performance and test scores was 0.45.

The researchers concluded that, although their samples of cases and physicians were small, there was a “substantial difference” between competence and performance, and the doctors generally did better in the test situation. However, these physicians performed below the practice standards both in actual practice and on the competence test. The authors suggest that national standards, even though carefully developed, may need to be further validated in light of actual practice.
The Journal Club in Psychiatric Residency Training

SIR: Journal clubs are used in medical education to develop students’ critical reading skills of medical literature (1). Educational research attests to the important role the journal club plays in postgraduate clinical training (2-4), including psychiatric education. A survey found that 86% of psychiatric residency programs rely on the journal club as a way of introducing trainees to psychiatry as a scientific academic discipline (3). Journal clubs serve to educate both medical students (5-7) and residents (8-10). Beyond residency training, a journal club may be used as a collegial vehicle to meet continuing medical education requirements (11). When the effectiveness of journal club training was studied, it was found to have a measurable impact on family medicine residents’ reading habits and their understanding of research methodology (6).

Methods

At the University of Cincinnati, we designed a small study to determine whether a journal club had significant effects on psychiatric residents. Progress in reading and comprehending clinical research literature was measured over a predetermined time frame of 12 months. A questionnaire was used to assess whether participation in a weekly journal club would have an impact on various factors reflecting reading habits. The measurement variables included the number of periodicals or of clinical research articles read every month; self-rated level of comprehension of research papers read; and, specifically, degree of understanding of data analysis and statistics. The questionnaire also asked about reading preferences for various types of papers and parts of scientific articles.

Second-year residents were assessed in August and again in June; senior residents and faculty were assessed in June, at the end of the academic year.

The experimental group was the PGY-2’s (n = 12), who were starting the journal club at the beginning of the academic year. Senior resident groups, i.e., PGY-3’s and -4’s who had already had their journal club education (n = 19), served as a comparison. Data analysis consisted of a within-group analysis (before vs. after) in the PGY-2 group and an intergroup comparison between the “treated” junior residents (i.e., after they had had the journal club), senior residents, and faculty (n = 26).

Results

After 10 monthly journal club sessions, the total number of scientific psychiatric periodicals perused had increased from 3.08 ± 1.08 (mean ± SD; range 2-5) to 4.33 ± 1.37 (range 2-8; paired t = 4.10, df = 11, P = 0.002; two-tailed).

The number of articles read in a month increased also. The distribution of differences here was not normal, however. Eight respondents indicated no change in number read (average 5.75 articles), whereas 4 residents reported increases by 1 to 10 articles from baseline. A similar dichotomous distribution was obtained for the question about subjective satisfaction with the understanding of articles read in the American Journal of Psychiatry. Four respondents said they felt “satisfied” with their level of comprehension after the journal club, as opposed to “partly satisfied” before the intervention. The other 8 residents saw themselves unchanged in this respect.

Only 3 respondents indicated improved understanding of data analysis techniques from “dissatisfied” to “partly satisfied,” 8 saw no change, and 1 indicated a drop from “partly satisfied” to “dissatisfied.”

Review articles remained favorites with 7 residents both before and after the journal club. The popularity of clinical research papers increased; they were named as the most
preferred type of article by only 2 residents before, but by 4 after the journal club.

Both before and after the journal club, respondents indicated that the beginning (abstract, introduction) and end (discussion) of a paper are most often read; methodology and results sections are found to be the most difficult to understand.

Finally, we saw no difference in number of journals read, articles studied, or perceived levels of comprehension in a between-group comparison (two-tailed t-test) between the PGY-2 group at the end of the journal club exercise and the senior residents. Collectively, residents read fewer journals than did faculty—3.90 ± 1.42 vs. faculty’s 5.54 ± 2.21 (t = 3.23, df = 24, P = 0.0038). On all other measures, there were no significant differences between trainees and faculty.

Discussion

The results suggest that the exposure to journal club training has an impact on trainees’ reading habits and skills. The small size of the changes associated with the journal club is probably a reflection of the relatively small investment of 10 hours of formal didactic input spread over a whole year. More intensive teaching efforts might yield proportionately greater measurable outcomes.

Our study may suggest a method to enhance objective validation of educational effort. In order for such research to become practically important—for instance, to indicate whether to continue a class or a particular type of teaching—the methodology ought to be refined. It would be particularly useful to increase the sample size and to include a matched comparison group without the “treatment” to control for confounding variables.

Ole J. Thienhaus, M.D.
Lawson R. Wulsin, M.D.
Department of Psychiatry
University of Cincinnati
Cincinnati, OH

References

11. JAMA Journal: Division of Continuing Medical Education. Chicago, American Medical Association, 1988

Recruitment for Psychiatric Residency

SIR: Drs. Kay and Bienenfeld (1) presented a nice overview of the role of the residency training director in psychiatric recruitment and some of the problems of recruitment. It is certainly important to improve recruitment, and the authors provide excellent suggestions. But reading their article and another (2) published in the same issue of Academic Psychiatry (Dr. Gabbard’s “The Big Chill” about the nightmare of managed care) invokes the most important issue in psychiatric recruitment: what do we have to
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offer to medical students?

A medical specialty in which physicians are no longer in charge, as Dr. Gabbard pointed out, and cannot adequately treat their patients according to their best conscience? A medical specialty split by a schism between biological and psychological models? A profession in which many of us talk about clients or consumers instead of patients? One of the lowest-paid medical specialties during times of increasing student loan debts? A medical specialty that leaves a big part of treatment to other non-medical professionals?

A medical specialty where, in some institutions, a “therapist” can say, “You cannot see your psychiatrist unless you see me for therapy” but a psychiatrist cannot say the opposite? A medical specialty with the stigma of taking care of “untreatable” mentally ill patients?

Well, it certainly is not as bad as it looks, but it looks bad! I do not have good answers to all these problems, but I believe that we must address them vigorously to improve our specialty so we have something better to offer to our potential successors. Maybe these issues should be addressed in a recruitment conference.

Richard Balon, M.D.
Department of Psychiatry
Wayne State University School of Medicine
Detroit, MI

References


In Reply

SIR: Dr. Balon has rightly drawn our attention to some critical forces potentially influencing the current crisis in psychiatric recruitment. Although there is indeed pessimism and cynicism about the future of psychiatric practice in many quarters, the concerns may be overstated. For example, we can experience the disruption to our clinical work by some managed care practices as foreshadowing the demise of our specialty or we can accept new, and sometimes intrusive, cost-containment practices as a challenge to us to deliver more rigorous and scientifically based care. Can we not rise to this challenge (which, by the way, is being faced in virtually every other medical specialty) by scientifically demonstrating the efficacy of our interventions? Can we not speak systematically to the ethical issues involved in supporting or withholding appropriate care through the establishment of practice guidelines, as is currently being done through the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry?

As for the issue of schism in American psychiatry, might it not be better to approach human behavior in both health and illness from a broad base that integrates various theoretical ideologies, thereby conveying to medical students the richness and diversity of our theories and our clinical armamentarium? Few in academic health science centers would disagree that the last great frontier in medicine is the central nervous system, which includes both the brain and the mind. The most exciting research in neuroscience, to our thinking, is being conducted in learning and memory, where it is enabling us to integrate the biological with the psychological in an extraordinary way. This research is demonstrating over and over that it is not helpful to view our patients in terms of “either/or” models.

Although psychiatrists are not at the upper end of income earners in medicine and surgery, neither are we at the bottom. We still make reasonable incomes, and we are, at the same time, rewarded by the intellectual excitement of our discipline. The
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available career satisfaction studies of medical practitioners have shown that most of us in psychiatry continue to find our work challenging and growth-promoting. Can this excitement be conveyed candidly alongside information about the changing practice environment so that students are intrigued and not deflated?

Stigma remains an enormous problem, but it is not psychiatry's problem exclusively. Stigma about mental illness is above all a reflection of our society at large; it can be, and is being, addressed through collaborations with mental illness consumer organizations and effective legislation on both local and national levels.

Dr. Balon is right to call for a national recruitment conference, and, indeed, one took place in May 1992. The recommendations from this conference, to be published shortly, offer effective strategies and specific interventions to address the critical issues raised by Dr. Balon. Ultimately we as teachers have a great deal to contribute to helping our students and residents appreciate the great legacy and hope of psychiatry.

Jerald Kay, M.D.
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CORRECTION: In Figure 1 on page 181 of the Winter 1992 issue (16:4), the bars in the graph were incorrectly labeled (D. Braun and V. L. Susman, "Pregnancy During Psychiatry Residency: A Study of Attitudes"). Here is the corrected figure:

FIGURE 1. Rate the effect of pregnancy on residents' work performance.

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<th>Female</th>
<th>Male</th>
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<td>7</td>
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<tr>
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<tr>
<td>Interferes</td>
<td>48</td>
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Psychiatric Education at the APA Meeting
May 23–27, 1993, San Francisco, California

From the preliminary program for the APA Annual Meeting, here is a preview of sessions that focus on academic psychiatry. Names listed are those of program chairpersons or session leaders.

MONDAY, MAY 24

7:00–8:30 a.m.
Resident’s Session: Meet the Experts: Sunny-Side Up

9:00–10:30 a.m.
CW1. Learning to Treat the Dually Diagnosed. Marc Galanter, M.D.
CW4. The Joy of Research. Thomas A. Grieder, M.D.
CW6. Consultation/Liaison Psychiatry: Role in Medical Student Education and Recruitment. Mark R. Nathanson, M.D.
W8. The Recruitment Crisis: A Trainee’s View. Matthew R. Schneider, M.D.
W22. Profile of Psychiatric Residents Assaulted by Patients. Nalini V. Juthani, M.D.

11:00 a.m.–12:30 p.m.
CW15. Essentials for Planning Effective Continuing Medical Education Programs. Pauline R. Langley, M.D.
W31. Integrating Research into Clinical Programs. William H. Wilson, M.D.
W35. Religious Issues in Residency Training. Shimon Waldfogel, M.D.
W42. Group Therapy Training for Residents in the 1990s. Eileen R. Wachter, M.D.
W45. Moonlighting by Psychiatric Residents. Kenneth L. Matthews, M.D.

2:00–5:00 p.m.
S1. The Psychiatry Recruitment Crisis: Origins and Solutions. Joint session with the Association for Academic Psychiatry.
A. Analysis of AAMC Data on Recruitment Success. Sidney H. Weissman, M.D.
B. Factors Contributing to the Decline in Residency Applicants. Jerald Kay, M.D.
C. The Chairman’s Role in Fostering Recruitment. Allan Tasman, M.D.
D. Perspectives from the Dean’s Office Regarding Recruitment. Herbert Fardes, M.D.

A. Psychiatric Training in Venezuela: Realities. Antonio Pacheco, M.D.
B. Colombian Psychiatry: Future and Expectations. Roberto E. Chaskel, M.D.
C. Psychiatric Residency in Brazil. Dorigval Caetano, Ph.D.

TUESDAY, MAY 25

9:00–10:30 a.m.
L0. The Radical Change in Health Care: How Will Psychiatry, Medicine, and Academic Medicine Survive? Herbert Pardes, M.D.
CW30. Choosing a Residency That’s Right for You: Taking the Vital Signs. Carol A. Bernstein, M.D.
W50. The Balint Seminar Training Experience. Marilyn S. Jacobs, Ph.D.
W59. Managed Care and Ethics Training in Residency. Patricia Ryan Recupero, M.D., J.D.

11:00 a.m.–12:30 p.m.
[PS]53. Psychiatry Clerkships in Primary Care Settings. Cyril M. Worby, M.D.
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<tr>
<td>9:00 a.m.</td>
<td>Learning and Practicing Ethical and Effective Psychotherapy in Today’s World. Layton McCurdy, M.D.</td>
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<tr>
<td>10:30 a.m.</td>
<td>Asserting African-American Values in White Institutions. Robert T.M. Phillips, M.D.</td>
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<tr>
<td>Noon</td>
<td>Moonlighting Unmasked. Ivan C. Walks, M.D.</td>
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<td>11:00 a.m.</td>
<td>Teaching Human Sexuality to Medical Students in the 1990s. David G. Kretetz, D.O.</td>
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<td>11:00 a.m.</td>
<td>Stress Intervention Programs for Residents. Mark E. Servis, M.D.</td>
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<td>Noon-1:30 p.m.</td>
<td>How and Why To Be a Spokesperson for Psychiatry. Andrea S. Moskowitz, M.D.</td>
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<tr>
<td>7:00-10:00 p.m.</td>
<td>E. Academia, Disarmament, and Legitimacy. M. Andrew Murray, D.D.</td>
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**THURSDAY, MAY 27**

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<tr>
<td>9:00-10:30 a.m.</td>
<td>Psychotherapy and the Future of Psychiatry. Norman A. Clemens, M.D.</td>
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<tr>
<td>11:00 a.m.</td>
<td>PTSD Following Internship: A Study of Residents. Debra L. Klamen, M.D.</td>
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<tr>
<td>Noon-12:30 p.m.</td>
<td>A Model of Teaching Medication Backup to Residents. Michelle Riba, M.D.</td>
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<tr>
<td>Noon</td>
<td>Why Medical Students Select a Psychiatry Career. Jeanette M. Zaimes, M.D.</td>
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<tr>
<td>Noon-12:30 p.m.</td>
<td>Moving Beyond the Gender Gap in Academic Psychiatry. Claire Zilber, M.D.</td>
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<tr>
<td>1:00 p.m.</td>
<td>The American Board of Psychiatry and Neurology Update: 1993 With Emphasis on Subspecialization and Recertification. Joint Session with the American Board of Psychiatry and Neurology. Stephen C. Scheiber, M.D.</td>
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<tr>
<td>Noon</td>
<td>Women in Psychiatric Subspecialties. Catherine A. Martin, M.D.</td>
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<tr>
<td>Noon</td>
<td>Psychiatric Training in Public Mental Health Settings. Mark E. Servis, M.D.</td>
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Information for Contributors

The American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry have joined together to sponsor Academic Psychiatry, a peer-reviewed quarterly journal published by American Psychiatric Press, Inc. Formerly the Journal of Psychiatric Education, Academic Psychiatry is dedicated to the publication of work concerning educational efforts by and for psychiatrists, and articles addressing teaching, research, administrative, clinical, organizational, and economic issues relevant to the academic missions of departments of psychiatry. The Editors invite high-quality submissions that further knowledge in psychiatric education and stimulate improvements in academic psychiatry.

Peer Review: All submissions are reviewed by at least two experts to determine the originality, validity, and importance to the field of their content and conclusions. Reviewers of a manuscript will be blind to the authors' identity, and authors will be sent reviewer comments that are judged to be useful to them. Academic Psychiatry has initiated a rapid review procedure, and authors can expect to receive notification of the Editor's decision regarding their submission within three months of receipt of the submission by the journal office. To foster rapid publication, any required revisions are expected to be accomplished by the authors within an additional two-month period.

Manuscript Specifications: Manuscripts must be prepared according to the manuscript specifications of The American Journal of Psychiatry. All manuscripts will be edited for clarity, conciseness, and conformity to journal style.

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New Ideas: This section includes descriptions of innovative programs, curriculums, teaching strategies, techniques, and technologies worthy of broad dissemination to the field. Generally, the programs being described should have been implemented, and some form of evaluation should be reported. Submissions for the New Ideas section are limited to 3,750 words (15 double-spaced pages).

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