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In Appreciation and Farewell

It is with a sense of accomplishment, mixed with sadness and some relief, that I relinquish the editorship of Academic Psychiatry at the end of 1994. It has been a very gratifying experience to help transform the Journal of Psychiatric Education into Academic Psychiatry over the last 6 years and to see it firmly sponsored and supported by the AADPRT and AAP, and read by psychiatric educators throughout the world. I have appreciated the courage and goodwill of the authors who have submitted their work to our developing journal and hope that they have felt respected and, regardless of the publication decision, rewarded by our review process. It has been a personal pleasure to work with so many authors through multiple revisions of papers to arrive at final products we are all pleased to see in print. It also has been a special privilege to work with two outstanding Deputy Editors, Will Sledge and Phillip Slavney, an Editorial Board of expert psychiatric educators, and the panel of dedicated “teaching reviewers” listed below, all of whom have played pivotal roles in rejuvenating Academic Psychiatry.

I am pleased to turn over the journal to the keen intelligence of Sam Keith, an experienced editor with many exciting new ideas for Academic Psychiatry. I trust that before the end of the year the publishing contract with APPI will be renewed, as the editorial and technical support provided by APPI’s professionals has been a major component in the journal’s improvement.

Although leaving the editorship, I am pleased to remain on Academic Psychiatry’s Editorial Board and hope that I can contribute to its further development. I appreciate the kind words and broad support I’ve received as Editor over the last 6 years from all of you and feel that your ongoing support of the journal under Sam Keith’s leadership will be the key element to its continued success.

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Special Article

Perspectives on Screening and Interviewing International Medical Graduates for Psychiatric Residency Training Programs

Nyapati R. Rao, M.D.
Arthur E. Meinzer, Ph.D.
Sheldon S. Berman, M.D.

The authors have found that international medical graduates (IMGs) constitute a valuable pool of applicants for residency training. The wide variation in their medical educations, prior careers, and cultural backgrounds requires a special approach to screening and interviewing IMGs. The authors share techniques and viewpoints developed in their program to screen applicants about their autobiographical statements, medical credentials, reference letters, and visa and immigration statuses. Interviewing guidelines that are sensitive to the applicant's career phase and that assess the person's interest in psychiatry, communication skills, character, acculturation, family context, and suitability for the specific residency program are presented. (Academic Psychiatry 1994; 18:178–188)

International medical graduates (IMGs) have occupied about one-quarter of all U.S. psychiatric residency positions in the past decade (1) and continue to be a valuable applicant pool for residency training programs. However, the preparation and professional attainments of IMGs are more difficult to assess than those of U.S. medical graduates (USMGs). IMGs are a more heterogeneous group who come from widely diverse cultures and medical education systems, have a primary language other than English and different motives for pursuing a career in psychiatry, and apply to U.S. residencies at different life stages.

This heterogeneity affects the selection process in many ways. At the initial screening stage, difficulties for residency programs stem from an unfamiliarity with foreign medical schools, the absence of ways to acquire reliable information about the applicant's medical school performance, and complex immigration issues. The IMG interviewer is faced with the difficult and complex task of assessing an applicant who 1) comes from a markedly different cultural and linguistic background, 2) more often than not has graduated from medical school several years before applying for the current residency, 3) may not be able to articulate conventional reasons for choosing psychiatry as a career, and 4) may be affected by intense emotional reactions to the process of

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migration in addition to the usual interview stresses.

Despite these formidable hurdles, residency training programs can effectively assess IMG applicants provided the programs are prepared to devote the needed time and energy. At the Brookdale Hospital Medical Center, we have found this to be a rewarding endeavor that has provided us with talented and dedicated residents, and we share here some of the methods and guidelines that we have developed. We will describe our methods based on our 25 years' experience in screening and interviewing IMG applicants from the Indian subcontinent, the Far East, the Philippines, the Caribbean, Africa, the Middle East, and Europe, as well as USMG applicants.

SCREENING APPLICATIONS

The goals of the screening process are to learn about the person and his or her interest in psychiatry efficiently and effectively through the application, and to determine the applicant's medical credentials and visa status. These goals are important because the applications are sometimes poorly prepared and/or packaged, the reference letters do not illuminate the applicants' personal and professional qualities, and the medical school transcripts and the educational systems that they describe may be unfamiliar. It can be difficult to assess applicants' psychiatric training and interest because of limited opportunities for undergraduate experience in psychiatry in many foreign medical schools.

Faced with these difficulties, as we found in an earlier study, training directors depend heavily on the applicant's scores on standard U.S. qualifying examinations in determining whom to interview (2). While the face validity of the Educational Commission on Foreign Medical Graduates (ECFMG) examinations in measuring clinical knowledge and competence is obvious, we have not been able to find studies of their predictive validity for psychiatric training, and such validity should not be assumed. For example, in another area of prediction of medical training performance, one study of 210 U.S. medical students found that the Medical College Admission Test predicted only 4% of the variance in clinical competence ratings during medical school clerkships. Psychosocial measures such as self-esteem, sociability, locus of control, and the quality of childhood relationships with parents, on the other hand, predicted an additional 14% of variance in clinical competence ratings (3).

Thus, while ECFMG scores have provided important data for us, if we were to limit ourselves to the applicant's examination scores, we would overlook valuable data relating to the applicant's medical education background, and our view of the applicant as a person and a potential psychiatrist would be restricted. By following the procedures we will now describe, we have obtained useful and thorough data on the applicant's suitability for psychiatry in general and our program in particular.

Autobiographical Statement

We require our applicants to write an autobiographical statement detailing their reasons for choosing psychiatry. This requirement has proven to be a very useful method of assessing IMG applicants at the preinterview stage. Because IMGS may not be as familiar as USMGs with the degree of personal disclosure expected in a psychiatry residency application, we explicitly tell them what we would like them to include. We ask the applicants to characterize themselves as individuals and to describe their reasons for choosing psychiatry, their family background and formative experiences, academic record in medical school, mentorship relationships, and their artistic, literary, and other special interests.

Dr. A., for example, submitted a poorly constructed application with sketchy and uninformative letters of reference, tran-
scripts written in a foreign language with poor translation, and unexceptional performance on the qualifying examinations. However, in the autobiographical statement, he vividly described how his work with political refugees and drug abusers had enriched his understanding of human struggle in the context of social and political conflict. He also described how his interest in the United States developed through his visits there as a teenager and to the U.S. Cultural Center in his country. These factors played a role in his decision to emigrate. He further described his use of painting as a mode of personal development.

While Dr. A.'s statement was written in his own style and words, without sophistication, we saw in it his ability to communicate honestly his conflicts and to explain his decision to emigrate in the context of these personal struggles. He succeeded convincingly in conveying his anxieties, hopes, vulnerabilities, and strengths. He conveyed a caring interest in others, as well as an assertiveness and a drive for productivity. His decision to emigrate to the United States appeared to have been based on realistic experiences rather than idealization. When he was interviewed, these impressions were validated: he was accepted into our residency and has been an exceptional resident respected by patients and staff.

In contrast, Dr. B. wrote a very straightforward, matter-of-fact statement about his medical education, his psychiatry training and experience in his home country, and his scientific achievements. In a few words he described his academic accomplishments at institutions that we determined were quite distinguished. While his statement revealed no great saga of personal struggle, it did quite accurately reflect the applicant's character: a serious and modest, quite bright, and accomplished future psychiatrist with a scientific bent.

We place premium on the originality of the statement rather than on literary style, since one can have a well-crafted personal statement prepared by another. We also look for the applicants' ability to present multidimensional views of themselves and to reflect on their lives rather than merely to recount events. Poorly written statements are usually cliché-ridden, try too hard to create a favorable impression, and have an ingratiating tone: "Psychiatry gives me the opportunity to serve humanity," "I come from a noble family and my parents always instilled great human values in us," and "I am sure I will be a great psychiatrist." Generic applications and personal statements that have been written for a barrage of applications in a "shotgun" approach to gaining entry to the U.S. medical system will be evident from their vagueness and extensive use of hackneyed phrases. We have seen obvious clues such as "psychiatry" written by hand in a typed application, or psychiatry in a list of several desired specialties.

Assessment of Medical Education

Accreditation of the applicant's medical school by a national body can be determined by reference to the World Health Organization's World Directory of Medical Schools. It provides information about the official language of instruction, the number of students accepted, the year the school was established, the number of graduates, and various other data. Shortcomings of this directory are that it is updated infrequently, and there is no qualitative rating of schools and no monitoring of the standards and procedures of the national accrediting bodies.

We supplement information from this document by gathering impressions from IMG colleagues from the country in question, regardless of their specialty. One very general observation that we have made over years of screening, selecting, and training IMGs is that state schools in developing countries tend to be more competitive and selective in their admissions procedures and
more rigorous in their training than private schools, but there are exceptions.

Honors and Accomplishments

Honors systems in many foreign medical schools may differ from those in U.S. schools. We look for gold and silver medals, high placement in class rankings, and high scores on competitive examinations for postgraduate education in the home country. Conducting and publishing a clinical or research study may represent considerably more effort and dedication for an IMG in the person's medical school environment than for a USMG who may be readily able to fit into an ongoing project and receive publication credit.

Reference Letters

Ross and Leichner (4) found that U.S. training directors felt that the letters of recommendation, along with the personal interview, were the most valued tools for selecting Canadian medical graduates in Canadian psychiatric residency programs. However, we found in our previous study (2) that U.S. and Canadian psychiatry training directors thought that letters of recommendation were less useful for selecting IMGs.

Reference letters from foreign schools often do not elaborate on an applicant's professional and personal qualities. Many are brief, emphasize qualities that are valued in the applicant's culture of origin, and do not address the applicant's shortcomings. However, for IMGs who have worked in health-related fields in the United States before they apply to residency positions, it has been useful to request additional letters from, or speak directly to, their immediate supervisors in the United States.

Qualifying Examinations

To undergo graduate medical education in the United States, an IMG must be certified by the ECFMG. ECFMG certification requires passing the qualifying examinations and documenting completion of educational requirements to practice medicine in the country where they attended medical school. Also, most U.S. states require ECFMG certification for licensure.

The ECFMG examination includes a medical science examination and an English-language proficiency test. Past medical science examinations include the Visa Qualifying Exam, last administered in September 1983; the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), last administered in July 1993; the National Board of Medical Examiners examination (NBME), last administered in April 1992; and the Federation Licensing Examination (FLEX), last administered in 1993. Currently, the United States Medical Licensing Examination (USMLE) is given to both USMGs and IMGs.

Applicants may present with complicated permutations of these examinations. For example, an applicant can be eligible for ECFMG certification by having passed a part of the FMGEMS and a part of the NBME examination or a part of the USMLE. As of 1993, the USMLE replaced all other qualifying examinations, but those IMGs who have passed the previous examinations and have acquired the provisional ECFMG certificate will still be eligible to enter a U.S. residency training program.

The ECFMG encourages training directors to verify an applicant's performance. The training director must also be aware that the ECFMG process of collecting documentation from the IMG's medical school will begin only after the IMG has passed the qualifying examination. This process can be subject to considerable delays from the applicant's medical school. If time is at a premium, it may be a useful practice to interview only those candidates who have the provisional ECFMG certificate and a valid visa.
We encourage applicants who have taken the USMLE to show us their USMLE Performance Profile. We note their performance in psychiatry in the "Discipline Profile" and their performance in Mental Disorders and in Diseases of the Nervous System and Special Senses in the "ICD-9 Disease Process Profile." The consideration of these data along with the applicant’s prior training and personal qualities is a more useful procedure for us in judging the applicant's suitability for psychiatry than to consider only the overall examination performance score.

Visa and Immigration Issues

IMGs may face complicated immigration issues. If the training director does not have a working knowledge of these issues, it can result in disappointment and considerable delays. We will now outline what information we think is essential to know about immigration issues. We follow the latest developments in this area through professional meetings organized by the New York State Medical Society, immigration lawyers' newsletters, and, importantly, from the IMG applicants themselves. In addition, training directors can look to their hospitals' medical education departments for additional expertise in negotiating these complex and time-consuming issues.

The Accreditation Council for Graduate Medical Education (5) permits foreign-born IMGs with provisional ECFMG certification to enter U.S. residency programs if they are naturalized citizens or hold a permanent resident (immigrant) visa or either one of the temporary exchange visitor visas, J-1 or H-1B, or a federal work permit. Those having J-1 exchange visitor visas can only enter residency programs in medical school hospitals or hospitals affiliated with medical schools. The J-1 permits the candidate to reside in the United States for the purpose of acquiring medical training for a maximum of 7 years, or until completion of training, whichever is shorter.

In addition, J-1 visa holders must obtain permission from their governments to pursue training in a specialty that is in short supply in their native country. They are also required to commit themselves to return to their native country after completion of training in the United States to practice their specialty for at least 2 years. There are exemptions possible for this return rule, but the procedures are extremely lengthy, costly, and uncertain in outcome.

The H-1B visa was originally intended only for research activities but has recently been broadened to include clinical training. The H-1B visa permits the candidate to pursue medical training for up to 5 years in the United States. However, it requires the candidate to have passed the FLEX or USMLE-Part 3 and to hire an attorney to process the paperwork and follow through with a labor certification process with the U.S. Naturalization and Immigration Service. The training institution hiring the candidate must participate in the certification process. The H-1B visa can eventually be converted to permanent resident status without the need to exit the United States for a period of time as the J-1 visa requires.

THE INTERVIEW PROCESS

Some issues are either unique to IMGs or more prevalent in this group than their U.SMG counterparts. These issues require particular attention from our interviewers. We conduct a thorough and comprehensive interview process with each applicant, including meetings with the training director, meetings with two other interviewers from the selection committee, and a luncheon meeting with a resident representative. In addition, each applicant receives a department tour. We provide an opportunity for applicants to attend seminars, and we then discuss with them their observations and thoughts.
Selection Committee

We have found it useful to carefully construct a selection committee composed of several IMG and USMG senior psychiatrists, psychologists, and chief residents. Only those who have good interviewing skills and have evinced interest in and understanding of cross-cultural issues are invited to join this committee. The committee participates actively in all stages of resident selection. Committee discussions have been invaluable in providing useful information about the cultures and educational systems of our IMG applicants' home countries and in confronting our own stereotypes.

For example, Dr. C., a physician from the former Soviet Union, was interviewed for a PGY-1 position. While the selection committee was satisfied with her medical credentials, medical knowledge, and qualifying examination score, it was concerned, perhaps based on stereotypes of candidates from that part of the world, that the applicant might have a rigid character structure and therefore be difficult to work with. A Russian physician who was a senior resident in the program interviewed the candidate and was able to convince the committee that what was seen as rigidity was essentially an anxious reaction to the experience and that the candidate was, in fact, a quite flexible, assertive, and psychologically minded person. This assessment was born out in her subsequent training.

Acculturation and Career
Phase-Sensitive Interviewing

As the APA Census of Residents demonstrates, two out of five IMGs entering psychiatric training in the United States in the past decade have come from Asia (1). These IMGs more often than not have been transported into a culture where the food is strange; gender role relationships are radically different; the streets appear sparsely populated; and a dazzling, cold technology organizes an efficient society. Furthermore, many IMGs have moved from a group-oriented society to one that confronts them immediately with expectations based on individualistic ideals. In their contacts with residency programs, IMGs are struck by a relative lack of formality in the workplace. IMGs may often be unfamiliar with legal, administrative, and financial aspects of U.S. graduate medical education, as well as with the state of American psychiatry.

An encounter between an immigrant and a new culture often results in what Garza-Guerrero (6) has called the "culture shock syndrome." Shock symptoms may include mourning for the lost culture, severe anxiety in adapting to a new culture, and consequent identity disturbances. The Grinbergs (7) state that the phenomenon of migration can awaken in the immigrant persecution anxieties in face of change, depressive anxieties that lead to the mourning for the objects left behind and the lost parts of the self, and disorienting anxieties over the failure to distinguish between the old and the new.

Interviewers who are sensitive to the applicant's "raw," anxious state during the interview—and are aware of the applicant's fears, expectations, and idealizations—will be in a better position to assess accurately the applicant's strengths and weaknesses. An interviewer's empathic remark that conveys an understanding of the applicant's predicament can help make the applicant feel more comfortable and open.

Assessment of Applicants' Postgraduate Years

On the average, IMGs in psychiatry residency training have graduated from medical school earlier than their USMG counterparts. Based on the APA Census of Residents (1), the median number of years since graduation from medical school to
start of postgraduate specialty training in the United States is 8 years for IMG residents and 2 years for USMG residents. This lag is both an asset and a liability for IMG applicants. They may have gained valuable life and career experiences through professional work since graduation from medical school. They may have obtained additional postgraduate medical qualifications and administrative or research experiences or may have worked in various cultures. Conversely, others may have had several years without professional experience and further postgraduate education. Our interviewers assess each applicant's knowledge of current medical practice by asking questions that include knowledge of recent developments in psychiatry and medicine.

Some IMG applicants originally migrated to the Middle East, Europe, Africa, and/or the Caribbean, where they had acquired further postgraduate qualifications or worked in various health-related fields before entering the United States. These multicultural medical experiences more often than not have made these applicants more mature, seasoned physicians who have a broad perspective on medicine and excellent adaptational abilities. In addition, their prior exposure to other cultures has made them culturally sensitive, an asset to their training in psychiatry. Exploring these experiences provides valuable opportunities for interviewers to assess the applicants' medical knowledge, motivation for migration, understanding of various cultures, and interest in psychiatry. It has been helpful for us to have knowledge of typical global migration patterns of medical graduates from various countries in order to place each applicant's migration into a normative frame of reference.

Dr. D., for example, a physician from the Indian subcontinent in his late thirties, applied to our program for a PGY-1 position. His application revealed to us that after medical school he had worked as a physician in the Middle East, Europe, and East Africa. While his scores in the qualifying examinations were satisfactory, the interviewers were concerned about how current his medical knowledge was and whether he would adapt to the role of a trainee. In his interview he came across as a mature, highly motivated, and conscientious physician who was able to work in various cultures and medical systems. We found that he had taken a postgraduate fellowship in public health in Europe. From this experience, he had proven that he was able to work with various supervisors without conflict and showed a flexibility and eagerness to learn, which eased our initial concerns. The first few weeks of his training were quite rocky: the medical practices in his previous health care settings were deeply ingrained and were often at odds with medical practices here. He had to learn new medical techniques and skills. With our contextual understanding of his difficulties, we were able to provide support, reassurance, and appropriate education. Improvements were noted within several months, and he subsequently demonstrated excellent knowledge, skills, and leadership abilities.

If the applicant has had a prior residency, the interviewer assesses the person's attitude toward additional graduate medical education and toward other trainees who may be younger. We attempt to determine whether the applicant can shift motivationally and narcissistically to the role of trainee. Many IMGS come to U.S. psychiatric residencies with prior postgraduate training or practice in medicine: three-quarters of our present IMG residents had prior training in various medical fields, including psychiatry. We have found that most are willing to undergo the professional demands of additional training as a part of the broader change that they have chosen to introduce in their lives, that is, immigration to the United States and entry into new social and medical cultures.

The issues encountered by the older USMG psychiatric resident described by
Burt and Yager (8), such as isolation from the group of younger residents, inflated expectations of them on the part of the younger residents, and conflicting role obligations, may be faced by some IMG residents who have had prior accomplishments in psychiatry. We listen for applicants' awareness of these potential problems and consider with them their adaptive abilities.

Assessment of Interest in Psychiatry

We believe that with an increasing availability of residency positions in other medical specialties, IMGs who seek positions in psychiatry training programs usually have a genuine interest in the field. A sign of this interest is the acquisition of postgraduate psychiatric qualifications in the country of origin. We ask them to describe their experiences with psychiatry during medical school, thus eliciting data on the development of genuine interest. The interviewer may question the motivation of those applicants who have had postgraduate training in other specialties. While we acknowledge that there may be someIMGs whose priorities are more directed toward gaining entry to the U.S. medical system than toward entry into a particular specialty, we do not assume poor motivation on the part of an IMG applicant who has prior training in another specialty. We realize that in many developing countries there are few opportunities for postgraduate training in psychiatry. Also, in many developing countries it is more common for women to take a residency in obstetrics/gynecology or pediatrics than in psychiatry.

Dr. E., for example, an IMG who had completed a year of training in internal medicine in the United States before returning to her native country to work as a family practitioner, applied for a PGY-1 position in late spring. While the selection committee was impressed with her medical knowledge and credentials, they were concerned about the interruptions in her professional practice and her motivation to seek training in psychiatry at this point in her career. Committee members asked her directly if she was primarily seeking a way to regain entry into the American medical system. However, the applicant was able to convincingly discuss how her experiences as a family practitioner in her native country led her to develop an interest in psychiatry. Also, she explained that her moving to various countries resulted from her husband's career changes. She proved that her seeking training in psychiatry was out of genuine personal interest in the field. Her career decision stemmed in part from a childhood trauma. The committee accepted her, and she proved to be a dedicated psychiatric resident.

On the other hand, Dr. F., a young physician just out of medical school, stated quite emphatically that he was very much interested in psychiatry. He was accepted on the basis of his credentials, presentation, and stated interest. However, after a few months into his first year of training, he decided to change to internal medicine. In hindsight, we felt that his unusual enthusiasm for psychiatry, particularly in the absence of any prior psychiatric experience in medical school and his inability to talk about his past with psychological sophistication, should have alerted us to the possibility that he only wanted to gain entry into the U.S. medical system through our program.

The interviewer also assesses the applicant's familiarity with American psychiatry and medical practice. The interviewer may ask the applicant for his/her understanding of how psychiatry is integrated into the structure of medical specialties in the United States, and how the conditions of practice may differ from his/her home country. This information helps us determine the applicant's thoughtfulness and motivation in seeking psychiatric training. The interviewer asks the applicant to describe a psychiatric patient she/he treated. A method that we are testing in our department in the current selection season is to use a video-
taped interview of a psychiatric patient. We ask applicants to talk about their reactions to the interview and their understanding of clinical issues.

Assessment of Communication Skills

Of primary importance for the interviewer is an assessment of the applicant's communication skills with respect to pronunciation, grammar, grasp of idiom, and vocabulary. The applicant's attunement to the rhythms of verbal exchange will be evident. In listening to the applicant's responses to questions, the interviewer can assess the applicant's ability to express and understand abstract thought.

Assessment of Character and Acculturation

Assessment of character is routine, whether the applicant is an IMG or a USMG. It should be noted that cultural differences between the interviewer and the IMG applicant may make this task exceedingly difficult. We try to interview an IMG with an open mind and with an awareness of our stereotypes that may impinge on the assessment process. We strongly recommend that if possible one interviewer come from the same country or a similar cultural background as the IMG applicant (refer to the example of Dr. C. described earlier).

We have learned much about the applicants' character and adaptability by asking how they came to the decision to emigrate, what were their reasons for immigration, and what were their emotional reactions to both leaving their country of origin and arriving in the United States. We may ask applicants to describe a life experience that was psychologically painful and to discuss how they dealt with it. The interviewer determines whether the applicant is able to discuss these experiences with openness, frankness, and self-awareness.

Our interviewers try to be aware of conflicts between values implicit in U.S. psychiatry and those held by the applicant's culture and religion (e.g., homosexuality, duty to the family, female assertiveness, authoritarian vs. egalitarian principles in medical practice). As examples, we may ask the following: "How do you take a sexual history, and how do you feel about doing that?" "What is adolescence like in your home country; is the experience of adolescence undergoing change?" "What changes or problems are elderly people experiencing?" We expect value conflicts, and we assess the applicants' awareness of such conflicts and their readiness to try to solve these conflicts as part of their professional and personal development.

Our interviewers also determine the extent to which the applicant is acquainted with U.S. popular culture, for example, sports, TV, radio, movies. With the global distribution of U.S. popular culture, it is reasonable to expect that an IMG would have had some exposure in his or her home country. Furthermore, the extent to which those who have resided here for a while have acquainted themselves with U.S. popular culture speaks to their curiosity, adaptability, and flexibility, in contrast to insularity. Also, being able to talk about U.S. culture without either defensiveness or overidealization is a sign of advanced acculturation.

Applicants married to a U.S. citizen or to someone from the home country who is actively involved in American everyday life by working outside the home, or who have children in school, have more opportunities for acculturation. The resident who has more of these opportunities may more quickly feel at home in the new culture, as well as gain the cultural knowledge needed to practice psychiatry.

We are looking for a person who has sufficient ego strength to tolerate the anxiety that accompanies migration and entrance into American medicine. We have found that those applicants flexible enough to acknowledge any form of discomfort and subsequent identification of conflict will most
probably respond to the rigors of training and acculturation with less rigid, more adaptive responses. Questions such as we have described are meant to elicit not just informational answers but also give us insight into applicants’ character structure and, in particular, their ability to tolerate the tension and anxiety that is so much a part of every physician’s training and practice today.

Assessment of Humanistic Interests

The interviewer may ask whether the applicant has written a literary piece, plays a musical instrument, or produced a work of art. In our experience, interest and skill in the arts may demonstrate a degree of sensitivity, psychological mindedness, and disciplined application that can aid in the psychiatry residents’ work. The interviewer may ask about great literary works, what the applicant would recommend reading, and why. An applicant’s discussion of biographies or fiction may give the interviewer a sense of whether the applicant is aware of the complexities of human personality or is merely interested in them as stories of one-dimensional, idealized heroes or characters.

Assessment of the Family Context

Our interviewers may try to determine how the applicant’s spouse views the applicant’s psychiatric career in the context of cultural expectations of gender roles. We try to ascertain the spouse’s role in evaluating and selecting the applicant’s residency placement. These are important questions in determining the continuing “goodness of fit” between the program and the resident. We keep in mind that if a nonworking spouse feels isolated and has few socialization opportunities, it may have an impact on the resident’s functioning and satisfaction with and continuation in the program.

Relative Weighting of Selection Criteria

In an earlier paper (2) we reported that psychiatry training directors used many of the same criteria for evaluating USMGs and IMGs. Training directors placed greater emphasis for both groups on personality factors, psychological mindedness, ability to communicate, and interview performance. They saw qualifying examination scores as more important in screening IMGs, whereas transcripts and reference letters were seen as marginally more important in screening USMGs.

While we also see these factors as being important, we use an approach that attempts to see the whole person, so that each of the factors that we have just discussed are woven into a matrix of understanding. We do not prioritize the criteria because what is important is how each of the factors relates to the others and to the qualities and resources of the training program. We attempt to obtain the best possible fit between the resident applicant and the particular characteristics of our program. We identify potential problem areas that we are capable of remediating, and we will accept a qualified resident knowing that we will need to address those problems.

In our experience, we have found that the applicant’s prior training in psychiatry, capacity for sensitivity and empathy, good language skills, and freedom from significant psychopathology have often outweighed qualifying examination scores in our decision to screen or select an applicant.

Evaluation of Our Selection Methods

We have made no formal evaluation of our selection methods: such studies are very difficult to pursue since one cannot determine the outcome in the residency of applicants not accepted to the program. However, our program, which can be no better than the residents it selects and the way we work with them, has shown signs of health. Most
residents complete their training here: over the past 5 years 72% have graduated from the program, and an additional 11% have transferred to child/adolescent psychiatry to complete their training. The residual group includes 6% who stopped because of physical health reasons (not an outcome that could have been foreseen in the selection process), 6% who were terminated by the program, and 5% who moved out of the region.

Our residents' scores on the Psychiatric Resident In-Training Examination have risen over the past 5 years (particularly the scores of PGY-3 and PGY-4 who have experienced the maximum impact of the program). In comparison with the results of a national survey of psychiatric residents (9) that indicated that 2% of residents dropped out or were terminated from their training programs for psychiatric illnesses, or committed suicide, none of our residents' training ended for those reasons during the past 7 years.

CONCLUSION

Psychiatry is undergoing yet another recruitment crisis, and educators need to develop ongoing strategies to deal with the continuing need to recruit appropriate trainees. One strategy, the recruitment of IMGs, may be overlooked because of the difficulties in assessment. IMG recruitment is indeed a complex process and may require more attention than the recruitment of USMGs. We have described screening and interviewing approaches that have helped us recruit and select competent and dedicated IMGs. We hope that our practical guidelines and suggestions will facilitate and improve the selection process for other programs, making it an enriching and rewarding experience.

References

Regular Articles

Psychiatric Resident Moonlighting

A Review and Modest Proposal

Stephen Ruedrich, M.D.
Kenneth Matthews, M.D.
Carlyle Chan, M.D.
Paul Mohl, M.D.

Moonlighting by psychiatric residents remains controversial, with debate surrounding the ethical, legal, financial, and educational risks involved in the practice. The authors present a literature review of resident moonlighting, which encompasses the policy positions of various organizations responsible for graduate medical education; surveys of various groups and specialties regarding the prevalence, form, and justification for moonlighting; and models of moonlighting programs in several institutions. The authors conclude with specific proposals for research regarding psychiatric resident moonlighting and, more importantly, emphasize the need for research on the effects of moonlighting on resident performance and education. (Academic Psychiatry 1994; 18:189–196)

Moonlighting—defined as additional work beyond one’s regular employment—has a history as long as work itself. The term originally was used to describe persons who, in order to avoid paying rent, exited their residence “by moonlight,” and later came to identify other unsavory characters, such as smugglers and prostitutes, whose employment necessitated the cover of darkness (1). By 1900, moonlighting merely meant working an extra job, generally at night, but something of the original dark and secretive nature of the activity has persisted to the present. The practice of moonlighting by physicians has a shorter, but equally controversial history, with proponents and detractors vigorously debating the ethical, legal, financial, and educational risks and benefits involved (2,3).

In resident education, moonlighting by psychiatric house officers is similarly viewed with ambivalence by those responsible for the educational process—training directors, chairpersons, other faculty, hospital administrators, and residents themselves (4,5). This ambivalent attitude toward resident moonlighting has caused training directors to adopt a variety of responses, sometimes encouraging, often ignoring, occasionally banning, or more commonly, lamenting but allowing their residents to moonlight (6).

A review of the literature on house officer moonlighting is surprisingly sparse in
content: of 37 articles from mostly refereed sources, the majority are editorials. About one-third report survey data regarding some aspect of house officer moonlighting, and only four describe specific programs or practices in this area. The preponderance of editorials may reflect the controversy involved; the paucity of data-based information may be a reflection of the unwillingness of educational systems to examine in-depth a discomforting but widely practiced activity such as moonlighting. Early editorials are unequivocal in their portrayal of moonlighting by resident physicians as a “practice to be discouraged,” with statements endorsing residency education as “full-time,” and considering “moonlighting as a symptom of a diseased residency, to which a cure must be found” (7). More recent opinions note the prevalence of the practice (8–13) and recommend methods to address the administrative (14–19), financial (20–22), educational (23,24), and legal (25,26) ramifications of house officer moonlighting.

POLICIES

As might be expected, given the potential effects of moonlighting on resident education and hospital function, a number of professional organizations, accreditation agencies, and licensing authorities have taken official policy positions with respect to resident moonlighting. The American Association of Medical Colleges (AAMC) has taken a strong negative stance on moonlighting, consistent with its pro-education position. In 1974, the AAMC Executive Council adopted a resolution stating that moonlighting is “inconsistent with the educational objectives of house officer training” and that institutions that permit moonlighting should take great care to preserve the educational character of their graduate programs (18). Such care should include an approval process via the hospital governing board and attention to the individual, personal, educational, and financial needs of any house officers permitted to moonlight. In 1988, the AAMC Executive Council re-endorsed this position, stating, “Accrediting institutions, medical schools, teaching hospitals, residency program directors, and faculty should work actively to halt moonlighting” (27). This occurred as part of a more comprehensive AAMC position statement about total resident work hours, at least partially in response to the report of the Bell Committee in New York State, which made recommendations for setting maximum resident work hours in the wake of the Libby Zion case (28).

Other organizations have taken somewhat different positions with respect to moonlighting house officers. In 1974, the American Medical Association (AMA) House of Delegates (substitute resolution 53) stated that (29)

> The specifics of off-duty hours and extramural activities should be negotiated between house staff and their employers. As a basic human right, house staff may spend this time in any way they see fit, provided primary institutional responsibilities are not compromised. Any disciplinary action related to extramural work must accord due process. The house staff contract or agreement should provide that a member of the house staff is free to use his off-duty hours as he/she sees fit, including engaging in outside employment if permitted by the terms of the original contract or agreement. Such activity should not interfere with obligations to the institution or to the effectiveness of the educational program to which he/she has been appointed.

This policy, supported by the AMA-Resident Physician Section, was re-endorsed in 1992, and today represents the AMA’s official policy on moonlighting and residents (30). The AMA has also taken a position on total resident work hours, asking the Accreditation Council for Graduate Medical Education (ACGME), which is responsible for residency accreditation, to require the Residency Review Committee (RRC) in each
specialty to set a maximum number of hours a resident can work (31). Another ACGME parent organization, the American Board of Medical Specialties, agreed that specific provisions for maximum hours should not appear in the ACGME general requirements covering all residencies, but took the position that each specialty's RRC should address this issue in its special requirements (32). Thus, the ACGME requires, in the general requirements for residencies, that "each resident be offered for acceptance a written agreement encompassing the following... practice privileges and other activities outside the educational program."

This is further specified in the special requirements in psychiatry, which state: "the (residency) program should carefully monitor any activity outside the residency that interferes with education, performance, or clinical responsibility. The program should carefully monitor all on-call schedules and hours within and outside of the residency to prevent interference with education, performance, or clinical responsibility." (33)

No specific discussion is made of the form or extent of such monitoring, leaving the process to the discretion of individual hospitals and residency programs. The American Psychiatric Association (APA) and the American Association of Directors of Psychiatric Residency Training (AADPRT) have no official policies. On the other hand, state health departments and medical regulating boards, responsible for the licensing of physicians, have implemented restrictions on resident work hours (which include moonlighting hours), to essentially regulate moonlighting (34). These restrictions have already taken effect in New York State and are under active consideration in several other states (California, Michigan, Hawaii, Pennsylvania, Massachusetts, Illinois) (35). Clearly, moonlighting remains controversial, with policy positions dependent on the mission of the respective agency or institution.

SURVEYS

In nonpolicy areas, a number of authors have attempted to examine the who, what, where, why, and how of resident moonlighting. Surveys have been directed at hospitals, residency directors, chief residents, medical alumni, and residents themselves in order to determine the extent and form of participation in moonlighting. In a 1984 report, moonlighting was permitted in 70% of pediatric residency programs (10), and in 1987, moonlighting was permitted in 97% of nonmilitary family practice programs (13). It was described as "sanctioned" for 44% of PGY-2 and 60% of PGY-4 residents in psychiatry in a 1989 AADPRT survey of residency training directors (P. Rodenhauser, November 1989, personal communication), and only 19% of hospitals reported an institution-wide ban on moonlighting in the AAMC Council of Teaching Hospitals survey in 1991 (9) (although the same hospitals reported that up to 38% of individual programs did prohibit the practice). Surveys of individual residents and programs have similarly revealed widespread practice. In the mid-1980s, nearly one-third of the residents who responded to the AMA Survey of Resident Physicians reported holding a second job (20); around the same time, studies of single or multiple programs revealed that 72/181 (40%) of internal medicine residents were moonlighting (21) and 67/73 (92%) of family practice graduates reported moonlighting as residents (11). Men were 1.5 times more likely to moonlight than women, and international medical graduates were more likely to moonlight than U.S. medical graduates (20).

Regarding what types of additional work is done by moonlighters, and where, the available survey literature reports that moonlighting residents engage in professional activity both inside and outside of their residency program and hospital (10,13,22,25), as well as inside and outside of the specialty they are learning as residents (2,8,36-38). Both sets of circumstances raise
important educational and legal questions about resident moonlighting. Employment outside of one's residency program and hospital has been justified 1) as a method to broaden one's educational and/or clinical experience (13,23), and 2) inside of one's program as a method to more accurately monitor such activity, arrange for supervision, and provide liability insurance for moonlighting activities (10,25). Several authors have noted the ethical issue involved when a house officer represents himself or herself as a fully trained specialist when moonlighting (36); others have noted the liability issues surrounding residents in one specialty (e.g., psychiatry) moonlighting outside of their area of expertise (e.g., emergency rooms, walk-in medical clinics) (2,3).

Much more agreement exists, however, regarding the explanation and justification for resident moonlighting. Across all surveys, economic necessity has been identified as the single greatest factor in the decision to moonlight (8,12,20,21,24). Much of the reason has been ascribed to the significant indebtedness that a majority of medical school graduates now incur (20,21,39). In a recent AAMC survey, 81.2% of medical school graduates owe an average of $50,000 at time of graduation (40). With recent policy changes that prohibit deferment of repayment during residency for most loans, most house officers must begin repaying their medical school loans during their residency training. Multiple surveys have linked indebtedness to decisions to moonlight (20,21,24); one other factor significantly correlated with moonlighting is also economic, that is, number of dependents—spouse and children (21). Compared with other specialties, psychiatric residents often incur an additional economic expense during training—the cost of personal psychotherapy. Such therapy, sometimes required but generally not funded by the residency program, has been described as an additional economic justification for resident moonlighting (41). Other reasons given for moonlighting have included the opportunity for personal growth (5,24), independence of practice (11), expanding one's residency experience (13,21,23), and investigating postresidency career opportunities (24). A final justification for moonlighting has been the clinical service moonlighters provide to otherwise unserved and underserved patients (5,6,24).

In the largest survey to focus exclusively on moonlighting by psychiatric house officers, Buch and Swanson (41) in 1983 sampled 3,745 residents in 133 residencies with 1,013 (27%) responding to their questionnaire. Moonlighting varied significantly based on year of training, with 66% of PGY-4 residents reporting moonlighting activity. A majority of respondents spent less than 9 hours per week moonlighting, but 17% reported spending more than 16 hours per week. Significantly, nearly 12% of the respondents reported moonlighting without malpractice insurance, and 5.6% did not have individual medical licenses in their state. In the researchers' sample, total indebtedness (but not educational indebtedness) was significantly associated with active moonlighting, as was having children and total number of dependents. Finally, more than 75% of the respondents stated they would stop moonlighting if their salary was substantially increased. Buch and Swanson speculated that many residents moonlighted to provide a more middle-class professional lifestyle than was possible solely on a resident's salary, and the authors called for further investigation of the most important question and controversy surrounding resident moonlighting, that is, does it adversely affect resident performance in the training program?

MODELS

Not surprisingly, only a few studies have discussed moonlighting practices or programs in order to address the educational and legal questions just outlined. In an early paper, Draper and Nitzberg (6) described a
nonrandom survey of 40 psychiatric residency directors, and reported that the majority of respondent programs had a set of procedures (either unwritten guidelines or a written policy) on moonlighting. Reported procedures generally prohibited private practice, prohibited moonlighting by beginning residents, and stipulated that moonlighting not interfere with training responsibilities. The authors then described a program at their institution in which residents were permitted one-half day per week to “moonlight” during regular working hours, at a site chosen from a number of community consultation opportunities. Each site or agency had to be registered with the program coordinator, provide supervision of the moonlighter, and provide income that was monitored and tracked through the coordinator of these consultations.

Similarly, S. Cohen and Leeds (25) described a program at the University of Massachusetts Medical Center (UMMC), entitled “extended employment,” in which residents in a variety of specialties moonlight in affiliated agencies and hospitals that must meet certain standards of participation with the parent hospital in order to be able to employ resident moonlighters. In the UMMC system, each hospital must be licensed and accredited, have on-site and on-call supervision, attending physician back up, and quality assurance and risk-management procedures. Malpractice coverage is provided through the UMMC parent organization, compensation to the resident runs through UMMC, and each participating resident needs a signed approval from UMMC to participate.

A similar system was reported by R. Cohen (22) at the University of Pittsburgh, in which the residency training director and parent hospital served as a clearinghouse for all moonlighting opportunities, and entered into service contracts with employers, who paid both the resident moonlighter as well as a designated faculty supervisor for each activity done while moonlighting. Billing for these costs takes place through the faculty practice plan, and malpractice coverage is provided by the parent institution. Although Cohen reported “universal approval” of this process by residents, residency program, and employers, a letter by Piening (42) identified this system as representing a method that medical school faculties have “calculated” to generate revenue from resident moonlighting.

Finally, Yingling et al. (43) described a program in which house officers in one internal medicine program wrote guidelines for themselves on which clinical services in their residency could permit residents to moonlight, and set up a committee of residents to voluntarily peer review colleagues’ moonlighting. The authors noted that this system provided both a sense of individual control over moonlighting activities and resident awareness of their peers’ performance in this area while maintaining the enforcement power in the residency program and hospital.

SUMMARY AND RECOMMENDATIONS

Moonlighting by resident physicians has remained controversial. Historically, the issue has been fraught with a number of ethical, legal, and professional considerations. Although a number of professional organizations have taken positions with respect to moonlighting residents, today the only national organization with the capacity to regulate moonlighting is the ACGME, through its RRCs and the residency accreditation process. On a state level, to date only New York, through its health department, has placed restrictions on total resident work hours and by extension on the capacity of residents in that state to moonlight. The RRC for psychiatry requires programs throughout the country to monitor any activity (e.g., moonlighting) outside the residency that “interferes with education, performance, or clinical responsibility.” The only data avail-
able to date in psychiatry about this process comes from a survey of residency directors coordinated by the AADPRT in 1989, which revealed that only 44% of programs did monitor their residents’ moonlighting activity at that time.

An intuitive conclusion could be that as the indebtedness of medical school graduates continues to rise and the terms for loan repayments become more restrictive (i.e., earlier in residency training), the pressure on residents to moonlight to repay loans and/or otherwise provide for their living expenses will also increase. This rising pressure to spend more time outside of residency training engaged in money-making activities is on a collision course with legislation under consideration in many states similar to that in New York, which sets limits on the number of total hours (including residency work hours and moonlighting) that a house officer can work. Although the RRC for psychiatry has no current policy with regard to maximum work hours, other specialties (such as internal medicine) already specify maximum work hours in their specialty requirements for residency training (33). Although there is little current evidence that medical student indebtedness affects career specialty choice (41), recent initiatives to increase the number of generalist physicians, which hope to promote generalist careers through preferential loan interest rates and/or forgiveness, will not alleviate psychiatric residents’ need to moonlight and cannot help but add to psychiatry’s continuing recruitment difficulties (44).

What should be the response of our field with respect to moonlighting by psychiatric house officers? First, it seems clear that current times demand that our field give up all pretense of prohibiting moonlighting by residents. Editorials and the AAMC’s policy aside, multiple surveys have demonstrated the prevalence of moonlighting across all medical specialties. The realities of mounting medical student indebtedness and the rising cost of living for residents dictate that moonlighting is here to stay. Only drastic reductions in medical school tuitions, and/or increases in residency stipends, would appear to obviate the need for residents to earn additional income outside of the training program. Neither seems likely. The situation will remain particularly difficult for psychiatry, in which there are neither proposals for loan deferments or forgiveness based on specialty, nor the prospect of earning sufficient income immediately after residency to easily accommodate large loan repayments. As a result, it appears a more constructive approach to moonlighting would be to incorporate it, in multiple forms and configurations, into the educational and administrative components of training in order to monitor, guide, and control the practice.

To facilitate solutions, additional research on the scope and nature of psychiatric resident moonlighting is needed to inform hospitals, training directors, and accreditation systems now responsible for monitoring. The most recent comprehensive survey of psychiatric resident moonlighting was reported by Buch and Swanson in 1986 (41). Given the changes that have taken place in graduate medical education since then, an updated extensive survey will be needed to assess the current prevalence of psychiatric resident moonlighting, as well as the specifics of locations, types, income, and justifications for moonlighting. Highlighted in such a survey should be a focus on the specific duties that residents perform when moonlighting, the availability and use of supervision for each type of duty or practice, and the availability and type of malpractice insurance for moonlighting activities by residents. Such a survey would most appropriately be done under the official auspices of the AADPRT, through its information committee responsible for member surveys. Alternately, the Association for Academic Psychiatry Residency Section, or the APA Office of Medical Education, could sponsor an updated survey.
Next, both successful and failed methodologies and policies for prohibiting, permitting, monitoring and/or providing moonlighting by psychiatry residents should be reported, so that programs and hospitals can choose a position and policy that best meets the needs of the residents and the institution. In addition, such individual institutional moonlighting policies should be examined regarding their effects on the residency program accreditation process and on medical student recruitment into psychiatry. In this latter area, research should focus on the financial aspects of moonlighting by current psychiatric residents, addressing how debt or other financial obligations are related to resident moonlighting. Such research should attempt to tease out, within the broad area of financial considerations, whether resident moonlighters are doing so in order to make loan repayments, maintain a lifestyle not possible on current resident salaries, finance personal psychotherapy, or combinations of these or other reasons.

Finally, a major area of research focus should be directed at the heart of the moonlighting dilemma, that is, does moonlighting negatively affect residency education, and if so, how? Little or no systematic investigation addresses this issue, particularly in psychiatry. Although methodologically difficult, such research would not be impossible and could address aspects of resident performance that might be affected by sleep deprivation and/or continuous on-call availability (45,46). Specific research, again ideally organized through AADPRT or other organizations, should address the effect of moonlighting on performance in the residency. Performance as a dependent variable could be assessed in several ways, including the number and/or ratio of satisfactory vs. unsatisfactory performance evaluations, stratified scores on the Psychiatry Residency In-Service Training Exams, presence or absence of disciplinary problems, preparation for residency didactic seminars (reading) as rated by the residency director or specific instructors, and, after residency, passing grades on parts I and II of the psychiatry board exams. In each area, the performance of residents who moonlight could be compared with that of nonmoonlighters overall, or attempts can be made to examine such variables against the degree and level of moonlighting. Only in this fashion can our field begin to make informed, data-based decisions about the effects of the additional work inherent in moonlighting on the education of psychiatrists.

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A Survival Guide for Aspiring Academic Psychiatrists

Personality Attributes and Opportunities for Academic Success

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Many residents in psychiatric residency training are interested in an “academic career.” Recognizing that current academic departments require excellent teachers, clinicians, and administrators in addition to researchers, medical schools and their universities are wrestling with titles and tenure as they attempt to provide opportunities via a variety of academic career paths. What constitutes the most suitable career path for the academic aspirant depends on the person’s goals, motivations, interests, values, personality style, talents, background, and training, as well as historically and geographically available training, mentoring, and employment opportunities. The authors examine alternative definitions of “academic success,” relate these to the variety of personality types and opportunities found in academic settings, and provide some guidelines for advancement along the available career paths. (Academic Psychiatry 1994; 18:197–210)

Several reports note that many psychiatric residents aspire to academic careers: An Association of American Medical Colleges (AAMC) survey of 491 American medical students entering psychiatric training at the PGY-1 level in 1986 found that 13% anticipated taking a research fellowship (with an additional 27% undecided) and that 30% hoped to receive a full-time academic faculty appointment focusing on clinical service, teaching, and research (1). Only 0.4% wanted a full-time appointment with a focus on basic research. In a similar vein, Haviland et al. (2), using AAMC data, reported that of the medical students entering psychiatry in 1985 1.7% anticipated full-time faculty appointments focused on basic science research and teaching, and 0.2% anticipated careers as basic scientists, figures not too different from those for other medical specialties. Bashook and Weissman (3) followed a cohort of psychiatric residents throughout training and found that 15% of 196 residents graduating in 1986 planned to take research fellowships. In a study of 1986 applicants to the University of California at Los Angeles (UCLA) psychiatric residency program, Yager et al. (4) found that 25% to 35% indicated career interests in teaching and research. Finally, in surveying program

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directors about starting positions for residents graduating in 1986–1988, El-Mallakh and Riba (5) found that 9.7% of graduating residents reportedly took a half-time or greater academic position as an initial postresidency job.

The data suggest considerable variation in exactly what an academic career signifies. To a small percentage an academic career suggests commitment to basic research and teaching. To a much larger group it signifies a life in an academic setting devoted full- or part-time to teaching, clinical work, administration, and applied research. In our experience, of these four activities most young academic aspirants areleast certain about and least familiar with what is entailed in the research aspects of an academic career. Some have a firm “calling,” with a deep, longstanding desire to do research or to teach. Others are initially academic window-shoppers who, through an experiential, iterative process, will discover whether they are truly suited for an academic life. All academic aspirants must determine whether worshipping at the altar of Academic Medicine sets them on a course toward finding their “true God” or lurching after a “false God”; they must resolve for themselves the question posed by Alpert and Coles regarding careers in academic medicine: “triple-threat or double fake?” (6).

Very few of those aspiring to academic careers, including not only housestaff and fellows but also many junior faculty members already in place, actually know much about the variety of “academic” career options available, the requirements for each one, and the rules for successful career-building. Here we will attempt to put the various pathways and options into perspective. We will discuss the interaction of psychiatrists’ interests and personality styles with the variety of environmental factors and job opportunities present in academic environments, consider personal strategies that promote academic careers, and ultimately suggest that the most critical element for fashioning a successful academic career, in addition to luck and determination, is considerable self-awareness about one’s personal needs, values, motives, and capacities. After all, one’s assessment of success depends not only on achievement, but also on what one really wants.

Definitions of “academic success” vary with persons and with institutions. Many of the most illustrious and creative figures in psychiatry’s past never got a grant or a university-tenured position, and would therefore not be considered academic successes by these measures (e.g., Freud, Adler, Jung, Kohut, and Menninger who essentially “endowed” their scholarly work with their own practice fees or other sources of nonacademic income).

For those who find themselves interested in careers centered at universities and affiliated teaching hospitals, a great many paths are now open. Individual aptitudes, motivations, competing needs, and intercurrent opportunities all appear to contribute to the evolution of careers. For the aspiring academic, “know thyself” is an excellent place to begin.

INTERESTS, PERSONALITY, AND COGNITIVE STYLE IN RELATION TO ACADEMIC CAREER PATHS

To start, those contemplating academic careers should identify for themselves which aspects of academic life they find most attractive, what personal needs would be served by such a career (and at what cost), and how one’s professional and personal life are to be balanced. If to the classic “three-legged stool” on which academics perch (service, teaching, and research) (7) one adds the additional leg of academic administration as well as the importance of attending to family and other personal interests, the result can be a very demanding piece of furniture on which to sit. Attaining academic tenure may not be all it’s imagined to be, and getting there may be too much of
an ordeal relative to one's other needs. The requirements and difficulties of current academic medicine are even more demanding than they were in the past, and the future is more uncertain (7,8).

Our observations of the personal styles and evolving career paths of several hundred psychiatric residents and faculty over the past two decades sparked formulation of some speculative hypotheses about specific characteristics that seem to differentiate those likely to have successful careers as productive research professors from those who find academic success primarily as full- or part-time paid clinician-teacher-administrators or as members of a volunteer clinical faculty. Some of the interests, personality traits, and cognitive styles, admittedly impressionistically and stereotypically presented, are shown in Table 1. Although these impressions may seem archaic, they are widely held within academic circles. Indeed, because some of these traits might also be viewed as "sexist," we've checked our impressions of these characteristics with academic colleagues of both genders, and we found that our peers generally concur with our views. The qualities seem to us to reside along a continuum, with those academics more closely identified with research academic careers leaning toward the left column of the table and those academics identified with clinical teaching careers leaning toward the right column of the table.

Another way to approach the question of appropriate career path is via an academic-potential self-assessment test. The aspiring academic should consider the extent to which he or she might endorse each of following seven statements (with a minimum of self-deception):

First, you truly aspire to gain new scientific knowledge. You will enjoy the doing of research. You are willing to spend tedious hours writing elaborate grant proposals that have about a 10%-20% chance of getting funded, gathering detailed and elaborate data, meticulously going over results, arduously writing up the results for publication, and undergoing the critical peer-review process. Furthermore, because your favorite form of extrafamilial bonding is with your research collaborators and co-authors, you don't really mind that much of the work you publish is unlikely to ever be cited by anyone else (9). After running this intellectual gauntlet, ultimately presenting your findings at national meetings, and seeing your results

<table>
<thead>
<tr>
<th>TABLE 1. Interests, personality traits, and cognitive styles in successful academic careers</th>
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<tbody>
<tr>
<td>Professor/Research Series</td>
</tr>
<tr>
<td>Inner-directed</td>
</tr>
<tr>
<td>Quantitative</td>
</tr>
<tr>
<td>Idea-oriented</td>
</tr>
<tr>
<td>Competitive (with self or others)</td>
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<tr>
<td>Goal-oriented</td>
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<tr>
<td>Single-minded</td>
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<tr>
<td>Driven by academic reward systems</td>
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<tr>
<td>Enjoys research more than teaching</td>
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<tr>
<td>Original research</td>
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<tr>
<td>Laboratory research</td>
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<tr>
<td>Analytic research</td>
</tr>
<tr>
<td>Analytic scholarship</td>
</tr>
<tr>
<td>Research team leader</td>
</tr>
<tr>
<td>Works long hours</td>
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<tr>
<td>Self-sacrificing</td>
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<tr>
<td>Persistent</td>
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accepted into the corpus of scientific knowledge, you will be satisfied with obtaining a modicum of renown for your accomplishments, some small measure of thrill, and intimations of immortality not achievable in any other way.

Second, you are drawn to the apparent collegiality of the academic life, although you don’t fancy yourself a genius researcher in your own right. You will be gratified to contribute in some small way to ongoing research efforts.

Third, you are drawn to an academic life because you crave the excitement of juggling multiple activities: clinical work, administration, research, and teaching.

Fourth, you hope that an academic life will protect you to some degree from potentially contaminating motivations that might afflict you in a fee-for-service private practice setting.

Fifth, you are drawn to the idea of being in a “stimulating” environment in which your colleagues and students are expected to keep up with the latest developments. Although you like “research,” what you really like is reading others’ research findings, so that you can feel that you are on the cutting edge of teaching and clinical care. You are hopeful that your students will keep you on your toes and that you will learn as much as you teach.

Sixth, you are drawn to the academic life because you enjoy creative speculation and original ideas. Although you do not have the patience to arduously work them out and test their validity, and you could not stand to do statistical analyses if your life depended on it, you are happy to have a ready and serious audience for your intellectual pursuits.

Seventh, your motivation for an academic career derives largely from the high status accorded to “professors” in your family, even higher than to physicians. Entering an academic life is one way to compensate and reduce your need to apologize for having selected psychiatry instead of another field of medicine. For psychiatry, “academics” is not having to say you’re sorry.

Responses to these statements will permit academic aspirants to assess how their particular interests and aptitudes correspond to the various academic paths. Strong affirmative responses to statement 1 suggest a gravitation toward the traditional professorial “triple threat” academic track; affirmative responses to statements 2 through 6 suggest a gravitation toward the compensated and voluntary clinical faculty; and positive responses to statement 7 suggest the need for some sort of academic role, regardless of series.

THE EVOLUTION
OF CONTEMPORARY ACADEMIA

Academic psychiatry as we know it today has evolved primarily during the past 50 years (7). During that time, university medical schools, expanding their clinical bases for medical students and housestaff, became affiliated with a wide variety of county, city, Veterans Affairs (VA), state, and nonprofit community and private hospitals. Thus, many departments grew extremely large in a wide variety of configurations, liberally rewarding affiliated physicians with a cacophony of academic titles, so that psychiatry departments with hundreds of academic, paid clinical, and voluntary appointments became commonplace (7,8).

But over the past two decades, the curves of previously unrestricted growth have shifted downward, with federal dollars for postgraduate clinical training and medical student psychiatric education having been cut drastically. The National Institute of Mental Health (NIMH) clinical training grants for psychiatric education have fallen precipitously (10) to the point where they are now virtually nonexistent. More recently funds for training psychiatric physician researchers have also been cut. For years the amount of federal money available for funding actual psychiatric research has also not
kept constant with inflation (11,12), and the chance that an approved grant proposal will actually be funded has fallen from about 1 in 5 to 1 to 10 or even less. As a result, academic physicians have been forced to generate more of their salaries through clinical activities.

At the same time, downturns in the general economy and changes in funding for medical care related to cost competition fostered by managed care organizations threaten even those clinical revenues upon which academic departments and faculty have come to rely. It appears that the very existence of many academic medical centers may be threatened in the near future. It is within this setting that current and future academic lives are to be fashioned.

**ACADEMIC PATH OPTIONS**

Academic tenure connotes different meanings at different universities, and the ground rules for titles and promotion are changing rapidly. A 1989 AAMC-commissioned survey of U.S. medical school deans, which had a 90% response rate, revealed that active changes and redefinitions were occurring with regard to tenure track promotion in 78%, criteria for nontenure track promotions in 65%, development of nontenured tracks in 50%, and affirmative action incentives in 64% of the responding schools (13). According to AAMC data, the use of tenure is decreasing, with the proportion of full-time faculty with tenure dropping from 41% in 1985 to 38% in 1989 (14,15). The survey also revealed that five U.S. schools awarded tenure to basic sciences faculty only, and an additional seven had no tenure-appointment system. A number of schools are freezing or severely limiting the award of tenure compared to before (13).

A confusing array of university academic titles and series is currently in use in medical schools: examples include professor, professor of clinical psychiatry, clinical professor of psychiatry, compensated clinical professor, adjunct professor, professor-in-residence, research professor, and university professor, among others. Because there is no universal agreement about how these terms are used or what they signify, the specific meaning and responsibilities of the titles often vary from university to university. Universities are currently experimenting with several methods for reducing the number of titles. For example, at an increasing number of medical schools, persons who have achieved the rank of associate or full professor may use those titles without additional modifying terms, regardless of tenure, clinician vs. researcher status, or salary source. These shifts reflect a growing awareness that researchers, clinicians, administrators, and teachers are needed to do the work of the contemporary medical school, acknowledging the fact that all "legs of the academic stool" make important contributions. For example, at Harvard Medical School five tracks to professorship now exist, with separate criteria for advancement from assistant to full professor for laboratory investigators, clinical investigators, teacher-clinicians, clinician-scholars, and part-time faculty. Each has its own criteria for advancement from assistant to full professor. At some medical schools physician clinician-teachers are promoted in a "professor (without tenure)" or "professor of clinical psychiatry" (which may or may not have the possibility of tenure) track.

Academic salaries are funded through a variety of sources. The most frequent sources are university-funded full-time equivalent (FTE) academic positions (an academic billet with funding from the university); academic funding exclusive of formal FTE positions (flexible payment with university funds but without the allocation of an official billet); hospital or medical center funds and positions (from university, private, community, VA, state, county, or city sources); grants (federal, state, foundation, private donors, industry); contracts (federal agency, industry); and, increasingly, clinical
practice.

Table 2 outlines some of the characteristics for the three most prominent series: professors in research series; professors in clinician-teacher series; and clinical professors, usually part-time or voluntary faculty. These arrangements, typical for the University of California and several other universities, may vary considerably elsewhere.

Tenure

It should be emphasized that the proportion of titled faculty members of a department of psychiatry who hold university-tenured positions ordinarily constitutes a very small percentage of departmental faculty members. Enormous diversity exists in regard to what tenure means and what salary guarantees it brings. Many schools have never had written guarantees. In 12% of schools tenure guarantees "total salary," and in 42% of schools tenure guarantees "continued appointment at designated rank without salary guarantee" (13). In the others tenure generally means that some portion of salary is guaranteed, usually a specified university contribution or a portion guaranteed through a state budget, but does not include practice plan money, grant-generated money, or other contributions. In the University of California system "university tenure" has meant that the university guarantees the faculty member's "base" salary, but for clinician-teachers this amount ordinarily constitutes only half or less of the faculty member's total negotiated salary. Other sources must be found for the additional compensation, usually tied directly to the faculty member's ability to generate funds via research grants, clinical income, or hospital- or university-funded supplements for major, time-consuming administrative jobs. A variety of other intermediary and novel arrangements exist as well, and many schools' bylaws are silent on the matter of guarantees. At one prestigious medical school the base salary is usually zero for physicians who are awarded tenure. At another, individuals appointed to tenure are awarded an "Individual Compensation Reserve" that contains 250 base points, each equivalent to 1% of annual compensation. Individuals who experience a shortfall in total compensation from internal or external sources may withdraw base points from this account, until it runs dry (13). At UCLA only 14 of more than 950 faculty members in the Department of Psychiatry and Biobehavioral Sciences hold professorships that are tenured by the regents of the university through the medical school dean.

In most instances, tenure is vested in full-time faculty in the "regular" or "ladder" series ("professor of psychiatry") who meet the university's expectations for original research and/or original scholarship and/or grant productivity at the time of promotion from assistant professor to associate professor (in the ordinary course of events 8 years after appointment as assistant professor). However, some universities grant tenure only upon promotion from associate professor to full professor, whereas in other universities the decision to award tenure is independent of promotion decisions.

Problems with the current tenure system are considerable. First, mandatory retirement of tenured faculty is being abolished (16). This development may further plug the tenure system, requiring some process to clear a path for younger faculty members on the way up. Second, young physicians entering academic careers are faced with having to prove themselves as "quadruple threats" (researchers, teachers, clinicians, and administrators), whereas young nonphysician academics must only produce research or scholarly work and teach. Third, it is harder for physicians to have the same research productivity as nonphysician academics because the former have to devote time to clinical work that takes time away from research focus and productivity. Finally, most medical school-affiliated positions do not equate security of
Table 2. Characteristics of prototypical academic series for psychiatrists

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Professor of Psychiatry/Research Series</th>
<th>Professor of Psychiatry/Clinician-Teacher Academic Series</th>
<th>Clinical Professor of Psychiatry/Volunteer or Part-Time Series</th>
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</thead>
<tbody>
<tr>
<td>Full-time vs. part-time</td>
<td>Usually full-time. (&quot;Full-full&quot; or geographic, depending on department.)</td>
<td>Usually full-time. (&quot;Full-full&quot; or geographic, depending on department.)</td>
<td>Mostly part-time. Some full-time hospital physicians in university-affiliated hospitals. (If part-time, may be as little as a few hours per week, or a specified number of hours per month or year.)</td>
</tr>
<tr>
<td>Salary sources</td>
<td>Often includes university &quot;base.&quot; May be derived exclusively from nonuniversity sources (e.g., hospitals).</td>
<td>Often, but not always, includes university &quot;base.&quot; May be derived entirely from nonuniversity sources (e.g., hospitals).</td>
<td>Usually practice income or hospital staff. No income from the university per se.</td>
</tr>
<tr>
<td>Promotion</td>
<td>Based mainly on research/scholarly productivity, grants, and to a lesser extent on teaching. Often requires 15–50 peer-reviewed publications.</td>
<td>Based on outstanding teaching, administration, and to a lesser extent on research/scholarly productivity and grants.</td>
<td>Based on documented outstanding teaching; formal recognition as a professional leader; contributions to the university and professional community; excellence in practice; and scholarship.</td>
</tr>
<tr>
<td>Tenure</td>
<td>May be tenured, but many universities now have non-tenured series as well.</td>
<td>May be tenured, but many universities now have non-tenured series as well. Some universities are using &quot;term appointments&quot; (e.g., 5 years) for these positions. Some universities limit the total percentage of faculty positions that may be assigned in this series.</td>
<td>None. Appointment generally contingent upon ongoing contributions to the department.</td>
</tr>
<tr>
<td>Teaching expectations</td>
<td>Usually several hours per week. Often in laboratories (with fellows, postdoctorals) and clinical settings as much as in courses or seminars.</td>
<td>Strong expectations for outstanding teaching and teaching administration. Promotion often requires innovative teaching; local, regional, and national recognition as an outstanding teacher; major contributions to teaching administration (e.g., running a training program, acquiring training grants).</td>
<td>Strong. Usually specified by the department in terms of hours per week, month, or year. Some appointments may be related to hospital staff or university/community service activities rather than to teaching per se.</td>
</tr>
<tr>
<td>Clinical practice expectations</td>
<td>May be none at all. Depends on salary sources.</td>
<td>Depends on salary sources.</td>
<td>Expected to be excellent clinical practitioners.</td>
</tr>
<tr>
<td>Administrative expectations</td>
<td>Ordinarily requires participation in academic departmental committees. Hospital committee obligations depend on other salary sources.</td>
<td>Depends on salary sources. Often has large administrative responsibility for educational and training programs or clinical services.</td>
<td>Depends on salary source. Some departments accept contributions of administrative time in lieu of direct teaching or clinical work to satisfy faculty obligation.</td>
</tr>
</tbody>
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(continued)
employment with academic tenure. Even a full professor whose salary depends entirely on grant-derived funds for which there are no renewal guarantees may become unemployed if the grant well runs dry. Clearly, those psychiatrists who consider embarking on an academic career should learn in detail the local meaning and significance of tenure at their institution and what is required to achieve it.

**Differences Among Series**

Differences in the titles just described are virtually meaningless to all but academic insiders. To the extent that the budding academic aspires to the academic title of "professor" in order to achieve narcissistic fulfillment and family pride, one series may be as good as the next. Although real differences exist with regard to eligibility to be principal investigator on a research grant (if that is what one desires), academic senate membership (which confers mostly administrative chores and the capacity to sit on usually uninspiring committees), and eligibility for sabbatical leave (in most instances accompanied by only a small percentage of one's usual salary), many of the differences are purely symbolic.

As shown in Table 2, several forces mediate the differences in these series, including activities, value systems, and funding. The professor of psychiatry/research series refers to those full-time faculty appointments that at the assistant professor salary level are traditionally associated with the academic climate of "publish or perish." Review for promotion is based on original scientific or scholarly contributions, publications, and grants, but teaching and clinical and/or administrative service are also considered: hence, the notion of the "quadruple threat" faculty member—capable in research, teaching, clinical work, and administration. Some universities make further distinctions between fundamental (bench or laboratory) researchers and clinical or applied researchers. Requirements for academic review from assistant to associate professor after 8 years resulting in "up or out" are usually reserved for this series. At

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**Table 2. Characteristics of prototypical academic series for psychiatrists (continued)**

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<tr>
<th>Research/scholarly expectations</th>
<th>Scholarly and research expectations are considerable, although usually not necessarily in quantitative laboratory research. Clinical research is acceptable. Production of original teaching material (reviews, textbooks) matters.</th>
<th>Ordinarily few. May help with promotion. Reviews, chapters, textbooks, case reports all considered. Presentations at national/regional/hospital conferences encouraged.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong research and scholarly expectations. Major thrust is for the creation of new knowledge (original rather than applied). Tenured positions are increasingly reserved for quantitative laboratory scientists, especially in the 25 or so &quot;research medical schools,&quot; but conceptual originality often counts as much as data production. Quantitative clinical or social science research may be acceptable. Work is judged primarily by peer-reviewed grants received and quality and quantity of publications in peer-reviewed journals.</td>
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least part of the salary is usually paid by the university for academic work.

Clinician-teacher series, increasingly encouraged and used in medical schools, recognize that academic departments need to hire physicians who are not necessarily devoted researchers to see patients, teach, and administer departments. Tenure may or may not be granted even in the upper ranks. Academic productivity for clinician-teachers is assessed by the amount, quality, and originality of teaching; administration and grant funding; and scholarship of a “synthetic” nature, such as writing reviews, textbooks, and chapters, and producing well-regarded instructional material. Clinician-administrators are usually included in the clinician-teacher series. Their academic productivity is judged not only by their teaching and research, but also by the scope and responsibilities of their administrative assignment. Funding may or may not be provided by the university per se, with most resources usually coming from hospitals or other clinical sources.

**Funding Sources**

As alluded to before, important financial engines drive these systems: the large majority of department of psychiatry faculty members are paid by hospitals and medical centers rather than by universities, and these salaries are linked to specific tasks such as patient care, administration, and teaching assignments. Therefore, research-oriented junior faculty members funded by certain nonuniversity sources are often at less risk of losing their positions because of inadequate research productivity and/or grant writing than their university-funded colleagues. Indeed, for those hired into full-time federal, state, or county university-affiliated positions, civil service regulations often provide far better guarantees of “academic” job security than does university tenure. Many of these positions become “tenured” after only 6 months to a year of probationary employment. For example, a junior faculty member working at a university-affiliated VA medical center who is doing credible clinical work while undertaking research may fail to be promoted in the university research tenure track because the originality, scope, or quantity of his or her scholarly work does not meet local criteria for promotion in that series; however, such an individual may simply transfer to one of the university’s series designed for clinician-teachers or clinician-administrators, for example, the University of California’s “compensated clinical faculty” series, and keep the VA position.

**OPPORTUNITIES AND INTERACTIONS IN DEVELOPING ACADEMIC CAREERS**

In contrast to those who somehow correctly know that they will unswervingly pursue academic research careers from early in life and begin their preparations in high school, academic aspirations in others may not even begin to emerge until and unless predisposed individuals find themselves in nurturing environments, where suitable mentors and opportunities can be found. The exact paths taken by these individuals may depend largely on a series of iterative and formative experiences occurring at critical choice points in their late training and early career years. Some mechanisms by which academic aspirations are spawned include the following.

First, undergraduate institutions may make available enthusiastic mentors who are devoted to spending time and energy with young academic hopefuls.

Second, at the level of medical school training, students are given opportunities to take time off for independent research projects. For those students who wish to undertake independent research study as a head start toward the development of a successful academic career, opportunities are made available for attainment of a combined M.D.-Ph.D. degree.
Third, residents who wish to undertake academic pursuits may be encouraged to do so through the provision by the residency program of resources, time, and mentorship to facilitate and nurture these interests.

Fourth, many residency programs alert interested and talented residents to postresidency academic fellowships. Mentors may be assigned whose local and extended networks assist residents' placement in competitive postresidency fellowships.

Today's aspiring academicians are well served by fellowship training, and great care should be given to selecting the best-suited fellowships and mentors. Desirable opportunities during fellowship include time for the trainee to become knowledgeable and expert in both content areas and methods that will be a focus for later work; expectations and guidance for writing independent grants under a mentor's supervision; participation in research, writing, and publication of independent, as well as collaborative research and scholarship; and teaching assignments.

Fifth, following training, new psychiatrists sometimes find themselves with unexpected first job opportunities in the areas of direct clinical work, teaching, and administration. Opportunities may exist in the areas of medical student or resident teaching or clinical services. Young graduates who find themselves in such positions and who then show special talents in teaching and organization may earn the opportunity to remain as junior faculty within a clinician-teacher series.

Sixth, programs that provide assistance in the organization and writing of grant proposals may give residents, fellows, and junior faculty with limited grant writing experience the practical assistance they need to establish themselves in the academic arena.

Seventh, during their early faculty years, individuals should be open to the discovery of their own emerging academic and clinical affinities. This is enhanced through the ready availability of early feedback from mentors, collaborators, division chiefs, and department chairs on one's research, teaching, clinical work, and administration. Career guidance from these individuals for junior faculty can be a most useful mechanism to facilitate the honing of one's professional skills.

Eighth, all along the road academic aspirants must also factor in shifting and competing demands from other aspects of their lives and lifestyles. What are one's priorities and trade-offs with respect to time for family, other pursuits, and income?

Certain environmental opportunities facilitate the development of academic careers, and deliberations around these issues should be part of a new faculty member's discussion with his or her immediate supervisors, division chiefs, and department chair: What are the available entry-level positions? What is required to move into these positions? What is required with regard to direct clinical work, teaching, administration, and research? What is the availability of interested, capable, and relevant mentoring, research collaborators, seed funds, and protected time for research? What mechanisms exist to encourage the career development of women who will likely begin families, or who have new or young families?

Most departments provide a variety of initial receptor site positions for entry-level faculty. Four common entry positions with their typical subsequent career paths can be outlined.

Laboratory Scientist

Entry-level appointments are usually based on the acquisition of prior research fellowships and demonstrated research productivity. Sometimes entry-level research grants such as the NIMH's "First Award" or a career development award have already been applied for or obtained. In other instances "seed money" to start a research pro-
gram may be provided for 1 to 3 years, pending expected grant funding. The absence of demonstrated grant-getting capacity and research productivity within 3 to 5 years typically leads to a shift to another series or departure.

Clinical Service-Based Position

Examples include inpatient ward, emergency room, outpatient, and consultation-liaison psychiatrist. For these positions as well, a prior research or subspecialty fellowship is helpful. These aspiring academics begin by identifying an area of clinical interest, writing and getting grants, applying necessary research techniques (which may require time out to learn specific research procedures), and finding ways to free up clinical time to proceed with a research career. Having a clinical service as a source of patients with a particular disorder or problem may be especially helpful to clinical researchers. However, unless the research is substantial and innovative and has received significant grant funding, and in some cases even when scholarship is reasonably robust, such individuals are often promoted in the clinician-teacher or clinical professor series.

Designated Educator-Administrator

Examples include training director, assistant training director, or medical student educator. Often such positions are linked to additional administrative or service expectations. Consequently, working hours are often consumed by teaching, clinical work, and administration, leaving little time for research, except as a collaborator. Individuals with prior research training and backgrounds may still find it possible to develop and maintain independent laboratories or clinical research programs while devoting the substantial time and energy needed to be an educational administrator. Generally, promotion is in the clinician-teacher series.

Paid Part-Time Clinicians / Instructors or Lecturers

As teaching grants and other academic funds designated specifically for teaching have become much more scarce, part-time positions that pay faculty exclusively for teaching have also become harder to find. Such positions are not tenured and are frequently of relatively short duration. Appointments are generally in the clinical professor series.

STRATEGIES FOR PROMOTING ACADEMIC CAREERS

Given the diversity of personalities, academic pathways, institutional resources, and demands of different academic series, no one set of rules exists to assure success in academic psychiatry. However, the application of certain guidelines, based in large part on the recommendations of Wyatt (17), may be useful to maximize opportunities for academic accomplishment. Aspiring, ambitious academics are advised to consider the following 18-item list of suggestions.

First, learn the history of successful and unsuccessful faculty members regarding their quests for tenure or promotion in the series of one’s choice. How have others with similar interests fared?

Second, prepare well for your career. Those headed for a research career should take enough time to learn the research methodologies, biostatistics, and protocol preparation required. Most entry-level positions are too busy to permit adequate “on-the-job” learning of research and grant writing skills. These days doing serious research usually requires an initial fellowship period of several years in which research methods are learned, pilot data are collected, and initial grants are written. Those hoping to accomplish these formidable tasks while concurrently working at demanding clinical, administrative, and teaching posts are usually in for a rude awakening. Similarly, those
primarily interested in teaching would be well served by learning something about modern educational and evaluation theory and techniques. All aspiring academics can benefit by reading the literature of academic career development (18,19).

Third, discuss with veteran members of your department what covert as well as overt local rules govern promotion in the various series with respect to the relative importance of research, publications, grants, teaching, administration, clinical practice, and university, community, and professional service. Spend your time proportionally doing what matters most, but make sure that these efforts match to a large extent what you most enjoy and do best.

Fourth, participate in an ongoing, funded research group, where there are available mentors at both senior and intermediate levels. Experience firsthand day-to-day research, learn how to develop and organize ideas for your own grants, and then learn how to write those grants.

Fifth, if you aspire to a tenure-track research-oriented career, guard your calendar to ensure sufficient time to prepare grants, conduct research, and write. Teaching will count, but quality will often be preferable to quantity. Teach as much as possible in conjunction with your research and scholarly activities. Although it is essential to be a “team player” who contributes as a responsible citizen to the activities of the academic department, it is also essential to use time carefully to articulate your own goals and pursue your academically focused tasks.

Sixth, make a serious effort to obtain peer-reviewed grant funding. Although peer-reviewed grants are becoming increasingly difficult to get, they carry considerable weight in decisions regarding promotion to tenure. Successful passage through the grant application process generally signifies that the faculty member has developed the high degree of intellectual discipline necessary to produce a successful application, one that has sufficient quality to have favorably passed through rigorous peer review. In addition to helping individual investigators and their divisions conduct research by garnering resources for personnel, equipment, and the like, grants also bring “indirect” funds to the university, medical school, and department, funds that are the administrative lifeblood of most academic organizations. A somewhat cynical Marxian view would suggest that promotions committees reward young investigators primarily for attracting these funds. A study of the relative promotability of faculty who publish quality work with and without grants begs to be done.

Seventh, make every effort to publish as first author in respected, peer-reviewed journals. The prestige of the journals and the position of authorship within a group of collaborators matter. Academic trends suggest that promotions committees are more frequently being asked to consider the quality rather than quantity of publications (e.g., faculty being considered for promotion at some universities may be asked to submit their 10 best papers rather than their entire bibliography to the committee). Still, having a large number of publications, if they are not entirely redundant, may also signify that the faculty person has something valuable to contribute. Regarding where to publish, although prestige of a journal counts, actually having articles published or accepted and in press at the time one is being considered for promotion may count more in close-call decisions. Therefore, the value of submitting to journals with a faster turnaround time or better acceptance rate must also be appreciated.

Eighth, find a mentor, usually a successful full (or at least associate) professor in one’s series of choice who shares interests and life issues, and set up regular meetings regarding work and career plans. This mentor should be asked to review one’s curriculum vitae at regular intervals and to give feedback about career progression.

Ninth, pick areas of focus that are both
timely and important. Attention to these areas may increase the likelihood that work will be funded, published, cited, and even publicized in the lay press.

Tenth, explore all funding sources (grants, fellowships, departmental seed funds) and discretionary time (sabbaticals, other leaves) that can promote one’s academic activities.

Eleventh, if possible, serve on the promotions committee or other departmental and/or medical school committees likely to provide a view from the top as well as beneficial networking.

Twelfth, make yourself useful. Take on an important task and role in the department so that others know that you are working for the common good and “pulling your oar.”

Thirteenth, participate actively in regional and especially national and international professional organizations. Through presentations, holding offices, chairing committees, and serving on peer-review committees, you will be able to establish a wide network of colleagues who may subsequently be called upon to write to promotions committees regarding an assessment of your professional contributions and reputation. Promotion in clinical as well as “ladder” series usually requires such prominence.

Fourteenth, maintain a list of colleagues and students and keep adequate track of their whereabouts, so that promotions committees can readily request letters of reference regarding professional qualities.

Fifteenth, maintain file copies of teaching evaluations, reviews of your books, references to your published or presented work, “pink sheet” reviews of grants, clinical and administrative reviews, and any other documentation of external evaluation of your work.

Sixteenth, keep colleagues notified of your work by sending them pre-prints and reprints of publications, announcements of presentations and awards, and other information relevant to professional activities.

Seventeenth, take advantage of established support systems for junior faculty, which may include systematic linkages with senior faculty advisers and peer-group support mechanisms. Where such arrangements don’t exist, try to foster their development.

Eighteenth, realize that getting promoted is not the most important thing in the world, nor is it the only measure of academic success. Achieving satisfaction, fulfillment, balance, and a sense of having contributed comes in different ways for different people.

It should be recognized, too, that for women faculty members the paths have proven to be even more difficult than for men. First, there are far fewer women role models. Second, academic pathways have in many instances been relatively inflexible in providing young women faculty with sufficient leeway to satisfactorily combine the responsibilities of childbearing, child-rearing, family, and career. Third, a “glass ceiling” on the promotion of female faculty appears to have been, and may still be, present in some, if not many, institutions (20).

CONCLUSION

Today’s academic medical centers require the collaborative efforts of faculty who contribute a variety of skills, including research, teaching, clinical, and administrative work. It is increasingly clear that although few persons have the talents or temperaments to do all of these tasks, even fewer have the capacity—even if they possess the talents—to do all these things concurrently with any degree of competence and effectiveness.

Accordingly, departments of psychiatry are continuing to create a variety of career paths through which those interested in contributing to the academic effort can find a suitable and comfortable niche. If you aspire to an academic career, your most important tasks are to know your own needs and talents, avoid self-deception as to what they are, and realize that the deepest sources of contentment with your career will come
from enjoying and competently performing those tasks and roles for which you are best suited, regardless of title, series, or salary source.

An earlier version of this paper was presented at the annual meeting of the American Psychiatric Association, May 1991.

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New Idea

Teaching Psychiatry Through Literature

The Short Story as Case History

William M. Tucker, M.D.

The author proposes a simple systematic way to analyze short stories as if they were case histories. Class discussions are organized around five basic questions, stated in the article, and use Erikson’s framework of life stages to translate life experiences into the language of psychic conflict. Fiction writers effectively dramatize psychological and developmental issues in a way that makes them real and memorable to psychiatric residents. Stories may be of particular value in illustrating the process of change and in exploring the topic of prognosis, which are often overlooked in more traditional teaching formats. The author has presented this approach at several recent meetings of the American Association of Directors of Psychiatric Residency Training and the American Academy of Child and Adolescent Psychiatry, and workshop participants have reported success in its use, which depends on the teacher’s clinical rather than literary skills. (Academic Psychiatry 1994; 18:211–219)

The premise of this article is that teachers of psychiatry can use short stories in a systematic way to overcome several of the major difficulties psychiatric residents have today in learning dynamic psychiatry. These difficulties include the diminished familiarity with psychological thinking that many residents bring to the field with its focus on the biomedical, the unlikelihood of their undergoing psychoanalytic training during their residencies, and the current skepticism about the value of motivating them to think dynamically in assessing and treating patients.

Using literature to teach psychiatry is not new. Teachers of psychiatry have used literature to illustrate psychopathology in detail (1). A generation ago, Silberger led discussions at the Massachusetts Mental Health Center for residents and other staff by using literary examples (2). Barchilon (3) conducted seminars at the Albert Einstein School of Medicine and the University of Colorado on the use and place of the novel in psychoanalysis. Coles (4) used stories as a medium of communication between supervisor and resident. More recently, Rodenhauser and Leetz (5) recognized the value of literature to stimulate discussion about character in general and about residents’ own life experiences.

I believe the approach I present here is more accessible to residency training programs than these earlier efforts. It is more systematic, so that a body of data can be generated; it is less time-consuming, so that it can fit into the regular case format structure; and it requires less in the way of specialized knowledge and skills on the instructor’s part.

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WHY SHORT STORIES?

The short story is more accessible in content than the poem and in time than the novel or play. A short story takes only as long to read as does a case write-up and therefore fits nicely into the teaching schedule for case conferences. Once teachers have mastered this systematic approach, they may use other literary or nonliterary forms. Novels and films are more cumbersome, however, when one is trying to locate the particular passage or segment under discussion.

Most people can respond to a good story. It speaks to their life experience. We are all familiar with stories; we are brought up on them. Much of a liberal education revolves around reading and analyzing stories. Stories can have a dramatic effect that ordinary case histories do not, because fiction writers use condensation and symbolic detail. The symbol links thought and affect and speaks directly to the unconscious. Stories cover virtually the whole panoply of human emotions and conditions without resorting to the jargon or theoretical bias in psychiatric education.

For heuristic purposes a story may be compared to a course of psychotherapy or to a crucial session in its course. Taken in this way, stories offer a whole catalog of treatment summaries that are easy to recall and refer to.

It is possible to target stories to the interests and needs of various groups of residents. Stories fill gaps in their life experiences. Reading a story such as James Joyce's "Araby" can help residents to recapture elements of their lost adolescence and thus better assess normality in this confusing developmental phase. Similarly, a story such as Anton Chekhov's "Gooseberries" can help residents understand some of the despair and unresolved longings that even relatively well-adjusted older adults might feel at moments of heightened awareness. A resident who withdraws from involvement with elderly people facing deterioration and death may understand their fears better by reading Jean Rhys's "Sleep It Off, Lady." This story graphically depicts an elderly alcoholic woman's withdrawal from her familiar surroundings, with frightening consequences. Consultation-liaison psychiatry residents may find this story particularly useful.

It is not only residents who may forget earlier life experiences. Teachers of psychiatry as well find stories help them reexperience some of the difficulties they may have forgotten in their own learning process. A story such as D. H. Lawrence's "The Rocking-Horse Winner" helped a group of teachers of child psychiatry recall the difficulties in planning the treatment of a case. They had to decide whether to approach the child's problems directly or through treatment of the mother. Katherine Mansfield's "Her First Ball" is an example of intergenerational competition. This story helped a group of training directors to reexperience some of the intensity of a difficult supervisory experience, when some of them identified with the adolescent girl and some with the middle-aged man who breaks in on her reveries.

Great stories speak not only across generations, but also across cultures. Stories emphasize the commonality of human experience in a way that can help residents overcome deficiencies in cultural knowledge. Certain stories can break down cultural bias and stereotype. Ruth Prawer Jhabvala's "My First Marriage" illustrates the kind of play and freedom that the traditional Hindu family permits. In the public sector, where a number of residents are Asian, I found this story to be particularly useful in raising the residents' awareness of their own cultural biases toward the role of the guru and of animism. Even the highly problematic issue of race yields beneficial lessons using this approach. Ralph Ellison's "Flying Home" provides insight into the ineluctable and regressive forces of racism that draw the main character, a black pilot, down to earth and to humiliation. He has crash-landed in a
field in the South. But because of his color, he is considered and treated as insane rather than injured. After discussion of the story an African-American resident introduced several other stories relevant to racial issues, written by one of the first well-known black American fiction writers, Charles Chesnutt. This experience is typical: residents and teachers often bring in stories that have had a particular impact and relevance.

Stories can also provide insight into the dynamic issues involved in certain specialized and unfamiliar situations. Flannery O'Connor’s “Good Country People” illustrates the investment a deformed person has in the deformity; Katherine Anne Porter’s “He” illustrates the consequences of denying a retarded child’s limitations.

Teachers of psychiatry may also use stories in case supervision. When a resident was asked by a patient how he might take charge of his life, the supervisor suggested that the resident formulate an answer by reading Joseph Conrad’s “Secret Sharer,” which depicts one way in which the process might unfold. Furthermore, medical students learning psychiatry are able to relate particularly well to stories, since this approach does not depend on familiarity with psychiatric terminology.

In responding to stories one is both close to the events and characters and able to stand back and evaluate them. Strong negative reactions to characters in stories help residents understand what would be too painful to acknowledge with an actual patient, where negative reactions and fear of failure might cloud the resident’s awareness of the problem. Responding to Herman Melville’s “Bartleby,” one resident became impatient with the narrator: he announced that the narrator’s indulgence of Bartleby was not credible and that the story did not hold together. Later in the discussion he revealed that during his childhood his parents had taken in an uncommunicative old sailor, pampering him and insisting that their children cede a place to him in the family.

Furthermore, teachers of psychiatry may use stories to help residents understand psychoanalytic concepts. When asked to find the source of the downtrodden hero’s inspiration to buy himself a new overcoat in Nikolai Gogol’s “The Overcoat,” some residents correctly observed that Gogol was illustrating the comforting and inspiring effects of a transitional object.

Points of view vary with the age and life experience of the residents, demonstrating that there is no single interpretation of a story, any more than of a clinical case. Nevertheless, residents are able to maintain a consistent view of a character that they rarely do with their actual patients; they may even see characters as more human and, paradoxically, less objectified and pathological. Stories tend to depathologize; they make it easier for residents to engage on both an emotional and an intellectual level. Residents tend to speak more freely about stories than they dare to about their colleagues’ cases.

**HOW TO USE STORIES**

I have found it useful to structure discussion of a story around five questions. These questions become familiar to residents, who use them to structure their reading of stories. The questions also focus the discussion on clinical rather than literary issues and are analogous to topics such as history of illness, personal history, and the like.

I will use Ernest Hemingway’s “Short Happy Life of Francis Macomber” to illustrate these questions. This story answers these questions explicitly and is well known and readily available. The plot of this story is as follows: on an African safari Francis Macomber has run from a lion he was supposed to shoot. Francis’s wife, Margot, is disgusted with his cowardice and sleeps with the professional hunter, Wilson. Galvanized by his anger, Francis shoots a buffalo with bravery. During the shooting Margot kills Francis.
I will also cite additional stories when they are particularly applicable to individual questions.

1. Whose Story Is It?

It is important for each resident to select the central character on whom the questions will focus—the patient, so to speak, who is being treated in the story, or whom the resident might be treating after the story’s events have had their impact. Who that character is will vary among readers. A way of framing this question is to ask which character changes. Change is a central concept that links the literary focus with the clinical one. It is a fitting concept because the short story is about a life in process, that is, in which change is at least possible, just as there is hope of change during psychotherapy.

Macomber is usually seen as the central character even though more of the events are seen through Wilson’s eyes; however, some residents have seen Wilson or Macomber’s wife as the central character. Hemingway helps us by stating explicitly that Wilson has not changed, even though his opinion of Macomber has changed. The residents who see Macomber’s wife as the central character argue that she has tried for years to establish a relationship with Macomber; at the end, she recognizes the change in him and becomes more vulnerable.

Other stories are more ambiguous on this issue: a whole group of individuals may even be the main character. In Nikolai Gogol’s “The Overcoat” the central figure is an unremarkable copy clerk who hopes for greater involvement with his peers. This hope is symbolized by his buying a stylish new overcoat. However, after a brief moment of glory he dies an ignominious death, and this event gives pause to the whole self-absorbed populace of St. Petersburg. They are reminded of the clerk’s untimely death and reevaluate their own lives and values; their change is more durable than the clerk’s.

2. What Is This Character’s Problem at the Beginning of the Story?

This question is even more difficult to answer, because the possibilities are so varied. It is as varied as the psychiatrist’s understanding of why the patient has come for treatment at a particular time. I have found it useful to structure the answers to this question by referring to Erikson’s life stages (6). This framework, like the set of five questions, helps put the particular character’s conflict in clinical terms. According to Erikson there are eight age-specific conflicts that must be addressed in the course of the life cycle. These conflicts define the generic issues that underlie those of individual characters.

In Erikson’s framework Macomber’s conflict is between generativity and stagnation, that is, whether he will be able to invest enough energy and interest in his sporting activities, friends, and the relationship with his wife to sustain these activities and enlarge upon them. In particular, his problem is an incapacity to assert himself, stated positively at one point as an excessive capacity for “tolerance.” He is unable to act because of fear, or the fear of fear; it invades all significant spheres of living. He is knowledgeable about many manly activities through books and talk, but his inner strength has never been tested. As a husband he is a resource of which his wife has taken advantage. Though unhappy with this role he has been too frightened or too complacent to change it; thus, he is in danger of living the rest of his life in stagnation.

Wilson’s problem, for the residents who see him as the central character, is his tendency to retreat behind a facade of professionalism. He relegates his observations to a few simplistic formulas. He is on the verge of becoming more involved: he even quotes some Shakespeare to Macomber in a moment of admiration or at least camaraderie.

The character’s presenting problem in James Joyce’s “Araby” is initially difficult to
define, since the character seems to be free of pathology and struggling only with a developmental issue, first love. Erikson’s framework helps define the conflict as identity vs. role diffusion and thus focuses class discussion on the narrator’s relationship to his peers early in the story and on the kind of person he is becoming at the end when he reacts with “anguish and anger” rather than despair to the failure of his quest.

3. How Does This Character Change?

This refers to the actual process that leads to change. To be convincing, this process usually has at least two phases, a preparatory one, in which the events intensify progressively and create the conditions in which change is possible, and a moment of crisis. Typically, this crisis follows a great disappointment of expectations or results from the removal of the character’s usual supports, so that defenses are shattered and deeper strengths emerge.

A whole sequence of events prepares Macomber. The safari itself takes him away from his usual, stultifying milieu and exposes him to real danger. His failure to measure up—his actual cowardice—shatters the old facade he has built, not so much for his wife as for himself. Her infidelity is perhaps the most significant stimulus of all, for here, as in many stories and life situations, it is only the most abject failure that propels one toward painful self-examination. Residents analyzing this story have appropriately been doubtful about whether this character would have gone forward from this point. That he continues to hunt is an act of faith, on both his and the reader’s part. The critical motivator here is Macomber’s anger that has emerged at last.

The change lies in his losing his fear—of death, of his wife, of the inevitable lack of sufficient experience and knowledge. The familiar setting of the motor car kindles Macomber’s spirits. Wilson’s ordering him out onto level ground with the buffalo is only a small step further. Hemingway presents the change explicitly: “a sudden precipitation into action without an opportunity for worrying beforehand.” Macomber’s relationship with his wife is irreversibly altered: she becomes the fearful one, losing her excitement and taste for the chase and whimpering about the unfairness of pursuing helpless game. Her inability to accept a healthier relationship becomes her motive for destroying Macomber.

Another story that presents change explicitly is Flannery O’Connor’s “Good Country People.” Here the main character risks a sexual encounter with a psychopathic bible salesman, only to have her crutch—the wooden leg in which she has invested too much pride and interest—taken away. She becomes as helpless as a child and experiences an awakening expressed in religious terms.

4. What Is the Character’s Prognosis: How Will the Character Maintain This Change in the Face of Future Events?

This is necessarily speculative, since short stories like courses of psychotherapy are open-ended and not intended to provide the final word or solution. Will the patient/character maintain the gains in the face of future stresses or gradually revert to a prior, more limited mode of functioning?

Macomber’s internal restructuring had already won him new respect before his untimely death. Wilson had begun to admire Macomber, and his wife, to fear him. Macomber was likely to experience fear again—according to the Somali proverb, all hunters do—but it would no longer paralyze him or prevent him from asserting himself. As Wilson notes, cuckoldry has come to an end. Back in his sporting clubs, Macomber might become a less caviling and more quietly imposing figure. He might even provide what Erikson considers the crucial function for this life stage, namely, guidance to the next generation.
But is this dramatic turnabout credible? The three characters refer repeatedly to Macomber's change. When pursuing a wounded and dangerous animal for the second time, he "expected the feeling he had had about the lion to return but it did not." Most residents are sufficiently sophisticated to note that if the change is meant to be a lasting one the events of the story must be taken symbolically; that is, the events would have to happen repeatedly—there would have to be some sort of "working through." Otherwise, if the events are to be taken at face value, the change would be no more than a "transference cure," brought about through an identification with Wilson and propelled by Macomber's rage at him. It is one of the prerogatives of the story to break off after a single significant event, just as a course of treatment may end before it has been completed, when only the outline is clear.

At the end of Albert Camus's "The Adulterous Woman" the main character, Janine, has a moment of intense feeling in which she recaptures the sense of herself and of the expectations that she had as a young woman. Although she is likely to remain in her imperfect marriage, her life will be richer.

5. What Are the Transference and Countertransference Issues That Would Arise If a Person Like This Character Were to Present Himself for Psychotherapy by a Resident?

This question brings home directly the clinical goal of the story's discussion and forces the resident to see the character as a potential patient. It suggests that some approaches—presumably those provided by the author of the story if the "treatment" has been successful—would be more likely than others to promote change. Clues are embedded in the story.

Macomber has many attributes that would make him a suitable candidate for a traditional psychoanalysis. When he changes his mind about the drink he will order following Wilson's lead, he shows that he can form a dependent transference relationship. When he apologizes for underestimating the hunter's honor code, he shows that he is capable of reflection and self-criticism. When he acknowledges his cowardice, he shows that he can be open and childlike about his shortcomings. He can assimilate and use new information. Finally, he is capable of enthusiasm and of affirmation.

However, young residents in particular might find it hard to empathize with Macomber or like him. He neither works nor has much to his credit besides a few trophies. He has little feeling for servants and is quite willing to put them in mortal danger. He is ready to leave a wounded animal to suffer. For such residents the danger would be in distancing themselves from him, even inadvertently, by telling him what to do; even for more advanced residents the danger would similarly be of encouraging him too much and of managing him rather than treating him.

Wilson takes a more appropriate approach. His professionalism, as it would for a good psychotherapist, prevents him from being judgmental. As far as he is concerned the reactions he witnesses are mere details, and his function is to keep moving forward. As he reminds himself, "I'm still drinking [his] whisky." With this approach he is able to move Macomber forward to the short-lived success of the next day's hunt.

To treat the shy, awkward soldier who is the main character in Anton Chekhov's "The Kiss," the psychotherapist would need to take a more supportive approach. The soldier is no longer young but is inexperienced in love and in the ways of society. He receives a kiss in the dark from a woman who has mistaken him for another; nevertheless, in his efforts to find her or at least to imagine what she may be like, he continues to invest his world with a warmth and liveliness that he has never known. His inability
to sustain the gains this investment bestows upon him is inevitable, and he needs mostly to be brought down gently, to be helped to see his limitations without despair.

TEACHING METHODS

With Drs. David Joseph and Joseph Youngerman as co-leaders, I have conducted several workshops illustrating the use of short stories to teach psychotherapy several times in recent years at the annual meetings of the American Association of Directors of Psychiatric Residency Training and the American Academy of Child and Adolescent Psychiatry. In the workshops, the participants have reported on the successful use of this technique in their own adult and child residency training programs.

The teaching format generally involved a group of 8 to 12 residents at the same training level, similar to the format in traditional case conferences. Training directors noted the importance of rereading the story carefully shortly before the seminars and the inadequacy of relying on general familiarity with the story from past readings, since analyses could hinge on particular images and details. The equality of information held by all participants facilitated group process; in traditional case conferences the presenter is the only one with firsthand information. The training directors kept the discussion focused on what could be supported by evidence from the details in the text; inferences were used only if several pointed to the same conclusion. They reported that responses to the story in a group of this size typically fell into two or three lines of analysis, depending on who was selected as the main character, what was identified as that character’s problem, and whether that character was seen as changing or not.

Training directors noted three major pitfalls that sometimes derailed discussion: 1) the tendency to resort to information about the writer’s life and themes and about literary theories behind the work to “explain” the events of the story; 2) the impulse on their part and on the part of residents to “psychoanalyze” the story, to explain the characters’ motivations in terms of familiar, stereotyped psychodynamic formulations; and 3) the urge to analyze residents’ responses as countertransferential reactions. The first two of these pitfalls tended to promote intellectualization and, more significantly, to move the analysis away from the clinical situation to discussion of the abstract and literary, and the third tended to stifle free expression unless the residents themselves called their peers’ reactions countertransferential.

The training directors confirmed that it was not necessary for the teacher to be a literary scholar. The essence of this approach is that both teacher and resident analyze the stories in terms of immediate, spontaneous responses to characters and events. Such responses carried conviction in a way that applications of theory did not always do. Moreover, these teachers found they could increase their understanding of particular stories by teaching them several times, each time noting the group’s interpretations. It was not difficult to enlarge this corpus by adding additional stories, sometimes proposed by residents, with particular application to a case or clinical situation. Several paperback anthologies containing a sufficient number of excellent and varied stories are available (7-9) to facilitate distribution and uniformity of text and pagination.

Many teachers of dynamic psychiatry possess the requisite skills for using stories as case material. These include a curiosity about the full range of human experiences, an appreciation of detail, and the love of a well-told tale. Beyond these the principal requirement is a willingness to be taught by the residents, who in this format have as much information as the teacher and who invariably offer new interpretations, no matter how many times the story is used in teaching.
CONCLUSION

Residents report at least three rewards after being exposed to this learning format. First, they report that it was “fun.” It “took me back to the learning I did in college, before medical school”; it “exposed me further to great pieces of literature”; and it “validated the way I learned things in my life and made me feel everything was preparation for being a dynamic psychiatrist.” Second, they note the memorable quality of stories, not only the characters but whole plot sequences, and how they appreciated the experience of seeing people in their entirety, which they were able to take into their clinical work with renewed conviction and to call upon in otherwise unfamiliar clinical situations. Finally, the residents say that it gave the psychotherapeutic process that they were struggling to learn more validity; thus, in their own professional development, they repeated Freud’s experience of turning to the observations of the great classical writers to buttress his theoretical observations.

References

APPENDIX. Suggested stories

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<th>Author(s)</th>
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<td>Anton Chekhov: “Grisha”</td>
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<td>Initiative vs. guilt</td>
<td>36–60 months</td>
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<td>Industry vs. inferiority</td>
<td>5–11 years</td>
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<td>Jean Rhys: “Goodbye Marcus, Goodbye Rose” (molestation/abuse)</td>
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<td>D.H. Lawrence: “The Rocking-Horse Winner” [child as central character]</td>
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<td>Identity vs. role diffusion</td>
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<td>Katherine Anne Porter: “He” (retarded child)</td>
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Note: Specialized topics illustrated by the story are noted in parentheses.


Semb and Ellis identified 56 articles representing 96 studies that examined the retention of school learning. These studies met five criteria: they focused on knowledge retention rather than psychomotor tasks; the material was taught over a minimum of 2 different days; the retention interval was a minimum of 1 week; the subjects were junior high-school age or older; and they used original data. To make comparisons across studies, a percent relative loss score—how much was remembered of what was originally learned—was computed.

The overall mean loss scores were −16.17 for recognition tasks, −28.25 for recall tasks, and −13.32 for cognitive skills. The authors conclude that much of what is taught in school is remembered and that there is a higher rate of retention for higher level cognitive activities. Other findings revealed that while the amount of information retained declined quickly at first, the rate of loss slowed down or leveled off and that high ability students learned and remembered more than low ability students.

Based on their review, Semb and Ellis suggest that there are several strategies teachers can use to actively engage students in learning and thereby improve long-term retention. These include setting high criterion levels, giving frequent tests with feedback, individualizing some of the instruction, using peer tutoring, and providing multiple learning opportunities over time. The authors note that their findings run counter to the popular belief that most of what is learned in school is forgotten.
responds to several thousands of hours of practice" (p. 738).

The nature of expert performance across the life span is discussed briefly. Although the data are limited, it is suggested that the apparent decline in performance with age may represent a decrease in or termination of practice time.

The authors conclude that by studying the structure and acquisition of expert performance we can expand our understanding of human capabilities and methods for maximizing performance.


Kane begins his discussion of passing scores for high-stakes achievement tests by making a distinction between performance standards and passing scores. A performance standard is the conceptualization of the minimum adequate level of performance for some purpose, and a passing score is the operational version of that concept for a given examination. Validating a passing score consists of amassing evidence that a proposed passing score is a reasonable representation of the performance standard.

The two broad approaches to standard setting are test-centered models and examinee-centered models. Test-centered approaches are more commonly used and require judges to determine what level of performance should be considered just adequate for a given set of items. In examinee-centered models, judges make pass/fail decisions about examinees and then determine the point on the score scale that is most consistent with those decisions.

Within the test-centered model, the Angoff method is the most widely used for certification and licensure examinations. However, Kane points out that the evidence does not clearly indicate the superiority of this method over others that are available. With the Angoff method, judges are asked to estimate the probability of a minimally competent examinee getting each item correct. These probabilities are summed and averaged to produce a minimum pass level (MPL) for each judge, and then summed and averaged across judges to produce an MPL for the test.

The author then outlines the types of evidence that can be garnered to support the use of a given pass/fail point. He groups them into validity checks based on procedural evidence, internal consistency of the results, and comparisons with external criteria. Examples of information that could be collected include how judges were selected and trained, the relationship between MPLs for items and item difficulties for examinees near the passing score, and comparison with pass/fail decision made by other assessment methods.

While acknowledging that all standard setting is arbitrary because judgment is involved and there is a range of acceptable choices that could be made, Kane suggests that by addressing these issues more thoroughly, standards will be less capricious and more defensible.

Tamblyn R: Is the public being protected? Prevention of suboptimal medical practice through training programs and credentialing examinations. Evaluation and the Health Professions 1994; 17:198–221

Tamblyn argues that professional self-regulation through training programs and licensure and certification examinations has had little impact on the quality of medical care. She cites several bodies of research to support her position.

For example, there is evidence of significant variation in resource use (hospitalization, surgical procedures, laboratory studies,
and prescription drugs) within and between countries that has been attributed to the practice habits of individual physicians rather than differences in patient populations. Practice audits have shown significant rates of inappropriate use of prescription drugs and medical malpractice.

Tamblyn asks whether any of those physicians who consistently demonstrate suboptimal performance could have been identified in training or by licensure and certification examinations. She points out that examinations may not adequately assess those abilities that are important in practice. For example, physician communication skills have been shown to be positively correlated with patient satisfaction, compliance, and disease outcome, and yet they are not assessed on most licensure and certification examinations. To use Kane's terminology (see previous abstract), she also questions the validity of the pass/fail scores on those examinations—perhaps they are not set high enough.

She then outlines an extensive program of research that would establish the validity of these examinations for predicting practice performance and patient outcomes. While such an undertaking would require a great deal of resources, Tamblyn argues that "In light of the prevalence of inappropriate practice in medicine and the significant impact that individual physicians may have on health outcome, it is critical to determine if training programs and credentialing exams are serving their purpose" (p. 215).
**Discussing Ethnic Diversity With Medical Students: A Pilot Program**

SIR: Shifting populations and the increasing cultural pluralism make the provision of health care to ethnically diverse patient groups and the recruitment of ethnically heterogeneous health care professionals important priorities for American medicine. Attempts to care for and incorporate diverse groups within American medicine raise specific concerns for medical educators (1), including how cultural aspects of patient care are best taught and how to consider openly the emotionally charged issues that may arise when people from diverse ethnic groups interact (2). The first of these concerns, the teaching of cultural aspects of patient care, has been explored by medical educators through a number of pilot programs (3–5); a recent survey found that 59 of the 98 responding U.S. medical schools have integrated information on cultural sensitivity into their curricula (6). However, accounts of teaching methods for discussing issues of ethnic diversity among medical trainees are few (7). We describe a pilot program at the University of California, San Francisco (UCSF) that utilizes an experiential group learning format (2) to explore issues of ethnic diversity with first-year medical students.

These issues are particularly salient in San Francisco, where people of color comprise more than half of the population. Asians constitute 29% of the city’s inhabitants, Hispanics 14%, African-Americans 11%, Native-Americans 0.5%, and Caucasians the remaining 45.5% (8). UCSF’s commitment to providing care for San Francisco’s multiethnic population is reflected in the development of specialized clinical programs (9) and in the recruitment of diverse medical student classes. Across the past 4 years (1990–1993), the ethnic composition of entering UCSF medical student classes mirrored San Francisco’s population (i.e., 26% Asian, 14% Hispanic, 9% African-American, 1% Native-American, and 50% Caucasian).

The pilot program was designed for a 2-hour time block within the first-year psychiatry course in human development. Approximately 30 minutes were allotted for lecture and 90 minutes for small group discussion. The program’s goal was to allow students a forum to discuss their own ethnic heritage and experiences with individuals from similar and different ethnic backgrounds.

Before the lecture, the faculty received a handout recommending guidelines for conducting the workshop and a list of 15 suggested questions (2). Questions included the following: What is your ethnic background? What kinds of family experiences influenced your sense of ethnic identity? What kinds of messages were you given about racial differences and how to deal with racial issues? Have you ever been discriminated against because of your appearance? your age? your sex? your social and economic status?

During the lecture, the students and faculty facilitators received a preparatory overview of what to expect in the small group discussion. The lecturer emphasized the importance of describing one’s own background as a brief but revealing story of one’s life and heritage. After the lecture the students and faculty met in their ongoing small group seminars. Groups typically had 9 to 11 students and 1 or 2 faculty facilitators. While group discussions varied, the general format was to allow each student and facilitator 3 to 4 minutes to introduce himself or herself by answering the question, “What is your ethnic background or identity?” While some groups followed the questions outlined closely, others engaged in less structured dialogues. Discussion topics ranged from supportive comments and inquiries about individual backgrounds to heated conversations concerning discrimination.

Immediately following the small group discussions, the students and facilitators
completed a questionnaire. The questions asked generally about the students’ workshop experience and particularly about workshop facilitators’ performance. Responses were ranked on a scale from 1 to 5 (strongly disagree to strongly agree). Of the 141 students enrolled in the course, 117 (83%) completed questionnaires.

Overall, questionnaire responses indicated that the respondents felt the workshop experience was positive. Students’ ratings suggested that they felt understood by their colleagues when talking about their experiences (mean ± SD = 4.11 ± 0.80) and that they believed the session was a good use of their time (mean ± SD = 4.07 ± 1.08). Overall, the students rated their faculty facilitators as highly effective (mean ± SD = 4.35 ± 0.74). Although there was a generally positive response to the workshop, no data are available on the 17% of students who did not return their questionnaires and who may have been among the most disaffected participants. The major criticism from both students and faculty was that there was not enough time allotted for the small group discussion.

While this pilot program successfully broached issues of ethnic diversity with first-year medical students, further program development and research are required to establish the longitudinal impact of the seminars and to plan for the discussion of socioeconomic, gender, and sexual orientation issues. Future investigations need to assess pre-program attitudes concerning ethnic differences so that changes in students’ attitudes can be followed over time. Also, future evaluations will need to better distinguish process vs. outcome measures of workshop effectiveness. With regard to the exportability of the program, medical educators should assess whether this type of small group format is useful at medical schools that, in contrast to UCSF, have limited student diversity. One possibility for medical schools with minimal medical student diversity would be to invite multiethnic faculty, staff, or patients to participate in the seminar.

The aim of the ethnic diversity seminars is to create a forum where students and faculty can examine their own sense of ethnic identity, and attitudes, feelings, and behavior when caring for and working with individuals from diverse ethnic backgrounds. Our experience at UCSF is that psychiatrists and behavioral scientists are among the strongest proponents for a discourse on ethnocultural issues in medical education. Nationwide, psychiatric educators can play a leading role in developing educational programs that address issues of ethnic diversity. Our hope is that early discussions of diversity encourage ongoing reflection and inquiry among students and faculty. To date, it has been difficult to evaluate these aspects of the curriculum. However, given the results of this pilot program, UCSF will continue to offer ethnic diversity seminars as part of the first-year medical student course in human development.

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Information for Contributors

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