MEDICAL STUDENT NEWSLETTER

A Publication of the American Psychiatric Association Committee on Medical Student Education

From the Chair

By: Michael Vergare, M.D. (Chair, APA Committee on Medical Student Education)

After six years as a member, then chair of the Committee on Medical Student Education, I am pleased to be able to complete my term knowing that the partnership between APA and medical student members is as strong as ever. Our work has remained centered on expanding opportunities for medical students to learn about psychiatry and how it is applied to their work as physicians. Whether you decide to specialize in psychiatry or other fields of medicine, our hope is that you have had access to the latest developments in our field through our journals, scientific meetings, www.psych.org, and through local district branches and chapters of APA. Through the Office of Education and Career Development we have collected information about summer fellowships available to medical students.

This issue follows our pattern of introducing topics about psychiatry as well as other issues pertinent to medical education. Dr. Sierles addresses what is a building interest in psychiatry as the national generalist initiative has peaked. Dr. Fox elaborates on subspecialty training in child and adolescent psychiatry. Dr. Dickstein, a member of our committee, discusses boundary issues and violations in medical school and health sciences. There is information about our annual meeting in Philadelphia. I may be biased (Philadelphia is my home) but I promise you will have a great time if you are able to attend. The program is full of topics that cover all of our field, plus there is much to do after hours to round out your day.

I would encourage each of you to make full use of your membership to expand your knowledge of our field. Your suggestions for future directions are most welcomed and will help build on value of your membership.

IN THIS ISSUE

- Fututre of psychiatry
- Creating a psychiatry club
- Child and adolescent psychiatry
- APA Annual Meeting
- Academic Psychiatry
- And more....

Volume 11, Issue 1
Spring 2002

Predicting the Future: Prognostications for Psychiatry

Frederick S. Sierles, M.D.

Predicting how many U.S. graduates will choose careers in psychiatry—or any other specialty—during the next decade, and what the practice of psychiatry (or any other specialty) will be like during that time, is no more an exact science than predicting what will happen to the U.S. economy during the next year, let alone the next decade. Nevertheless, having said this, I predict cautiously that during the next 5-10 years we will see a respectable increase in numbers of our graduates choosing psychiatry, and that the quality of psychiatrists' professional lives will improve nicely. My reasons for saying this are 1) that 2001 saw an increase of 9% of US seniors choosing psychiatry compared to 2000 (1), 2) the demand for psychiatrists is increasing, in part because 3) the national generalist initiative appears to have peaked and, 4) most important, the scientific and intellectual basis of psychiatry, and our capacity to apply a biopsychosocial model literally, is progressing by leaps and bounds.

Recent Trends in the Match and in ERAS Applications

In 2001, 524 U.S. graduates matched into psychiatry, an increase from 428 in 1998, 482 in 1999, and 481 in 1999 (1). The numbers of U.S. senior medical students who made Electronic Residency Application Service (ERAS) applications to psychiatry residencies for 2002

(Continued on page 5)

Dr. Frederick S. Sierles is professor and chair of psychiatry and behavioral sciences, Finch University of Health Sciences. He is a visiting professor of psychiatry and human behavior at Thomas Jefferson University, and chair of the multi-organizational psychiatry workforce coalition.

Creating a Psychiatry Interest Club

By: Nancy Wu, M.D.

For more resources, visit APA's website at www.psych.org

Are you interested in psychosocial and mental health issues, i.e. anorexia/ bulimia, depression, alcoholism, development of sexual identity/orientation, ADHD, homelessness, etc.? Are you concerned that a classmate might be depressed but yet do not know how to approach him/her? Do you feel that your medical school does not adequately address the psychological well-being of its students? If you answer "yes' to any of the above, you might be interested in creating a Psychiatry Interest Club at your school. It can be a stimulating and fun learning experience for both the organizer and the attendees. Here are some general guidelines:

1.***Find a sponsor:***

The sponsor can be the medical student director of psychiatry rotations, a psychiatry resident, or ANYONE interested in psychosocial/mental health issues who can help you network with potential speakers. Depending on your topics of interest, the sponsor can help suggest names of faculty members or community leaders for your discussion seminars. Thus, when you call on them, you can use this sponsor's name to introduce yourself and the psychiatry interest club. This a great way to get speakers with busy schedules to volunteer their time as they generally enjoy teaching.

2.***Find funding:***

You will need money to provide food and beverage for your fellow students during the seminars. By creating the Psychiatry Interest Club as a student organization, you can generally get funding from the Student Affairs Office at your medical school. If by chance that is not available, brainstorm with your sponsor potential alternatives. Heads of clinical departments such as Psychiatry, Family Medicine, Internal Medicine, and Pediatrics might be open to sponsoring event(s) as a way to recruit medical students into their field. If none of the above is available, approach your Dean of Medical Student Education and make a case for why the Psychiatry Interest Club is a great way to enrich the current curriculum.

3.***Delegate:***

Find a co-organizer and two class representatives from Year I and Year II (third and fourth year medical students have a harder time attending the seminars unless they are scheduled in the evening). Since medical school is extremely demanding, having a co-organizer can be extremely helpful. By having class representatives, you can ensure maximum attendance by asking them to write and make announcements in class.

4.***Survey:***

Email all the classes and brainstorm with your classmates for potential topics of interest. The topics can include almost anything that might be of interest, e.g. "Everything you wanted to know but were afraid to ask about eating disorder, heroin addiction, suicide, post-partum psychosis, panic attacks, sexual development, Post-Traumatic Stress Disorder, etc". The goal of the club is to promote awareness, education, and open discussion of common psychosocial and mental health issues.

5.***Schedule:***

Use your class representative to find out the best time to hold a noon or an evening event. Avoid days when 1)half the class is off campus, 2)exams are coming up, or 3)multiple competing events are taking place. Depending on the topic, schedule it for noontime or early evening. For example, if you are organizing a panel discussion on "How to prepare for residency interviews?", it might be best to schedule it in the evening so that third and fourth year students may attend.

Sounds simple? It is! If you have any questions, feel free to write me at nwumd@hotmail.com.

Dr. Nancy Wu is a PGY III Psychiatry Resident at UCSF/Langley Porter Psychiatric Institute

Choosing Child and Adolescent Psychiatry as a Career:
Commonly Asked Questions and Answers
By: Geri Fox, M.D.

If you are a medical student considering subspecialty training in child and adolescent psychiatry, you probably have lots of questions. In my opinion, it's the most enjoyable specialty in medicine. As a child and adolescent psychiatrist, you do crucially important work that changes the lives of children. Your daily activities are interesting, challenging, and fun. Gaining an understanding of normal development and problems through the life cycle is fascinating, and utilizing that framework in one's daily life and work is a pleasure. Children's psyches are still relatively flexible; it is satisfying to see their often quick response to our interventions. Working with children and adolescents challenges our creativity, our imagination, and our sense of humor, as well as calling upon our cognitive skills and medical knowledge. In addition, the employment opportunities are terrific!

What does a child and adolescent psychiatrist actually do?

First and foremost, child and adolescent psychiatrists are also qualified general psychiatrists, Board-certified to work with both adults and children. The degree to which an individual practitioner focuses on a particular age group is a matter of choice. In order effectively help a child, the psychiatrist must also work with his family, school, and community.

For example, around half of my patients are adults. My patients range in age from infancy through their 80's. Many of my patients came to me first with a problem concerning their children. As part of my work with the child, I may work with the child individually or with his family. I might visit him at his school and work with his teacher. It could turn out that there are parental or marital issues. I may end up doing couples therapy, or treating a parent individually for depression, which ends up helping the child. Even if I see the adult individually and never see his family, the patient usually views my extra expertise in working with children and families as a bonus, helping me to better understand his own background.

A developmental perspective is helpful with patients of all ages. Child and adolescent psychiatrists often refer to themselves as the true general psychiatrists, because they are trained to treat patients throughout the life cycle. And, as noted above there is great flexibility in the choice and provision of treatment modalities. Child and adolescent psychiatrists are well versed in individual, family, couples, and group psychotherapy (long-term and short-term, dynamic as well as cognitive-behavioral) and are able to integrate pharmacotherapy into work with patients of all ages.

Child and adolescent psychiatrists can choose from a wide variety of professional venues. Opportunities include private practice in both individual or group settings; working as an employee in a managed care or government setting; or becoming a teacher, supervisor or administrator. Child and adolescent psychiatrists can select from a variety of continuum of care settings to work in, from inpatient to residential to partial hospitalization to outpatient. Consultation opportunities occur in schools, hospitals, or court settings, as well as consulting to agencies and professionals in other related fields. There is a tremendous need for academic psychiatrists, particularly in research. Some physicians develop specialized expertise in working with a particular age group (such as infants or adolescents), a particular diagnosis (such as obsessive-compulsive disorder or anxiety disorder), or a particular treatment modality (such as pediatric psychopharmacology or custody evaluations). In the public sector, child psychiatrists become active in their community or government as advocates for child mental health, becoming politically active or helping to develop wide-ranging programs to address issues at both the treatment and prevention levels.

Finally, it is important to remember that you don't have to pick one area to specialize in unless you want to: many child and adolescent psychiatrists enjoy combining a variety of professional activities and roles.

(Continued on page 7)

For any additional questions, please contact the Director of Child and Adolescent Psychiatry Training at your medical school. You may also contact The American Academy of Child and Adolescent Psychiatry, 1(800)333-7636, http://www.aacap.org

Boundary Issues and Violations, Clear Definitions, Appropriate Actions

By: Leah J. Dickstein, M.D.

The ATM compendium is available for purchase from the AAMC at www.aamc.org

Committee on Medical Student Education

Michael J. Vergare, MD (Chair)
Thomas Jefferson University

Leah Joan Dickstein, MD
University of Louisville

Tana Annette Grady-Weliky, MD
University of Rochester

Linda F. Pessar, MD
University of Buffalo

Carl Bruce Greiner, MD
University of Nebraska Medical Ctr

Brenda Roman, MD
Wright State University

Joshua T. Thornhill IV, MD
University of South Carolina

Myrl Manley, MD (ADMSEP)
NYU Medical Center

Nancy Wu, MD (CMHS Fellow)
UCSF Psych Training

Surender Punia, MD (CORF)
Creighton-Nebraska

Jamira Duffy (SNMA Liaison)
SUNY Stonybrook SOM

Jennifer Rosen (AMSA Liaison)
University of Pittsburgh SOM

Nancy Delanoche (Staff Liaison)

The topic of 'boundary violations' is, and must be, important to everyone at a medical school/health sciences center and its affiliated hospitals and clinics. Please read this article, share it with, and hold discussions with: peers, residents, faculty and administrators so that your education, and later training, will take place in a safe learning environment. We all learn and work best in an atmosphere of self and mutual respect, for and toward all, beyond titles, and different professional levels of power. Clearly, boundary violations occur when respect is absent.

Since 1990, the AAMC Graduation Questionnaire, in alternate years, has included questions regarding student mistreatment. Consistent results have shown that "mistreatment does occur and that gender, ethnic background, and/or sexual orientation are often involved."

"In 1999 the Liaison Committee on Medical Education (LCME) established a new LCME standard on Student Mistreatment: Each medical school, or its parent university, should define the standards of conduct in the teacher-learner relationship, develop, and widely promulgate written procedures that allow students to report violations of these standards <u>without fear of retaliation</u>. The procedures should specify mechanisms for the <u>prompt</u> handling of complaints, without negating repercussions for the griever and for the educational methods aimed at preventing student mistreatment." 1 p.3. ATM

Boundary violations must be clearly defined and understood by everyone at the health sciences center campus: women/men: administrators, faculty, staff, residents/students. Furthermore, patients and their significant others must also be made aware of appropriate professional-patient boundaries and appropriate behaviors so that violations do <u>not</u> occur in clinics, offices/hospitals.

"Sexual harassment includes but is not limited to words, signs, jokes, pranks, other verbal or physical (gestures) or contact, or violence. Harassment is not necessarily sexual in nature." American Board of Psychiatry and Neurology , Inc.

In 1988 the AMA began its study of sexual harassment (abuse of power) and sexual exploitation, between medical trainees and faculty supervisors and consequent effects on the quality of medical training, patient care, student/resident trainee (professional) evaluation and well-being."

The AMA stated, "The teacher-learner relationship should be based on mutual trust, respect/responsibility, carried out in a professional manner, in a (safe) learning environment that places strong focus on education, high quality patient care and ethical conduct (at all times).

The AMA report recommended to the ACGME (Accreditation Council for Graduate Medical Education and its RRC (Residency Review Committee) the mandate to (identify and) "eliminate instances of sexual harassment and/or sexual exploitation in academic and clinical training programs."

In 1998 I had the privilege and honor, as chair, to lead the AAMC GSA (Group on Student Affairs) survey sent to all medical schools of appropriate treatment in medicine. Responses, our work, with input from excellent existing programs was published as the AAMC <u>ATM Compendium</u> in June 2000, and sent to every medical school dean, thus is available to borrow, discuss/use, to ensure there are appropriate educational programs and safe reporting mechanisms at every school.

We must all be aware that a wide range of consensual sexual relationships between supervisors and trainees are possible within and beyond school and hospital walls, thus we must raise ethical concerns because mutual consent <u>is not possible</u> by 2 adults with "inherent inequality in status and power."

My recommendations to all readers are: First, obtain/read the AAMC <u>ATM Compendium</u> carefully to ensure your school's policies and prevention programs, or lack thereof, are/will be consistent with the excellent varied examples described. "Examples of inappropriate and unacceptable behavior include:

- Harmful, injurious or offensive conduct
- Verbal attacks, insults or unjustifiably harsh language in speaking to or about a person
- Public belittling or humiliation
- Threats of physical harm and actual physical attacks (e.g., hitting, slapping, or kicking a person)
- Requiring performance of personal services (eg., shopping, baby sitting)

Prognostications for Psychiatry, *cont. from page 1*

was 819 (2), a handful below the numbers (848) who applied in 2001, but also allowing for the possibility of considerably more matches into psychiatry this year than last year. In case you're puzzled by the 2001 discrepancy between 848 and 524, or the 2002 discrepancy between 819 and the number who will actually match, it has come to our attention during the past couple of years (remember, ERAS is only four years old) that because ERAS improves the efficiency of the application process, sizeable numbers of students apply through ERAS to more than one specialty; that is, well into their senior years (understandably, I think), considerable numbers of students remain unsure of what field they want to enter.

Increased Demand for Specialists, Including Psychiatrists

In the past two years, the number of jobs available for psychiatrists has increased. Sherer (3) writes, "Psychiatrists are in demand. After a six-year period during which primary care physicians were more sought-after than specialists, demand for all specialties—including psychiatry—has been on the increase over the last two years. In 2001, recruiters report difficulty in filling slots for psychiatrists in virtually every mental health care environment." I have noticed this in my department's residency. Our senior residents are widely sought after, often receiving multiple fine offers, in contrast to the relative paucity of jobs that were available to our residents graduating as recently as 1999. Most of my department's affiliate campuses have job openings, positions not available as recently as 1999. The same holds true for several other departments with which I am familiar.

Apparent Peaking of the National Generalist Initiative

Fueled in large part by managed care, during the past two decades there has been a National Generalist Initiative, whereby non-psychiatrist leaders of U.S. medical education and managed healthcare organizations have asserted that our greatest need—actually, economic demand, not medical need—has been for family physicians, general internists and general pediatricians. But this initiative has probably peaked and appears to be losing its momentum. The proportion of U.S. graduates choosing family medicine has been declining since 1997, and the number of seniors matching into internal medicine decreased between 2000 and 2001. In a recent article in Academic Medicine, two academic primary care specialists (4) wrote, "In what seems like an eternity ago, one of the selling points for the expanding role of the generalist would become more desirable…Obviously, we have fallen well short of these predictions. In fact, generalist physicians are probably more dissatisfied than ever."

Our Ability to Apply a Biopsychosocial Model

Having benefited from the striking research of the 1990-2000 Decade of the Brain, which included functional imaging demonstrations of the effects of successful psychotherapy on brain structure and function (5), and top-notch, rigorous demonstrations of the efficacy of psychotherapy, it has become possible to apply a biopsychosocial model of behavior in health and illness to an extent that even Engel would not have dreamed possible when he described the biopsychosocial model in 1977 (6). In 2001, Eric Kandel, a psychiatrist, won the Nobel Prize for medicine and physiology with his demonstrations of the biochemical and cellular basis of learning. Reading through Stahl's pharmacology text (7) makes it possible to envision—almost three-dimensionally—behavioral neurochemistry at a cellular level. And study after study strongly suggests that, as for virtually all the common conditions of general medicine (e.g., hypertension, diabetes), the etiologic contributions to the development of virtually all the common conditions in psychiatry—and personalty traits—are multifactorial, including multiple interactive gene networks (not single, "sledgehammer" genes) and shared (e.g., parents, neighborhoods) and unshared (e.g., going to different schools, choosing different occupations) environments.

And as has always been the case, more than any other specialty, psychiatry focuses on human behavior and the doctor-patient relationship, and its principal diagnostic strategy, and an essential therapeutic strategy is interviewing and the doctor-patient relationship.

For each of these reasons, I am optimistic.

References:

1. Association of American Medical Colleges report, 2001.
2. Electronic Residency Application Service, Association of American Medical Colleges, 2001.
3. Sherer RA. Specialists are key to quality health care. Psychiatric Times, October 2001.
4. Dwinnell B, Adams L. Why we are on the cusp of a generalist crisis. Acad Med 2001;76:707-708
5. Schwartz JM, Stoessel PW, Baxter LR Jr, Martin KM, Phelps ME. Systematic changes in cerebral glucose metabolic rate after successful behavior modification treatment of obsessive compulsive disorder. Arch Gen Psychiatry 1996;53:109-113
6. Engel GL. The clinical application of the biopsychosocial model. Am J Psychiatry 1980;137:535-544.
7. Stahl S. Essential psychopharmacology, 2nd ed. Cambridge UK: Cambridge Univ Press, 2000.

The City of Brotherly Love - Free to Medical Students

Attention Women Medical Students!

Join women members of the APA at the Women's Resource Center (WRC) at the Annual Meeting. The WRC hosts a number of informal sessions on such topics as passing the boards, succeeding in a research career, self-care during times of stress, and getting active with you local District Branch. The WRC will be held in room 303A of the Philadelphia Convention Center on Sunday, May 19 and Monday, May 20 from 7:00am-5:00 pm. Materials on women's programs at the APA and other organizations will also be available. We hope to see you there! For further information, please contact Tara McLoughlin at 202-682-6171 or tara@psych.org

As a medical student, your attendance to the APA Annual Meeting is free. Registration is fee-exempt for medical students with proper identification (i.e. copy of current ID card, letter from faculty member, etc.) This year's Annual Meeting will be held in historic Philadelphia, PA on May 18-23, 2002. Why should you attend (aside from the fact that its FREE!)?

- Highlighted scientific sessions of special interest to medical students
- Opportunities to interact with other medical students and psychiatry residents in training programs throughout the U.S. and Canada.
- Social and leisure time activities for medical students.

The APA has planned a wide variety of activities of interest to medical students. Among them are the following:

Sunday, May 19 from 10:00 am—11:30 am
"How to Survive the Annual Meeting" Orientation Session – This is an orientation session to highlight the activities of interest to medical students and residents during the Annual Meeting. Rooms 309-301, Level 3, Marriott

Monday, May 20 from 7:00 am - 8:30 am
"Meet the Experts: Sunny-Side Up" A Breakfast Session – At this breakfast session, nationally-recognized "experts" will sit at tables with small groups of medical students and residents to discuss a wide range of career issues and opportunities in psychiatry. Grand Ballroom Salon B, Level 5, Marriott

Tuesday, May 21 from 12 noon - 2:00 pm
Luncheon for Residents, Educators and Medical Students (Nancy CA Roeske, M.D. award presentation) - You are invited to join other medical students, residents, training directors and distinguished leaders in psychiatry at a luncheon sponsored by the APA Committee on Medical Student Education. The 2001-2002 winners of the Nancy CA Roeske Certificate of Excellence will also be awarded at this time. Philadelphia Ballroom, Lower Level, Wyndham

Thursday, May 23 from 9:00 am-10:30 am
"Career Choices in Psychiatry" - a component workshop sponsored by the APA Assembly Committee of Area MIT Trustees. Room 104 A, Street Lvl, Convention Center

For additional information on Annual Meeting registration, call the APA registrar at 202-682-6082. For more information on activities for medical students, discounted housing, etc., contact Nancy Delanoche at ndelanoche@psych.org

Introductory Textbook of Psychiatry, Third Edition

By Nancy C. Andreasen, MD, Ph.D., and Donald W. Black, M.D.

2001 · 912 pages · ISBN 1-58562-036-X · paperback $52.95 Item #62036

2001 · 912 pages · ISBN 0-88048-946-4 · hardcover · $72.95 · Item #8946

You can order online at www.appi.org

Introductory Textbook of Psychiatry, 3rd Edition

The third edition of this broad, lively text depicts psychiatry as a field virtually exploding with new knowledge rather than-as is too often the case-as a field mired in the past. Its two distinguished authors, whose work as scholars, teachers, and research scientists serves to further enhance this volume's wide appeal, present the fundamentals for practicing psychiatry in four sections: (1) *Background, (2) Psychiatric disorders; (3) Special topics* (Suicide & violence, psychiatric aspects of HIV, disorders of childhood & adolescence, sleep disorders, & legal issues); and (4) *Treatments* (Psychosocial and somatic).

In addition to exciting new findings about specific psychiatric disorders and new case vignettes, illustrations, and tables, the authors include expanded chapters on the psychiatric aspects of AIDS, reflecting the exponential increase in knowledge about this still-unchecked worldwide epidemic, and on somatic treatments, reflecting the burgeoning knowledge about new drug treatments.

The authors have also added the Beck Depression Inventory-a self-report patient questionnaire to help the clinician obtain an objective measure of the patient's condition-to their helpful appendix of diagnostic scales and measurements now being integrated into routine clinical care. An added bonus to this third edition is the authors' inclusion of model curriculum recommendations for students and psychiatry clerkship directors.

"A Resident's Perspective" A New Series in Academic Psychiatry

The journal *Academic Psychiatry* is featuring "A Resident's Perspective," a new series of columns by Joel V. Oberstar, M.D. Dr. Oberstar is in the first year of a Harvard Longwood residency.

The series describes the large and small challenges that face a new resident as he learns to accept his identity as a doctor.

In "Where Do I Put My Hands?" (Winter 2001), Dr. Oberstar recounts his first experience as the on-duty resident when a psychiatric patient has to be chemically restrained. He okays the restraint order, but as the staff sets to work he realizes he is unsure of his own role. A nurse quietly shows him the best way to just stand there and watch, in a posture that won't feel threatening to the agitated patient. In "That's My Doctor..." (Spring 2002), Oberstar recalls an elderly stroke victim on the neurology service who was his first patient to die, and he also describes his feelings on being referred to, for the first time ever, as "my doctor."

The journal is available online to subscribers or on a pay-per-view basis at http://ap.psychiatryonline.org.

SPECIAL OFFER TO MEDICAL STUDENTS
Subscription to Academic Psychiatry, which includes online access, is only $43.50 per year (4 issues).

Child and Adolescent, *cont from page 3*

What are the job prospects?

The job opportunities in child and adolescent psychiatry are excellent. The 1990 Council on Graduate Medical Education National Advisory Committee report projected a need in the year 2010 for 32,075 child and adolescent psychiatrists, but a supply of only 3,942 (a ratio of only 12.3%). A tremendous shortage of child and adolescent psychiatrists continues. Anecdotally, I can tell you that graduates from our training program are greatly in demand, and that job opportunities are regularly offered to them well in advance of graduation. The same is true in most major urban and rural areas. Most institutions and agencies pay a higher salary to psychiatrists who have completed child and adolescent training. Employers in public, private, and academic settings continually seek those qualified to work with both adults as well as children and adolescents.

What does child and adolescent psychiatry residency training involve?

Becoming a child and adolescent psychiatrist requires completion of an internship (which may include pediatrics and pediatric neurology), two to three years of general psychiatry residency, followed by 2 years of specialty work. It is possible, though less common, to do child and adolescent psychiatry training before general psychiatry training. You may choose to do your child and adolescent psychiatry training at the same institution as your general psychiatry residency, or at a different university. There are also several "Triple Board" programs in the country that offer combined, extended training and Board-eligibility in psychiatry, child and adolescent psychiatry, and pediatrics. The requirements for child and adolescent psychiatry training, and a list of training programs, are available at **http://www.acgme.org.** Beyond these requirements, however, there is a lot of room for leeway. Programs are delightfully varied in their content, according to the strengths and philosophy of each institution. You should compare and contrast programs.

In general, a child and adolescent psychiatry residency provides training in working with children from infancy through late adolescence. You learn how to work with the parents, extended families, schools, hospitals, courts and communities where these kids live. Training is provided in different therapeutic modalities and continuum-of-care settings. You will learn how to be a teacher, a supervisor, and an administrative leader. You will be trained to work well with interdisciplinary teams as well as on your own. You will receive some training in pediatric neurology and in hospital consultation-liaison to pediatrics. You will participate in extensive classroom experience involving extended coursework in normal developmental theory throughout the life cycle, as well as the gamut of clinical syndromes and their treatments. You will also be exposed to research methodology, with the level of expected research participation varying between programs.

Dr. Geri Fox. is an Associate Professor of Clinical Psychiatry and the Director of Graduate Medical Education Programming at the University of Illinois at Chicago

Medical Student Newsletter

Editor in Chief:
Michael Vergare, M.D.
Managing Editor:
Nancy Delanoche

American Psychiatric Association
Office of Graduate and
Undergraduate Education
1400 K Street, NW
Washington, DC 20005
Tel: 202-682-6126
Fax: 202-682-6102
Email: ndelanoche@psych.org

VISIT OUR WEB PAGES
www.psych.org
www.appi.org
www.psychiatryonline.org

NON-PROFIT ORG
U.S. POSTAGE
PAID
WASHINGTON, DC
Permit 9128

Are You Graduating in June?

Are you planning to enter psychiatry residency training? If so, please contact the APA Membership Department for information on changing your status to Member-in-Training. Learn more about the benefits of resident membership in APA and the local psychiatric society in your area. Please call 1-888-35-PSYCH x6069 or send an email to membership@psych.org.

Boundary violations, cont. from page 4

- Threatening with a lower grade or poor evaluation for reasons other than course/ clinical performance
- Sexual Harassment
- Discrimination on the basis of race, gender, sexual orientation, religion, ethnic back ground, age, or physical disability
- Intentional neglect or lack of communica tion
- Taking credit for another individual's work
- Disregard for student safety
- Any other behavior which is contrary to the spirit of learning and/or violates the trust between the teacher and learner."

Second recommendation: follow the **12 Steps to Success on ATM's inside cover, which are:**

1. Agree that treating others with respect is what this is all about.
2. Legitimize the importance of this issue by asking the Dean for a statement
3. Review your school's GQ data on student mistreatment for the past several years
4. Establish a committee that is broadly representative of the academic community to define abuse and draft a Standards of Conduct Statement.
5. Focus on the theme of respect for the roles of teacher and student in the learning process.
6. Think positively – that is, how to treat others with respect – rather than focusing on the punitive.
7. Everyone needs to know the rules.
8. Everyone needs to be held to the same standards.
9. Even though everyone agrees to treat everyone with respect, someone will err at some point in the future, so you need an adjudication process that is fair.
10. View ATM as the "appropriate culture" at your school. Be a leader. Spread the word!
11. Develop ongoing educational programs that assume that everyone wants to treat everyone with respect.
12. Provide for evaluation and continual improvement of ongoing programs.

Dr. Leah Dickstein welcomes feedback from medical students. She can be reached by email at ljdick01@louisville.edu.