



Psychiatric Resident Newsletter

Committee of Residents and Fellows: Looking Behind

By: William Wood, M.D., Former Chair of CORF

Members-in-Training (MITs) hold a prominent role within our Association and participate in all levels of governance, including local district branch committees, Area MIT representation to the APA Assembly, APA component membership, industry-sponsored fellowship involvement, and election to the APA Board of Trustees. In all, there are over one hundred residents participating at the national level, and countless more involved in local and area APA activities.

MITs have a significant voice in the APA governance, yet we often do not realize the degree of influence that we have in the de-

cision-making processes of the Association. In part, this is related to being new members in a large organization that has many vocal senior members. Moreover, MIT groups have historically been relatively isolated from one another, so there is a tendency to feel isolated into a subgroup such as "member of the Assembly Committee of MITs" or "APA/Bristol-Myers Squibb Fellow" rather than feeling like a coherent constituency of trainees.

However, this past year has been a time of significant progress for residents

and fellows within the American Psychiatric Association. Movement towards greater communication, integration, and collaboration is underway. The APA Board of Trustees approved the two elected MIT trustees to become *ex-officio* members of the Committee of Residents and Fellows (CORF) and the Assembly Committee of MITs (ACOM). This effectively increases the communication that the elected MITs have with resident representatives, adding greater voice and focus to MIT perspectives on the APA Board of Trustees.

(continued on Page 4)

Committee of Residents and Fellows: Looking Ahead

By: Lea DeFrancisci Lis, M.D., Current Chair of CORF

The Committee of Residents and Fellows is off to a good start. The fall components meeting at the JW Marriott was a great success for the Members in Training who participated. Members of CORF served on the various committees of the APA such as the Ethics Committee, the Council on Medical Education, the Committee of Public Affairs, and the Committee of Asian psychiatrists.

CORF sponsored 2 events at the Institute of Psychiatric Services. One was titled "9/11: What Happened to The Children? Trauma, Loss, and Working with

the Media". This workshop explained how the terrorist attacks on 9/11/2001 had the distinction of affecting more children in the United States than any other single act of violence. Moreover, many children watched the disaster on television and were traumatized by the graphic images of this disaster. Participants were shown the HBO film "Through a Child's Eyes" which described the media's effect on children. The film was followed by a discussion about the impact of media on children's reaction to terrorism. The workshop was well received thanks to our speakers Dr Harold

Koplewicz, Chairman, Department of Child and Adolescent Psychiatry and Founder, NYU Child Study Center and Dr. Eugene Beresin, Director of Child and Adolescent Psychiatry Residency Training Massachusetts General Hospital and McLean Hospital. Dr. William Wood, former chair of CORF, and I served as co-chairmen of the seminar.

CORF also sponsored an "Informational Overview of the Boards" during the IPS in both 2005 and 2006 with presenters

(continued on page 2)

More Questions than Answers

By: Molly McVoy, M.D., PGY-2 Psychiatry Resident at University Hospitals of Cleveland

"We learn more by looking for the answer to a question and not finding it than we do from learning the answer it-self." (Lloyd Alexander)

Residency training is often an exercise in learning how to ask questions, where to find the answers, and what to do when there do not appear to be any answers. Residency training in psychiatry is often an exercise in learning what to do when there are no answers or many conflicting answers. Learning how to learn may be one of the most important and most difficult skills developed in residency. Learning how to learn while in the midst of treating a patient is a skill that will carry residents through their careers.

Learning the "best way" to treat psychiatric patients acutely and in the long term appears, at the outset, to be the task of a psychiatry resident. However, after only a few months on the inpatient wards and in the emergency room, it becomes clear that there may not be a single "best way." There may not be one right answer to the questions of what drug to use, what dose to start with, or what therapy to initiate. The task of a resident then be-

comes to find the "best way" for each individual patient.

After months spent in internal medicine, pediatrics and emergency medicine, a resident may consistently look for those evidenced-based medicine algorithms and care paths to help guide their care of patients. When transitioning to months of inpatient and emergency psychiatry, those algorithms and care paths are much more difficult to find. In addition, when they are available, there are frequently several to choose from and each claims to be "evidence based." Much of the "evidence based medicine" can appear tainted by drug company sponsorship while so much of the research is still waiting to be done.

Learning not only how to ask the questions and where to look for those answers, but to critically analyze those "answers" becomes integral to the development of a resident.

It has been said that if you ask five doctors for their opinion, you will get five different opinions. This is perhaps nowhere truer than in psychiatry residency training.

Throughout medical school, some of the most important learning is done by listening to trusted attendings, following

the lead of competent senior residents and asking lots of questions. It becomes clear in residency, however, that, if you ask five attendings the same question, you may get five very distinct answers. Each answer may be from a respected and trusted advisor and each may claim that her answer is "the best way." The next step in "learning how to learn" is sorting through all of the advice, clinical pearls, suggestions, and "the way I've done it for 20 years" to find a skill set you are comfortable with.

The long hours, difficult patients, uncomfortable call rooms and stressful nights come as no surprise to most residents. The amount of reading, studying and researching may not come as one either. However, the surprise may be that, at the end of the day, there are more questions than answers. One of the biggest lessons in psychiatric residency may be learning to treat patients in the best way when the answers are not entirely clear and the "best way" is a murky combination of advice, evidence based medicine and clinical experience.

Committee of Residents and Fellows: Looking Ahead (continued from page 1)

By: Lea DeFrancisci Lis, M.D., Current Chair of CORF

Nada Stotland M.D. former oral board examiner Carolyn Robinson M.D. former member of American Board of Psychiatry and Neurology (ABPN), and James Scully M.D. director of the ABPN and William Wood M.D. who recently passed the board. This workshop was for members in training who have anxiety about

the process of preparing for this challenging exam. The fact that this was standing room only indicated the need for programs of this type. The Committee of Residents and Fellows looks forward to a productive spring and the APA's annual meeting in San Diego.

My Experience as an APA/AstraZeneca Fellow

By: LaShondra Washington, PGY-5 Child Fellow at University of Maryland

Two of the greatest years of my young professional life began in the Spring of 2004, during my PGY-2 year at Tulane University in New Orleans. It was at this time that I was informed of my selection as an APA/AstraZeneca Minority Fellow. I embarked on a journey that was second to none.

The APA/AstraZeneca Fellowship is one of two fellowships in the APA Minority Fellowship Program (MFP); the other being the APA/SAMHSA Fellowship. Both fellowships attract residents who are committed to serving the mental health needs of minority and underserved populations. I first became aware of the Minority Fellowship Program as a fourth-year medical student at the University of South Carolina, and I vowed at that point that I would apply for this opportunity once eligible. The APA/AstraZeneca Fellowship is a two-year fellowship, and it was truly a blessing to be a part of such an experience for a variety of reasons.

First, the APA/AstraZeneca Fellowship provided an opportunity to be a part of the governance of the APA. During my tenure as an AstraZeneca Fellow, I was able to participate on two committees of the APA. One was the Council on Children, Adolescents and Their Families, truly one of the most popular committees of the APA in my opinion. Every fellow with even the slightest interest in child psychiatry hoped to be selected for one of the coveted spots representing the Minority Fellowship Program. In addition to serving on that Council, I was selected by my peers to represent both the AstraZeneca and

SAMHSA fellows on the Committee of Residents and Fellows (CORF). I was able to share history and accomplishments of both fellowships in the CORF handbook for APA members-in-training that was just published. I am extremely happy to continue my involvement in CORF as the area 3 representative.

Becoming an AstraZeneca Fellow provided the opportunity to travel to a variety of meetings. My particular fellowship provided funding for travel to national APA meetings, including the Components meeting in Washington, the Institute for Psychiatric Services in the fall, and the Annual Meeting. In addition, enough funding was available for me to travel to the 2004 AACAP Annual Meeting in Washington, DC. Travel to these meetings were valuable experiences that contributed to my personal and professional development.

The APA/AstraZeneca Fellowship provided the first, and so far the only opportunity to participate in presentations on a national level. I would normally avoid public speaking opportunities like the plague. However, I decided to put my public speaking fears to rest and present with four of my colleagues at the 2005 IPS Meeting in San Diego. Our presentation, which examined the shared minority status between minority therapists and minority patients received rave reviews from the audience and the fellows. I became confident enough to participate on another workshop on school-based suicide prevention at the 2006 Annual Meet-

ing in Toronto.

The APA/AstraZeneca Fellowship provided remarkable mentoring opportunities. National meetings were the arena for meeting senior psychiatrists in the organization. There is a definite feeling of being "star-struck" when you are sitting next to a psychiatrist who edited one of your psychiatry textbooks. One would easily feel intimidated by being among such a distinguished group. However, the senior members were truly approachable, friendly, and inspiring. The National Minority Mentors Network is a more intimate group that gives former fellows a way to stay connected with the Minority Fellowship Program. I have enjoyed this aspect in particular, as I hope to participate the Network next year as a mentor.

Last, and definitely not least, what I will remember most about my two years as an APA/AstraZeneca Fellow will be the friendships that developed. Minority fellows have been the first people that I look for at meetings, from AACAP to the APA Annual Meeting. Impromptu lunches or dinners at meetings were held quite often among fellows. Groups of fellows would convene in the hotel's lobby to discuss the location and time of the social gathering that would take place later that evening. I will truly miss my time spent in the Fellowship. I believe my colleagues who have moved on from the AstraZeneca or SAMHSA fellowship would agree.

Looking Forward to the End

By: Farah Munir, D.O., PGY-4 Cleveland Clinic Foundation and Dominique Neptune, M.D., PGY-4 Georgetown University

As fourth year residents only months away from graduation, we are often shocked to find ourselves in new and unfamiliar territory. We expect that years of sleepless nights on call (to be later replaced by sleepless nights of moonlighting), didactic education on psychotherapy practice, pharmacological management and research results and endless clinical rotations have taught us everything we will ever need to be successful clinicians in the community. Yet for many of us, one gaping hole in our fund of knowledge remains – how to conduct a job search.

If discussions with your residency training director, recent graduates or mentors still have not provided enough information, some online information is available to help you get started.

One easy way to begin is to

familiarize yourself with the resources available on the APA website (www.psych.org). Select the “Career Corner”, then continue to the section entitled “Conducting an Effective Job or Practice Search”. Among other things, this provides an overview of the entire process, a sample curriculum vitae and a self assessment questionnaire to help focus your search. Once you’ve registered, you can post your resume online for employers to view and perform a job search.

Other resources we’ve found to be helpful to get the process started include:

Transitioning into the Post-Residency Period (www.pn.psychiatryonline.org, then keyword post residency transition). An article in Psychiatric News that describes a program

presented by a NYC District Branch at St Luke's-Roosevelt Hospital in 2002. It gives a good overview for what residents should look for and also is a template for how individual residency programs can provide some education for their residents.

Psychiatry Residents and Career Planning: When to Start? by Noha Sadek, M.D. www.womenpsych.org, then go to Newsletter, then to Fall 2001, page 16). This article offers general considerations for residents in different stages of training.

Navigating the Transition to Practice by Catherine Hickey (www.apa-apc.org/Publications/Archives/Bulletin/2003/december/hickey.asp). An article in the December 2003 Canadian Psychiatric Association Bulletin that evaluates the emotional aspects of transitioning into the post-residency period.

Committee of Residents and Fellows: Looking Behind (continued from Page 1)

By: William Wood, M.D., Former Chair of CORF

A recently established listserv between MIT leaders on the Board of Trustees, CORF, ACOM, and each of the industry-sponsored fellowships will keep each group updated regarding the activities of other MIT groups. This allows for greater collaboration and synergy between various MIT efforts within the Association.

This increased collaboration is showing results. At the spring meeting of the Assembly, an Action Paper requesting senior mentoring of MITs participating at the national level was passed by the Assembly and later ratified by the APA Board of Trustees. The Action Paper was jointly sponsored by the Committee of Residents and Fellows and the Assembly Committee of MITs. The purpose of the Action Paper is so

that MITs who are active at the national level are able to maximize their learning about organizational Psychiatry and to continue effective involvement with the APA after completing training. If this initiative goes well, a next step will be to expand the mentoring so that all MITs in the Association are paired with a senior APA member as a mentor.

This is just one of many activities that CORF and other MIT groups have pursued over the past 12 months. In addition, we have been active presenting MIT-oriented workshops at national meetings, continuing our liaison with AADPRT (the training directors' national organization), and developing an MIT handbook for participation in

APA governance which we hope to have based on the APA's website shortly.

On a personal note, I would like to thank all the MITs, general members, staff, and colleagues who have made serving as the chair of CORF over the past three years a genuine pleasure. In particular, I would like to thank Debbie Hales, Caroline Cope, and Nancy Delanoché from the APA Division of Education for their amazing support and hard work in helping Members-in-training to maximize their participation in the APA. I would also like to thank the members of the Committee of Residents and Fellow for working hard and having fun together. Finally, I thank Lea DeFrancisci, who has assumed the chair position on CORF... good luck and enjoy!

Same-Sex Marriage and the APA

By: Arnaldo Moreno, M.D., Geriatric Psychiatry Fellow, UCSF

The emotional issue of same sex marriage has been in the forefront of numerous political discussions throughout the nation, and likely will continue to be a major theme in future elections. So where does the American Psychiatric Association stand on this charged issue? In June of 2005, the Board of Trustees of the APA approved a position statement supporting the legalization of same sex civil marriage, and opposing efforts to ban marriage equality. The position statement had been approved by the APA Assembly in Atlanta last May.

The APA's position statement declares as follows:

As physicians who frequently evaluate the impact of social and family relationships on child development, and the ability of adults and children to cope with stress and mental illness, psychiatrists note the invariably positive influence of a stable, adult partnership on the health of all family members. Sustained and committed marital and family relationships are cornerstones of our social support network as we face life's challenges, including illness and loss. There is ample evidence that long-term spousal and family support enhances physical and mental health at all stages of development.

This position statement is about the legal recognition of same-sex civil marriage, not religious marriage, and it does not pertain to any organized religion's view of same-sex marriage. Heterosexual relationships have a legal framework for their existence through civil marriage, which provides a stabilizing force. In the United

States, with the exception of Massachusetts, same-sex couples are currently denied the important legal benefits, rights and responsibilities of civil marriage. Same-sex couples therefore experience several kinds of state-sanctioned discrimination that can adversely affect the stability of their relationships and their mental health.

The children of unmarried gay and lesbian parents do not have the same protection that civil marriage affords the children of heterosexual couples. Adoptive and divorced lesbian and gay parents face additional obstacles. An adoptive parent who is lesbian or gay is often prejudicially presumed as unfit in many U.S. jurisdictions. Furthermore, when unmarried couples do adopt, usually one parent is granted legal rights, while the other parent may have no legal standing. These obstacles occur even though no research has shown that the children raised by lesbians and gay men are less well adjusted than those reared within heterosexual relationships. As the population ages, the denial of legal recognition of civil marriage has consequences for increasing numbers of older adults in same-sex relationships who face age-related health and financial concerns. Excluding these adults from civil marriage protections of survivorship and inheritance rights, financial benefits, and legal recognition as a couple in health care settings increases the psychological burden associated with aging.

The American Psychiatric Association has historically supported equity, parity, and nondiscrimination in matters that have an impact on mental health. APA has also supported same sex civil unions and the right of same-sex couples to adopt and co-parent

children. This is because APA has a longstanding interest in civil rights and legal issues that affect mental health as well as a code of ethics that supports and respects human dignity. Educating the public about lesbian and gay relationships and supporting efforts to establish legal recognition of same-sex civil marriage is consistent with the Association's advocacy for minority groups. Civil marriage is associated with a unique set of benefits that provide legal and economic protections to adults in committed relationships and to their children. Equal access to the institution of civil marriage is consistent with the APA's opposition to discrimination based on sexual orientation.

Therefore be it resolved that:

"In the interest of maintaining and promoting mental health, the American Psychiatric Association supports the legal recognition of same-sex civil marriage with all rights, benefits, and responsibilities conferred by civil marriage, and opposes restrictions to those same rights, benefits, and responsibilities."

Further information on the APA's position statement can be obtained from the APA website at www.psych.org.

Planning a Wedding During Residency

By: Heather Brice, M.D., PGY-4, St. Louis University

At the beginning of my 3rd year of residency I got engaged to be married. Planning a wedding can be as complicated or as simple as you, and the families involved, chose to make it. During residency, well that is probably not a good time to get too complicated, unless you have a lot of help! I chose to have a nice, traditional wedding, not too complicated, and had a fair amount of help from many friends and family. My now husband was a key helper, but some significant others may prefer to stay less involved. In a sense, if you take it upon yourself to do most of the orchestration, you are very much like the team leader in treatment rounds for example. As with any team oriented approach, you want to choose reliable people. I couldn't have done it without the help of many other people, especially my family.

As with anything, being organized and having a plan before you start is essential. I started by getting a 3 ring binder and divided it into the sections described below. I kept my research materials, deposits, receipts, contact phone numbers, etc in each section. The internet is an excellent resource, "open 24 hours a day". For dress, flowers, catering (things you have to see and arrange in person) I worked mostly with businesses that had evening or weekend hours. I did not attend one of those bridal shows prior, but this is a good way to see these things in person get a lot of information about all aspects of wedding planning all in one place!

1. **Date and location:** This is an obvious starting point. Depending on your religious and cultural background, this can vary quite a

bit. In my circumstance, we contacted our local church and the priest to confirm a date.

2. **Guest list and invitations:** Begin gathering addresses as soon as possible. Order invitations 6 to 12 months in advance and order extra rather than "just enough". Mail them 4-6 weeks prior. Many opt for the "Save the Date Cards" which go out 3 months or so before.

3. **Dress/Formal wear:** Very personal matter, be sure to give yourself enough time for alterations, for yourself and your bridesmaids or groomsmen. Remind everyone of deadlines.

4. **Photography/videography:** Reserve date 6-12 months in advance. Do research here; see at least 3 different options! Much of this can be done online, but a visit to the studio is best. If you chose to have a friend do this, its ok to ask to see examples of prior work so your expectations are realistic. We chose a studio that had evening hours so that engagement photos, pre-wedding and post-wedding meetings could all be done after work.

5. **Flowers:** Reserve the date 6-12 months in advance, but don't need to meet with until 2-4 months ahead to make selections.

6. **Reception:** Can be in a hall, outdoors, etc. Ours was in the church hall. Find out about facilities, what they provide and what you have to provide. This is where all the little details can add up. I had

the most help with coordinating this part. Some halls provide bar services for a fee, but you may need to hire services, similar to a caterer coming in.

7. **Cake:** We went with a personal referral which was excellent. Be prepared to know expected number of guests, flavor, icing color(s), cake topper, etc.

8. **Catering:** Again widely varies, but work with one who is flexible to meet and arrange and provide samples so you know exactly what you are getting.

9. **DJ/Music:** Can vary widely again, but whether it is live or DJ spun, a pre-wedding meeting to listen and select pieces is necessary. Again, we went with those who could meet with us after hours.

10. **Gift Registry:** Many options for this; we registered at 3 places. Each provides a printout for you and some can be accessed and changed online.

11. **Limo:** if you so chose.

Honeymoon: We opted to delay our honeymoon 3 weeks, mainly so that I did not miss too much work contiguously. This was actually more fun I thought, because we got to celebrate twice! If you are going out of the country, don't forget to get a passport ahead of time!

So that is how my binder was arranged. I took it to work and would make phone calls at lunch or between patients. I began planning in November and had a successful wedding 6 months later in April. So you may not have to sweat the 6-12 months listed above if you are flexible, if there are sufficient options in your area, or if the date is not in the prime of wedding season, May and June primarily. Have good help, and don't lose the love in the details! Good luck!

Area 5 Response to Katrina's Devastation

By: Justin Hunt, M.D., PGY-4 Chief Resident, University of Arkansas for Medical Sciences

Hurricane Katrina is quite possibly the most devastating disaster that has struck the United States in modern times. The short and long term psychiatric sequelae of such a tragedy will be increasingly apparent in the immediate disaster zone of coastal Louisiana, Mississippi, Alabama, and Florida as people struggle to piece their lives back together and mourn the loss of their loved ones. The mental health impact also has been observed throughout the entire APA Area V southern region which I represent on the Committee of Residents and Fellows. This widespread effect is, of course, secondary to the enormous population displacement secondary to the storm.

As the chief resident of the General Psychiatry Residency program at the University of Arkansas for Medical Sciences (UAMS), I have the responsibility to develop call schedules that adequately cover three major hospitals in Little Rock, the Central Arkansas VA, University Hospital, and Arkansas Children's Hospital. During the Labor Day holiday following Katrina, I received a flurry of phone calls and emails from administrators at these three respective training institutions. The hospitals were part of the National Disaster Medical System that was responding to the developing catastrophe approximately 300 miles to our south. "We need to form a group immediately to get out to the Little Rock Air Force Base to meet several planes of patients arriving from the Gulf Coast." As in severe disasters such as Katrina, the communication infrastructure was severely disabled and clear information was quite rare. Initially, there were reports of up to twelve planes full of patients that were to arrive that Labor Day weekend. How were we going to cover this massive influx on a holiday weekend? Psychiatric faculty, residents, and even two inexperienced interns

volunteered to leave their VA rotations on Friday, September the 2nd and subsequently traveled to the Little Rock Air Force Base to await the planes. Information understandably remained rather fluid... first, it was twelve planes, then it was down to five, and then finally one large plane arrived with multiple patients that were mostly admitted for acute medical issues such as dehydration and infection. The ED's of our training hospitals were busy as usual, but not abnormally overwhelmed with psychiatric patients. Our Department of Psychiatry at UAMS operated a clinic over the Labor Day weekend for any persons affected by Katrina that were distressed, depressed, or were in need of any help following the storm...very few patients arrived at this clinic.

Where were the patients with psychiatric needs? Many of them were physically well enough to escape the Gulf region via bus or car and were trickling into a variety of makeshift shelters throughout the state of Arkansas. They were filling up the country roads of southern Arkansas and even the freeways as far north as Little Rock. Places such as the Pine Bluff Convention Center and the Arkansas State Fairgrounds were filled to capacity. There indeed was a large number of evacuees in our state. Texas received by far the largest population of displaced citizens, but Arkansas' population reportedly grew by up to 3% during the days after Katrina...a substantial increase for a small, poor state.

UAMS and the Arkansas Department of Health chose to form teams of physicians including psychiatrists, pediatricians, internists, and family practice doctors. These teams then traveled to evacuate shelters throughout the state. They met a group of 600 evacuees at the Little Rock National Airport to

assist with their triage. A small army of health care workers were waiting to treat approximately 9,000 people that came through Fort Chaffee in Fort Smith, AR. 2,000 of them required medical evaluations. Arkansas State Troopers even aided in the swift delivery of medical supplies and prescription drugs to the Fort Smith area. It clearly was a massive effort, and I must say that I am personally very proud of the way my state and university responded to the challenge. Their overwhelming generosity exhibited during the aftermath of Katrina was indeed uplifting after watching the fault lines of our post-modern American society become so apparent on the national news coverage out of New Orleans.

The story written above was literally taking place in hundreds of locations throughout the South. APA members from San Antonio all the way to Atlanta were welcoming thousands that were suffering. Psychiatrists and mental health workers in the region are now working to develop successful long term interventions. Up to this point, many of the displaced citizens have been extraordinarily busy taking care of their relatives and basic physical and financial needs. When their lives settle down a bit in the upcoming months, we will likely see a steady swell of patients with psychiatric needs presenting to our ED's and clinics. I am confident that we will be prepared for this increase in patient volume. You cannot underestimate the generosity and determination of those living and working in Area V. With the support of the APA, the Department of Health and Human Services, and other federal agencies, we will meet this challenge and remain committed to the long term psychiatric needs of our patients.



Psychiatric Residents' Newsletter

Editor-in-Chief:
Lea deFrancisci Lis, M.D.
Editorial Staff:
Caroline Cope

American Psychiatric Association
Office of Graduate and
Undergraduate Education
1000 Wilson Blvd, Suite 1825
Arlington, VA 22209
Tel: 703-907-8663
Fax: 703-907-7849
Email: ccope@psych.org

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

COMMITTEE OF RESIDENTS AND FELLOWS

The Committee of Residents and Fellows (CORF) is a permanent standing committee of the APA, the specialty organization for the field of psychiatry. The Committee is composed of seven psychiatry residents, each representing the seven geographic areas into which the APA divides the United States and Canada. Additionally, representatives from the three fellowship programs participate as active members of the Committee. Each member is nominated by his/her residency training program and serves a three-year term.

Since 1971, the Committee has represented resident opinions and issues within the Association and have established effective and meaningful liaisons with many components of the APA, as well as with many other organizations that are involved in training and the profession.

AREA 1

Mireya Nadal-Vicens, M.D., Ph.D.
Massachusetts General Hospital &
McLean Hospital
mnadalvicens@partners.org

AREA 2, CHAIR

Lea DeFrancisci Lis, M.D.
Child Fellow, New York University
leadefrancisci@gmail.com

AREA 3

LaShondra Washington, M.D.
University of Maryland
lashondratw@aol.com

AREA 4

Molly McVoy, M.D.
Case Western Reserve/University
Hospitals of Cleveland
Molly.mcvoy@uhhospitals.org

AREA 5

Justin Hunt, M.D.
University of Michigan
huntjustinb@uams.edu

AREA 6

Shirley Liu, M.D.
California Pacific Medical Center
liusx@sutterhealth.org

Liaison from ACOM

Paul O'Leary, M.D.
University of Alabama
pjoleary@uab.edu

APA Minority Fellow

Sean Chappin, M.D.
Mount Sinai School of Medicine
schappin@gmail.com

APA/GlaxoSmithKline Fellow

Anna Gross, M.D.
Columbia University
ag2348@columbia.edu

APA/Bristol-Myers Squibb Fellow

Sarah Guzofski, M.D.
University of Massachusetts
guzofskis@umhmc.org