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Physician Burnout: An Epidemic or the New Norm?

Willa Xiong, M.D.

“[I]f your compassion does not include yourself, it is incomplete.”
—Jack Kornfield

Physicians often suffer significant burnout, with an alarming 54% reporting it in a national survey (1). This is an experience familiar to those across all levels of training, including medical students, half of whom also reported burnout (2). After spending nearly a decade in education and accruing financial debts, physicians wade forth into long hours, high-stakes decisions, sleep deprivation, work-life balancing acts, paperwork, medicolegal risks, administrative burden, and reimbursement issues. The satisfaction from being able to interact meaningfully with patients and contribute to the well-being of another is irrefutable; however, the cumulative effects of the aforementioned forces weigh heavily on the other end of the scale.

Burnout is referred to as a syndrome of emotional exhaustion, depersonalization, and a low sense of personal accomplishment. Like depression, burnout has its own validated measure, the Maslach Burnout Inventory. One of the inventory’s researchers referred to burnout as “an erosion of the soul caused by a deterioration of one’s values, dignity, spirit and will” (3). The diagnostic criteria and quantifiability of burnout may be argued, but the implications are clear. These include decreased quality of care, poor patient satisfaction, medical errors, and physician turnover. Burnout is also linked to personal repercussions for physicians, including relationship difficulties, substance use, and suicidal ideations (4). These consequences are resoundingly similar to the well-known increase in divorce rates, mental health disorders, and deaths by suicide in physicians.

There is a surprising paucity of evidence on how to address a problem afflicting one of every two physicians. The traditional approach is to treat the symptoms post-burnout. Apart from some programs that have incorporated mindfulness (5), interventions are lacking. This may reflect insufficient attention to burnout as a public health problem, lack of proposed prevention mechanisms, limited implementation of interventions, or a combination of the three. One hindrance to change is that the same qualities responsible for the success of physicians simultaneously make them vulnerable to burnout. Embedded into early medical education are two fundamental principles: “The patient always comes first” and “Never show weakness.” With these principles, the expectations of training and practice become a double-edged sword. Service extends into personal sacrifice and ultimate deprivation. Compassion crosses the line into either emotional depletion or emotional suppression in the hopes of preserving oneself. Furthermore, the inherent drive to “cure” and “fix” leads to a sense of perpetual inadequacy in the face of ambiguity.

Burnout is transitioning from being a pervasive epidemic to the new norm, albeit one that we should not readily accept; it is the byproduct of a system that hones physicians’ abilities to work until they can work no longer, and then to work some more. System-level interventions may provide some mitigation, but perhaps we need to go back to the drawing board, and re-evaluate medical training. It is time to uphold the Hippocratic Oath and its principles of beneficence and non-maleficence not only in the care of patients, but also for ourselves.

Dr. Xiong is a third-year resident in the Department of Psychiatry, Washington University School of Medicine, St. Louis.

REFERENCES
CASE VIGNETTE

“Dr. B” is a third-year internal medicine resident, supervising junior residents for the fourth consecutive month on an inpatient medicine service at a tertiary care hospital. Over the preceding 28 months, she has experienced more death, illness relapse, and treatment-resistant disease than she ever anticipated. Time and again, she has empathized with her patients’ caregivers, often long ing to express how intimately she understands their pain. For fear of being seen as unprofessional, she avoids sharing her feelings not only with patients’ families, but also with her colleagues and even herself.

Dr. B presents to employee health for her annual wellness visit. She endorses feeling persistently fatigued and says that engaging as she typically would with patients has become too cumbersome. She denies feeling hopeless, depressed, or suicidal but does disclose feeling dread about entering the hospital each day, fearing that things will inevitably go wrong under her care. With her family across the country and no current partner, she struggles to cope. Her sleep has been disrupted, and she often finds herself drinking 3–4 glasses of wine to get to sleep. Dr. B is hesitant to engage with a mental health provider when given a referral. She is perfectionistic and self-critical, making the thought of sharing how vulnerable she has become all but unbearable.

BURNOUT

Burnout describes a human response to chronic emotional and interpersonal stress at work, defined by exhaustion, cynicism, and inefficacy (1). The three main dimensions of burnout assessed using the Maslach Burnout Inventory (MBI) include emotional exhaustion, depersonalization, and a sense of low personal accomplishment (1). Burnout affects approximately one in three physicians at any given time (2). Risk factors for burnout in healthcare providers include long years of training, extended work hours, and witnessing patients die, suffer, and decline. The uncertainty inherent in treating human beings, the exorbitant cost of medical training, and traditionally low reimbursement rates also contribute to physician burnout (3–5). Compassion fatigue and vicarious traumatization describe cognitive and schematic sequelae that overlap with posttraumatic stress disorder (PTSD) (6–8). These syndromes assume that by empathically engaging with patients’ trauma and pain, being a healthcare provider might not only cause burnout, which waxes and wanes over time, but can produce enduring effects on one’s experience of the self, others, and the world.

While the exact nature of the association between burnout and suicide is unknown, we know the ratio for male physicians, compared with the general population, was 1.41, with a 95% confidence interval (CI) of 1.21–1.65, while female physicians took their lives at a rate 2.27 (95% CI=1.90–2.73) times that of the general population (9). Approximately one physician dies by suicide every day, and suicidal ideation increases approximately 4-fold during the first 3 months of residency training (10). The present review attempts to elucidate sources of burnout and to highlight ways to promote resilience.

BURNOUT IN TRAINEES

The effect of burnout on trainees cannot be underestimated. Investigators in the Netherlands measured burnout in 41.3% of trainees who completed the MBI. They found that 20.6% of trainees were classified as burned out based on survey results. Moreover, 12% reported having suicidal thoughts at least one time during their residency, and 1% reported suicidal thoughts more than one time during residency. Suicidal thoughts were also significantly more prevalent in the group with burnout compared with those without burnout (20.5% compared with 7.6%, p<0.001), supporting an association between burnout and suicide (11).

A 2010 prospective cohort study of 740 interns across 13 hospitals in the United States found that the proportion of patients who met Patient Health Questionnaire-9 (PHQ-9) criteria for depression increased from 3.9% prior to internship to 26.6% after internship (p<0.001). The study revealed that 41.8% of the 740 interns met criteria for severe depression (PHQ-9 score ≥10) on at least one of four quarterly assessments. Of the criteria assessed by PHQ-9, all increased significantly over the course of the internship year, with thoughts of death increasing by 370% (10). This study supports that while some people entering residency training have risk factors for depression, the internship year itself negatively influences mental health.

RESILIENCE

Resilience is defined as the ability to adapt successfully in the face of trauma, adversity, tragedy or significant threat (12, 13). While the capacity for resilience...
KEY POINTS/CLINICAL PEARLS
- Burnout describes a human response to chronic emotional and interpersonal stress at work, defined by exhaustion, cynicism, and inefficacy.
- Resilience is defined as the ability to adapt successfully in the face of trauma, adversity, tragedy, or significant threat.
- Burnout among trainees translates to reduced empathy and vulnerability to suicide.
- Resiliency building involves not just support to combat stressors but promoting a culture of mutual openness, understanding, and support to prevent burnout.

CBT endorsed suicidal ideation compared with 21.2% of interns assigned to the control group (relative risk=0.40, 95% CI=0.17–0.91, p=0.03). This compelling evidence that an easily accessible resiliency building intervention, for little cost, can help prevent adverse mental health outcomes in healthcare providers (17).

Another promising resiliency building intervention is mindfulness-based stress reduction (MBSR), known to promote relaxation and cultivate nonjudgmental awareness of sensations, thoughts, and feelings. In a randomized control trial of MBSR for medical and premedical students, MBSR was found to significantly decrease depression and anxiety and to increase the capacity for empathy (18). A functional MRI study found a significant correlation between burnout severity and reduction in empathy-related brain activity (19). In this study, reduced empathy-related brain activity was seen in burned out individuals and correlated with higher dispositional empathy scores and emotional dissonance (conflict caused by one’s inability to show empathy despite one’s self-perception as empathic). The authors concluded that an inability to regulate negative emotion may lead prenatally empathic people to dampen their empathic responses in the work setting, which over time might contribute to burnout. MBSR is a promising intervention in that it has been found to increase the activation of brain regions involved in emotion regulation as well as empathy (20). Integrating mindfulness practices into medical training might allow residency programs to cultivate physicians capable of experiencing and displaying empathy without becoming overwhelmed by their emotional responses at work.

CONCLUSIONS
In reference to the above vignette, Dr. B’s predicament is an all too common scenario, demonstrating the converging effects of multiple stressors and too few resources to cope. At one point, high achievement comes easily to most people who are in a position to pursue a career in medicine. Finding a way to succeed is usually the priority rather than finding a way to recover from adversity. Physicians have to juggle multiple expectations and stressors. To a perfectionist like Dr. B, finding herself in a scenario where she fears she has little more of herself to give is a nightmare. This sense that one’s resources have been depleted, that one is no longer herself, coupled with emotional exhaustion, loss of purpose, and loss of self-efficacy, underlie the burnout phenomenon that characterizes the doctor that Dr. B has become. Dr. B is not only struggling to take care of herself, but it is also easy to see how she will ultimately struggle to provide for her patients.

Finding ways to prevent this type of burnout is imperative. Making resiliency building a core part of medical training would help to prevent burnout and provide trainees with the tools they need to cope with stressors throughout their careers. This would also help to promote a culture of mutual openness, understanding, and support that would encourage struggling healthcare providers to accept the help they desperately need.
Dr. Rakesh is a third-year psychiatry resident at Duke University Health System, Durham, N.C.; he is also an Associate Editor for the Residents’ Journal. Dr. Pier is a fourth-year psychiatry resident at the Icahn School of Medicine at Mount Sinai, New York; she is also Editor-in-Chief of the Residents’ Journal. Dr. Costales is Chief Resident, Department of Psychiatry, Icahn School of Medicine at Mount Sinai, New York.

Drs. Pier and Costales thank Dr. Asher Simon, Associate Program Director, Icahn School of Medicine at Mount Sinai, for teaching a positive psychology course during residency, which has been invaluable in helping them to cope with stress and find meaning in their work.

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Writing a Scholarly Article
The American Journal of Psychiatry-Residents’ Journal Workshop
Residents, fellows, and students are invited to attend the 2017 American Journal of Psychiatry Residents’ Journal Workshop, to take place at the American Psychiatric Association Annual Meeting in San Diego.
• Write your first scholarly article in the session.
• Bring your thoughts and ideas about the Residents’ Journal
• Hear a brief presentation about the Journal’s new developments
• Meet with Residents’ Journal editors and editorial staff
• Meet the American Journal of Psychiatry Editor-in-Chief Robert Freedman, M.D.

Tuesday, May 23th, 2017 • 3:30 PM–5:00 PM • Session ID 2313
Room 28B, Upper Level, San Diego Convention Center
ARTICLE

Treating Physicians for Addiction

Aaron Winkler, M.D.

If you are in a workroom with six to seven other doctors, it is statistically probable that one meets criteria for alcohol use disorder, and nearly 1 in 10 of those have thought about suicide in the last year. A recent study of 7,288 physicians asserts that 15.3% of the profession may meet DSM-IV criteria for alcohol abuse or dependence. These practitioners are more likely to experience burnout, screen positive for depression, and have lower quality of life, and 8.8% reported suicidal ideation in the preceding 12 months (1). This is not a new problem. In 1973, the American Medical Association published a seminal report that summarized the central issue of doctors with addiction: A lenient approach to impaired physicians could risk patient safety; a harsh approach, often resulting in financial ruin and public shaming, might frighten practitioners into hiding illness precisely when care was most needed. The report called for action noting that, “Suicide is generally accepted to be one of the major behavioral consequences of mental illness. About 100 physicians commit suicide annually, equivalent to the size of the average medical school graduating class (2).”

AVAILABLE TREATMENT AND CONCERNS

State-based organizations began to form around the 1970s, often being run by physicians with a personal history of successful recovery (3). Today, physicians with substance use disorders are referred to these physician health programs (PHPs) for care. Concerns have been raised that these programs are invasive, coercive, expensive for the participant, and may need organizational oversight (4). Even so, a series of analyses based on an observational study data set that enrolled 904 consecutive PHP participants in 16 states from 1995 to 2001, which followed each participant for 5 years, found exceptional long-term recovery rates compared with other approaches: 78% of participants were without a single positive screen for alcohol or drug use over 5 years compared with 40%–60% relapse rates after just 6 months with standard treatments; 72% were licensed and practicing after 5 years (5, 6). Furthermore, one study of the PHP in Florida revealed that 92.5% of participants would recommend participation to others (7). A state audit of the North Carolina PHP found an organizational structure that might allow malfeasance but noted that none had occurred. A sample of 10% of all participants in North Carolina from 2002 to 2012 revealed that there was “sufficient, appropriate evidence to support referral to a treatment center” in every case (8).

HOW PHPS WORK

PHPs do not provide care; they provide case management. After referral by a loved one, colleague, or employer, physicians undergo assessment. If treatment is indicated, a PHP contract lasting 1–5 years is offered and generally includes “safe harbor” from prosecution or professional consequences pending successful completion. More than 88% run the full 5 years. These contracts usually require total abstinence, and 95% engage participants in 12-step-oriented treatment. Two-thirds of participants start by attending inpatient residential treatment for an average of 72 days. The rest attend intensive outpatient treatment initially. This is followed by close monitoring and 1–4 nights of contractual activities for the first year (e.g., 12-step meetings, case management). Contracts often require consent to contact family and ongoing access to all medical records. There are commonly duty-hour restrictions, unannounced work-site visits, and on-site monitors. On average, 48 random drug screens are collected in year 1, and around 20 are collected in year 5. Consequences for infractions, from refusing to provide a urine sample to being found intoxicated on the job, can result in further evaluation or treatment, a report to the licensing board, or more serious consequences (3). Fundamentally, “safe harbor” allows physicians to seek help without fear, while PHP intensity, invasiveness, and duration protects patients from impaired doctors.

Of all 904 physicians followed in the cohort mentioned above (5), 50% were referred primarily for alcohol use and 35% for opioid use. Thirty-one percent struggled with both drug use and alcohol use. Fourteen percent used intravenous drugs. One was prescribed methadone. Six percent were prescribed naltrexone, and 32% were prescribed an antidepressant for depression or anxiety. Twenty-two percent had one positive screen. Of these, 26% had a second positive screen. A total of 448 completed their contract. Eighty-nine extended their contract voluntarily. A total of 110 extended their contract involuntarily. Sixty-nine transferred to another state. Thirty-three were lost to follow-up after moving. Eighty-five withdrew, often retiring or surrendering their licenses. Forty-eight failed treatment and had their licenses revoked. Twenty-two died; of these deaths, two were substance-related and six were by suicide (6).

HARD TO SCALE

There is an ongoing effort to change the way addiction treatment is defined and measured to align with the PHP model (3, 9). But the length and expense, as well as the motivation inherent in the threat of license revocation, make it hard to
apply this model to other populations. Evaluation can cost $4,500 and residential treatment $45,000 (8). One study attempted 1 year of PHP-style monitoring in a general population and showed moderate benefit, but the program could only be offered to self-pay patients (10). With such high costs, the coercive nature of participation can become a hardship for allied health care professionals and physicians early in training. The Michigan HPRP [Health Professional Recovery Program], which manages care for multiple health care career fields, is being sued in a class action lawsuit brought by three registered nurses and a physician’s assistant because, per the filing document, “failure to ‘voluntarily’ submit to unnecessary and costly HPRP treatment results in automatic summary suspension by the Bureau of Healthcare Services [sic] without a pre-deprivation hearing” [correctly the Bureau of Community and Health Systems] (11).

LATE INTERVENTION

No source included an accounting of how many referred physicians were evaluated and found not to need treatment. The implicit conclusion is that all need treatment. While this raises the concern that conflicts of interest may lead to inappropriate coercion, the findings of the North Carolina audit (8) and the Florida satisfaction study (7) provide clear evidence to the contrary. Another possible conclusion is that physicians are only referred for this kind of evaluation when they have reached such extremity that intensive, long-term treatment and monitoring are always needed. It may be that physicians struggle with how or if to approach the problem of an impaired colleague (12).

CONCLUSIONS

Many physicians are likely to suffer from substance use disorders (1), and JAMA recently published a compelling opinion piece about the problem (13). To allow physicians to access care without fear while also providing for the protection of the public, state-based PHPs coordinate evaluation, case-management, and “safe harbor” from certain consequences pending successful completion of a PHP contract (5). Concerns have been raised (4), but PHPs produce better results than standard treatment (6). In apparent support, the American Medical Association recently released draft legislation to facilitate formal codification of the PHP paradigm (14). Although physicians may certainly seek care on their own, PHPs provide an evidence-based, though intense and possibly invasive, route to rehabilitation and recovery.

Dr. Winkler is a first-year resident in the University of Maryland/Sheppard Pratt Psychiatry Residency Program, Baltimore.

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KEY POINTS/CLINICAL PEARLS

- State-based physician health programs (PHPs) coordinate evaluation for substance use disorders, intensive initial treatment, long-term follow-up, and “safe harbor” from certain consequences contingent on successful contract completion.
- PHPs usually mandate participation in long-term, 12-step-oriented recovery that some believe is expensive, invasive, and coercive.
- PHPs achieve durable recovery far more often than standard care. Seventy-two percent of participants are licensed and practicing after 5 years, and more than 90% would recommend participation to others.
The Winding Road to Training in Child Psychiatry: Considering a New Path

Cordelia Ross, M.D., Philip B. Cawkwell, M.D.

The severe mismatch between demand for child and adolescent psychiatry (CAP) providers and the actual number of practicing clinicians has been well documented (1, 2), with the American Association of Child and Adolescent Psychiatry (AACAP) projecting a shortage of more than 4,000 CAP physicians by 2020 (3). This impending crisis has been examined from a variety of perspectives, including evaluating interest in the field among medical students and residents, early CAP mentorship, and reimbursement rates (4–7). One under-explored factor is a systems-level consideration: whether the current training pathway for child psychiatrists could be optimized.

The conventional pathway a new doctor takes to become a CAP psychiatrist is to complete a 4-year residency in adult psychiatry followed by a 2-year CAP fellowship. Additional options include “fast-tracking” into the CAP fellowship following the third year of the adult psychiatry residency, the triple board residency (a 5-year training program leading to board eligibility in pediatrics, adult psychiatry, and CAP psychiatry), and the 3-year post-pediatric portal program designed for residents who have finished their pediatrics residency training. There are also a small number of programs where medical students can apply for a residency position that guarantees a spot in the programs’ CAP fellowship following completion of their general adult training, as well as programs designed to attract residents interested in CAP research. There is no program that offers a focused and consolidated path tailored specifically for CAP.

It is notable that a psychiatry resident who is interested in CAP often has to wait 2–3 years before beginning any substantial training in child psychiatry. The Current Accreditation Council for Graduate Medical Education requirements only mandate 2 months of CAP exposure during the 3–4 years of general psychiatry training. A 2010 survey found that nearly two-thirds of general psychiatry residents seriously consider CAP as a career (5). And yet only roughly 20–25% of residents apply for fellowships positions in CAP (8). The mismatch between initial demand and final result is staggering.

The absence of a direct pathway for CAP hampers the growth of the field and further perpetuates the workforce crisis. A pathway that included intern-level training in pediatrics, a broad overview of adult psychiatry, but a predominant focus on CAP would be ideal. The importance of self-identification as a child psychiatrist early on in training cannot be overstated. Detractors might say that this design would lack sufficient depth in adult psychiatry. We would point to pediatric neurology, which has had a separate pathway from both neurology and pediatrics for decades. It is worth noting that a direct CAP residency is not a novel proposition; AACAP considered it almost 15 years ago, but cautioned that it would require extensive work to get off the ground (9).

There are at least five different pathways that residents may choose from to become CAP clinicians. Unfortunately, none of them offer direct, focused, and consolidated training. Medicine in the 21st century will be defined by individualization of care. The field of CAP deserves that same individualization: students, residents, and ultimately the children and families we serve will be better for it.

Dr. Ross and Dr. Cawkwell are first-year psychiatry residents at Massachusetts General Hospital and McLean Hospital, Boston.

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Trainees Training Trainees: A Resident’s Perspective on Medical Student Education

Jeffrey D. Reed, D.O.

At the start of every student clerkship a common question residents ask of themselves is, “How can I make this the best experience for my students?” Considering the high standards institutions hold for students and the milestones they are expected to meet, what role does a resident have in providing a well-rounded experience? Residents have a unique opportunity to teach and learn alongside a talented group in the nascent of their career. However, teaching can be challenging, and new residents often ask the question, “I’ve never taught before, what can I offer?” You passed your boards, survived The Match, and graduated medical school. You can teach.

Teaching is an essential part of a resident’s job; however, few have any formal experience. With the daily cost of medical school approaching nearly $166 per day (1), residents want to make students’ experience as meaningful as possible. In 2016, approximately 5% of seniors graduating from an American medical school chose to pursue psychiatry, while 56% sought a primary care residency, including family medicine, internal medicine, obstetrics/gynecology, or pediatrics (2). The majority of medical students we teach will have little training in psychiatry beyond their psychiatric clerkship, yet primary care providers will often be the principal source of mental health treatment (3, 4). Residents are therefore essential in helping to provide students with the psychiatric training needed in their future practice.

A rotation in psychiatry leaves a lasting impression, regardless of a student’s desired specialty, and residents serve as ambassadors to this experience. Some programs have evolved students’ learning through scholarly presentations, reviews (5), and student-run clinics that bolster clinical skills and interest in that specialty (6). An applied approach is to encourage students to present an article during rounds on a topic relevant to their patient. Another is to invite students to interview patients in the resident clinic to expose trainees to long-term care management. Given our relative closeness in age and training, residents can provide a comfortable, nonjudgmental structure for students, a relationship that may be more difficult to foster with faculty. Residents also serve as a valuable resource on subjects such as choosing a specialty, applying to residency, and managing life outside the hospital. It’s important to remember that the students you instruct today will in brief time be teachers and leaders in their own right.

It’s important to remember that the students you instruct today will in brief time be teachers and leaders in their own right.

Dr. Reed is a third-year resident in the Department of Psychiatry at Dartmouth-Hitchcock Medical Center, Lebanon, N.H.

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Do No Harm: The Story of the Epidemic of Physician and Trainee Suicides

Shinnyi Chou, Ph.D.

“There have been physician suicides in our community in recent years too”; my psychiatry department chair surprised me with this statement recently. I had thought that trainees such as myself would be notified of such tragedies, both to mourn the loss of a professional colleague and as a reminder to reflect on our own mental health needs. Perhaps there was a statement that slipped through my inbox, or even a community meeting I missed. Regardless, it is well known that physicians and trainees complete suicides at higher rates than the general population (1), yet only lately has the phenomenon garnered national attention. While medical institutions tout wellness-centric cultures, evidence regarding improvements remains inconsistent (2, 3).

My exploration into this topic led me to Dr. Pamela Wible and Robyn Symon. A family physician, Dr. Wible runs the blog Ideal Medical Care (http://www.idealmedicalcare.org/), publishing stories of unfair treatment during training and of physician and trainee suicides. She believes “we live in a culture of abuse—even the term ‘physician burn out’ blames the victim” (4). Wible is featured in documentarian Robyn Symon’s film Do No Harm. Other stories include that of a medical student who survived a suicide attempt and a parent of a student who completed suicide weeks before graduation. In a statement from Wible, she lamented, “When you talk about wellness but not suicide, you water down what’s going on. I’m on the phone with parents who have lost their kids, and unless you’re on the phone like that you wouldn’t really feel the pain and anger. My passion gets really strong around the fact that this is hidden, because that just means that more people are going to die” (4).

For Symon, her documentary explores the following questions: “Why is the medical culture so toxic?... If it’s an epidemic, I don’t understand why. If it’s Ebola, it would have been quarantined and dealt with immediately for public safety... When a physician jumps off a building it should be a national investigation” (5). It balances emotional anecdotes with rational arguments, featuring experts who study physician sleep deprivation and policy leaders such as Dr. Tom Nasca of the Accreditation Council for Graduate Medical Education, who concurred with the subject’s gravity. Symon hopes the film “achieves a compassion between doctors and patients.... Millennials patients are used to getting what they want, and if they don’t get good service it’s all over social media and doctors really suffer” (5). She is doing her part in promoting change, offering a VIP screening for the Association of American Medical Colleges. “I’ve been really happy and proud of how many courageous people have come out and tell their stories” (5), she says.

In an era when the complexity of wellness, duty hours, and physician competency are all under intense scrutiny, we are reassured by the constancy of imperfection. As a trainee who has long idealized this profession for its honorable intentions and worthwhile pursuits, I am inspired by those who value improving the system and the lives of the great men and women we call doctors.


Dr. Chou is a fourth-year medical student in the College of Medicine, University of Nebraska Medical Center, Omaha, Neb.

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BOOK FORUM

Being There: Medical Student Morgue Volunteers Following 9-11

Anita Kumar Chang, D.O.

They say a picture is worth a thousand words. In Being There: Medical Student Morgue Volunteers Following 9-11, Dr. Barry Goldstein provides powerful evidence of this. As a visiting professor at New York University Medical School, Dr. Goldstein, physician and photographer, used his insight and skills to record the stories of 16 medical students who volunteered at the morgue immediately following the attacks on September 11, 2001. His photographs and interviews were done 9 months after the events but still convey the depth of impact that this service had on these young medical professionals.

The book provides glimpses of these students’ lives, experiences, and coping mechanisms. Dr. Goldstein photographed them in the scrubs they wore while working at the morgue, with items or people that helped them deal with the strains of the work.

The first theme that arises is the sense of helplessness experienced after the attacks that drove many of the students to find a way to help at the morgue, which had expanded into the street using tents to deal with the sheer volume of work that needed to be done to identify the victims.

The DSM-5 expanded criterion A for posttraumatic stress disorder (PTSD) to include “experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains)” (1). Herein, we find the second theme, finding that many of the students describe not just this type of exposure but symptoms of PTSD, namely nightmares and intrusive images and thoughts related to their work. This is not to say one can diagnose them based on their narrative in the book, but it does show how providing forensics medical services had a lasting impact on these students.

Finally, the way the students found ways to cope with what they were going through gives a glimpse into the other side of the traumatic experience. One student talks about his “rehumanization” through writing (pp. 58–59). This points to the experience of removing oneself from a traumatic situation in order to get through it, a process described by several of the students. How then does one get back in touch with oneself? Each found their own way of processing: talking to friends and family, interpreting their experience through faith, just crying in the days and weeks that followed not just the attacks, but in the months some spent working in the morgue.

As the attacks of September 11, 2001, become part of history, this book reminds us of the humanity of it. A profound and reflective collection of stories and photographs, the one drawback of this book is the abrupt ending. It left this reader with feelings of shock and sadness, appropriate, yet unfulfilling. The last interview ends with a discussion of a loss of faith and conveys a sense of hopelessness. After skillfully weaving in the complex narratives and photographs to recreate a perspective of the fallout from the 9/11 attacks, Dr. Goldstein leaves us questioning what to believe in the face of what happened.

Dr. Chang is a fourth-year resident at Wayne State University/Detroit Medical Center, Detroit.

REFERENCE

Residents’ Resources

Here we highlight upcoming national opportunities for medical students and trainees to be recognized for their hard work, dedication, and scholarship.

*To contribute to the Residents’ Resources feature, contact Oliver Glass, M.D., Deputy Editor (glassol@ecu.edu).

APRIL DEADLINES

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<td>NIMH Outstanding Resident Award Program (ORAP)</td>
<td>This award recognizes residents with outstanding research and academic potential who are currently at the PGY-2 level. Award includes framed certificate, invitation to visit the NIH campus for a 2-day award program, and opportunity to present a poster about their own research.</td>
<td>Joyce Chung, M.D. (E-mail: <a href="mailto:chungj@mail.nih.gov">chungj@mail.nih.gov</a>, Phone: 301-443-8466, <a href="https://www.nimh.nih.gov/labs-at-nimh/scientific-director/office-of-fellowship-and-training/outstanding-resident-award-program/index.shtml">https://www.nimh.nih.gov/labs-at-nimh/scientific-director/office-of-fellowship-and-training/outstanding-resident-award-program/index.shtml</a>)</td>
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<tr>
<td>American College of Neuro-Psychopharmacology (ACNP) Travel Award</td>
<td>This travel award offers an opportunity to attend a scientific program in clinical and basic research on brain-behavior-drug interactions and to interact with internationally distinguished researchers and scientists. In addition to travel funds, benefits include an ACNP mentor, opportunity to present a poster, and invitation to attend additional ACNP annual meetings.</td>
<td>Erin Colladay (E-mail: <a href="mailto:ecolladay@acnp.org">ecolladay@acnp.org</a>, <a href="https://www.acnp.org/annualmeeting/travelawards.aspx">https://www.acnp.org/annualmeeting/travelawards.aspx</a>)</td>
</tr>
<tr>
<td>ACNP Deadline: April 28, 2017</td>
<td>Medical students and psychiatry residents. Applicants may be no more than 5 years post training.</td>
<td></td>
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</table>

JUNE DEADLINES

<table>
<thead>
<tr>
<th>Fellowship/Award, Organization, and Deadline</th>
<th>Brief Description and Eligibility</th>
<th>Contact and Website</th>
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<tr>
<td>American Academy of Child and Adolescent Psychiatry (AACAP) Educational Outreach Program (EOP) for General Psychiatry Residents</td>
<td>The EOP provides the opportunity for general psychiatry residents to receive a formal overview to the field of child and adolescent psychiatry, establish child and adolescent psychiatrists as mentors, and experience the AACAP Annual Meeting in Washington, DC, October 23–October 28, 2017.</td>
<td>AACAP Assistant Director of Training and Education (E-mail: <a href="mailto:training@aacap.org">training@aacap.org</a>, Phone: 202-587-9663, <a href="https://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Educational_Outreach_Program_for_General_Psychiatry_Residents.aspx">https://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Educational_Outreach_Program_for_General_Psychiatry_Residents.aspx</a>)</td>
</tr>
<tr>
<td>AACAP Deadline: June 30, 2017</td>
<td>General psychiatry residents who are AACAP members or have pending AACAP membership.</td>
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<tr>
<td>AACAP Educational Outreach Program for Child and Adolescent Psychiatry (CAP) Residents</td>
<td>The EOP provides the opportunity for child and adolescent psychiatry residents to receive a formal overview to the field of child and adolescent psychiatry, establish child and adolescent psychiatrists as mentors, and experience the AACAP Annual Meeting in Washington, DC, October 23–October 28, 2017.</td>
<td>AACAP Assistant Director of Training and Education (E-mail: <a href="mailto:training@aacap.org">training@aacap.org</a>, Phone: 202-587-9663, <a href="http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Educational_Outreach_Program_for_CAP_Residents.aspx">http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Educational_Outreach_Program_for_CAP_Residents.aspx</a>)</td>
</tr>
<tr>
<td>CAP Deadline: June 30, 2017</td>
<td>Child and adolescent psychiatry fellows who are AACAP members or have pending AACAP membership.</td>
<td></td>
</tr>
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Author Information for The Residents’ Journal Submissions

Editor-in-Chief
Katherine Pier, M.D.
(Icahn School of Medicine)

Senior Deputy Editor
Rachel Katz, M.D.
(Yale)

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(East Carolina)

The Residents’ Journal accepts manuscripts authored by medical students, resident physicians, and fellows; attending physicians and other members of faculty cannot be included as authors.

To submit a manuscript, please visit http://mc.manuscriptcentral.com/appiajp, and select a manuscript type for AJP Residents’ Journal.

1. Commentary: Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.

2. History of Psychiatry: Provides a historical perspective on a topic relevant to psychiatry. Limited to 500 words and five references.

3. Treatment in Psychiatry: This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2–4 multiple choice questions based on the article’s content. Limited to 1,500 words, 15 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

4. Clinical Case Conference: A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

5. Original Research: Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

6. Review Article: A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

7. Drug Review: A review of a pharmacological agent that highlights mechanism of action, efficacy, side-effects and drug-interactions. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

8. Perspectives in Global Mental Health: This article type should begin with a representative case or study on psychiatric health delivery internationally, rooted in scholarly projects that involve travel outside of the United States; a discussion of clinical issues and future directions for research or scholarly work should follow. Limited to 1,500 words and 20 references.

9. Arts and Culture: Creative, nonfiction pieces that represent the introspections of authors generally informed by a patient encounter, an unexpected cause of personal reflection and/or growth, or elements of personal experience in relation to one’s culture that are relevant to the field of psychiatry. Limited to 500 words.

10. Letters to the Editor: Limited to 250 words (including 3 references) and three authors. Comments on articles published in the Residents’ Journal will be considered for publication if received within 1 month of publication of the original article.

11. Book and Movie Forum: Book and movie reviews with a focus on their relevance to the field of psychiatry. Limited to 500 words and 3 references.

Upcoming Themes

If you have a submission related to the themes shown at right, contact the Section Editor listed below the topic. Please note that we will consider articles outside of the theme.

War, Terror, and Psychopathology
Anna Kim, M.D., anna.kim@mountsinai.org

If you are interested in serving as a Guest Section Editor for the Residents’ Journal, please send your CV, and include your ideas for topics, to Rachel Katz, M.D., Senior Deputy Editor (rachel.katz@yale.edu).