Chapter 42

MILITARY PSYCHIATRY GRADUATE MEDICAL EDUCATION

CARROLL J. DIEBOLD, MD*; WENDI M. WAITS, MD†; MILLARD D. BROWN, MD‡; AND DAVID M. BENEDEK, MD§

*Colonel, Medical Corps, US Army; Chief, Department of Psychiatry, Tripler Army Medical Center, 1 Jarrett White Road, Honolulu, Hawaii 96859-5001

†Lieutenant Colonel, Medical Corps, US Army; Chief, Inpatient Psychiatry Service, Department of Psychiatry, Tripler Army Medical Center, 1 Jarrett White Road, Honolulu, Hawaii 96859-5001; formerly, Child and Adolescent Psychiatry Fellow, Tripler Army Medical Center, Honolulu, Hawaii

‡Major, Medical Corps, US Army; Psychiatry Residency Director, Tripler Army Medical Center, 1 Jarrett White Road, Honolulu, Hawaii 96859-5001

§Colonel, Medical Corps, US Army; Professor and Deputy Chair, Department of Psychiatry, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, Maryland 20814

INTRODUCTION

Graduate medical education (GME) is an essential aspect of military medicine. To maintain a healthy and productive operational force primed for success in varied environments and scenarios, medical personnel must possess adequate training and experience to provide appropriate and timely healthcare to service members. The unique skills required for a military healthcare provider to thrive in both operational and garrison environments necessitate comprehensive training and education. General lessons learned from past conflicts revealed that healthcare providers acquired knowledge and experience treating casualties on the battlefield rather than relying on training received from civilian medical institutions. From the advent of military GME in the early 20th century, the primary mission has been to prepare medical personnel to function in all types of operations.

As military graduate medical education evolved, military-specific proficiencies were introduced early in the training process. Before beginning the first year of GME, most trainees complete the Basic Officer Leadership Course, in which rudimentary knowledge such as extending military courtesies, proper wear of the uniform, elementary leadership skills, and basic soldier proficiencies are taught.[1] Students who do not have the opportunity to complete the basic course prior to entering GME will complete this training shortly after graduation. Consistent with training given to all assigned soldiers, a military treatment facility (MTF) with a GME program may require trainees to participate in annual common task training to maintain proficiency in basic military skills such as nuclear, biological, chemical response; weapons familiarization and maintenance; and military communication procedures.

Psychiatry is the medical specialty with the greatest number of military-unique tasks. Like a civilian psychiatrist practicing in a public institutional setting such as a prison or forensic healthcare facility, the military psychiatrist is consistently confronted with dual-agency issues, necessitating consideration of the needs of the organization versus those of the patient.[2] However, unlike civilian behavioral healthcare providers, who can decide their degree of involvement in forensic and administrative psychiatric issues, military psychiatrists do not have a choice in participating in such cases, thereby requiring extensive training in military-unique behavioral health topics such as command-directed mental health evaluations, Rule for Courts-Martial 706 evaluations, security clearance assessments, and medical evaluation boards.[3–6] Each of these military-unique administrative evaluations requires specific training and experience to perform competently. In addition to unique administrative tasks, the military psychiatrist must develop diverse skills such as consulting with commands, briefing nonmedical military leaders, providing psychoeducation to soldiers and leaders, and constructing realistic treatment plans while taking into account a service member's duties.

This chapter will present the evolution of psychiatry GME in the military healthcare system from its origins in the early 20th century to the current process of training military psychiatrists. The US Army, Navy, and Air Force all participate in psychiatry GME, maintaining a pipeline of well-trained graduates who are frequently deployed to combat zones shortly after completion of training. Training programs vary in size and structure, including service-specific programs, programs sponsored by one service that accept trainees from other services, partnerships with civilian and Veterans Administration programs, and a joint service program in Washington, DC. All programs are accredited by the American Council of Graduate Medical Education (ACGME), fulfilling the same academic requirements observed by civilian programs, in addition to providing education in unique military psychiatric skills.[7] In addition to residency training in adult psychiatry, military psychiatry GME programs can offer subspecialty fellowship training in child and adolescent, forensic, addiction, and geriatric psychiatry.

Areas addressed in the chapter will include leadership of a GME program, role of the program director, faculty development and recruitment, curriculum, contribution of undergraduate medical education to psychiatry GME, and research opportunities within training programs. The relevance of military psychiatric training will be presented, in addition to recommendations on how this unique specialty education can be enhanced in the future.

HISTORY

Formal psychiatric GME in the US military is a relatively new entity, the development of which has mirrored civilian psychiatric training in the United States in many ways. In other ways, however, it has developed independently, establishing a unique legacy and creating for its alumni a broader clinical skill set than that acquired by most graduates of civilian training programs. Colonel (Retired) Michael

G Wise authored an excellent summary of military GME through the mid 1980s, the highlights of which are summarized below.[8]

The first psychiatric "residents" in the Department of Defense (DoD) appear to have been four servicemen—two from the Navy and two from the Army—assigned to work at Saint Elizabeths Hospital in Washington, DC, for a period of 2 years beginning in 1909[9] (the same year that Sigmund Freud first lectured at an American university, introducing the psychoanalytic movement to the United States and increasing American interest in psychiatry[10]). At the beginning of World War I, psychiatrists in the Army numbered only 50,[11] an amount drastically insufficient to treat the 4 million US soldiers who would eventually serve in the war.[12] In an effort to address this issue, the Army commissioned many psychiatrists from state hospitals, and nonpsychiatric Army physicians were enrolled in civilian neuropsychiatric training programs that lasted an average of 6 weeks.[11] By the time of the 1918 armistice, nearly 700 psychiatrists were serving in the Army.[11]

Following World War I, psychiatrists gradually left the military, to such an extent that by 1940 uniformed psychiatrists on active duty numbered less than 100.[13,14] One year after the attack on Pearl Harbor, an improved and standardized neuropsychiatry course for nonpsychiatric military physicians was established and offered at a handful of civilian institutions.[14] During the remainder of World War II, this 12-week course produced 1,300 graduates, referred to as "90-day wonders."[15]

In 1946, Congress passed the National Mental Health Act, which provided federal funds for a number of mental health initiatives, including training for mental health professionals.[10] Over the course of the next decade, eight military psychiatry residency programs opened and received accreditation from ACGME (Table 42-1).[8] The "90-day wonder" program remained active at Fort Sam Houston, Texas, from 1946 to 1950, while physicians in the new psychiatric residencies completed their training.[16]

The field of psychiatry was also gaining a foothold in the civilian sector. During this same decade, the first Institute on Psychiatric Services meeting was held, the *Psychiatric Services* journal was established, the American Psychiatric Association authorized the creation of district branches, the first meeting of the American Psychiatric Association Assembly was held, the first *Diagnostic and Statistical Manual of Mental Disorders* was published, and psychoactive drugs were introduced in the United States.[9]

Perhaps as a result of psychotropic medications being introduced and the subsequent decreased number of psychiatric hospital admissions, three of the US military's first psychiatric residencies closed shortly after opening: the Navy's Great Lakes, Illinois, program in 1948; the Navy's San Diego, California, program in 1954; and the Army's Fitzsimons, Colorado, program in 1958.[8] However, the remainder of the programs stayed open for many years (Figure 42-1).

TABLE 42-1

AMERICAN COUNCIL OF GRADUATE MEDICAL EDUCATION ACCREDITATION HISTORY OF US MILITARY PSYCHIATRY RESIDENCIES

Year	Programs Accredited or Discontinued
1946	Bethesda (Md), Great Lakes (Ill), and Philadelphia (Penn) Navy programs accredited
1948	Walter Reed (Washington, DC) and Letterman (Calif) Army programs accredited; Great Lakes program discontinued
1950	Fitzsimons (Colo) Army program accredited
1951	San Diego (Calif) and Oakland (Calif) Navy programs accredited
1954	San Diego program discontinued
1958	Fitzsimons program discontinued
1965	Wilford Hall (Tex) Air Force program accredited
1976	Dwight D Eisenhower (Ga) Army program accredited; Philadelphia program moved to Portsmouth (Va) and accreditation continued
1977	Wright-Patterson (Ohio) Air Force program accredited
1978	Tripler (Hawaii) Army program accredited
1981	San Diego program reaccredited
1983	Oakland program discontinued
1993	Letterman program discontinued
1999	Dwight D Eisenhower program discontinued

Data source (through 1987): Wise MG. The past, present, and future of psychiatric training in the US armed services. *Mil Med*.1987;152:550–553.

During the 1980s, as memories of the Vietnam War were fading and a Cold War conflict seemed increasingly less likely to materialize, pressure from the federal government to consolidate US military installations increased.[17] After a preliminary round of DoD-initiated closures in 1988, Congress passed the US Department of Defense Base Realignment and Closure Act of 1990 (also known as the "BRAC law" or Public Law 101-510),[18] which established a non-DoD committee and a schedule for the evaluation of military bases for closure. As a result of this legislation, additional BRAC rounds occurred in 1991, 1993, and 1995.

Closure of military psychiatry residency programs took varied paths. The Presidio in San Francisco, California, home of Letterman Army Medical Center,

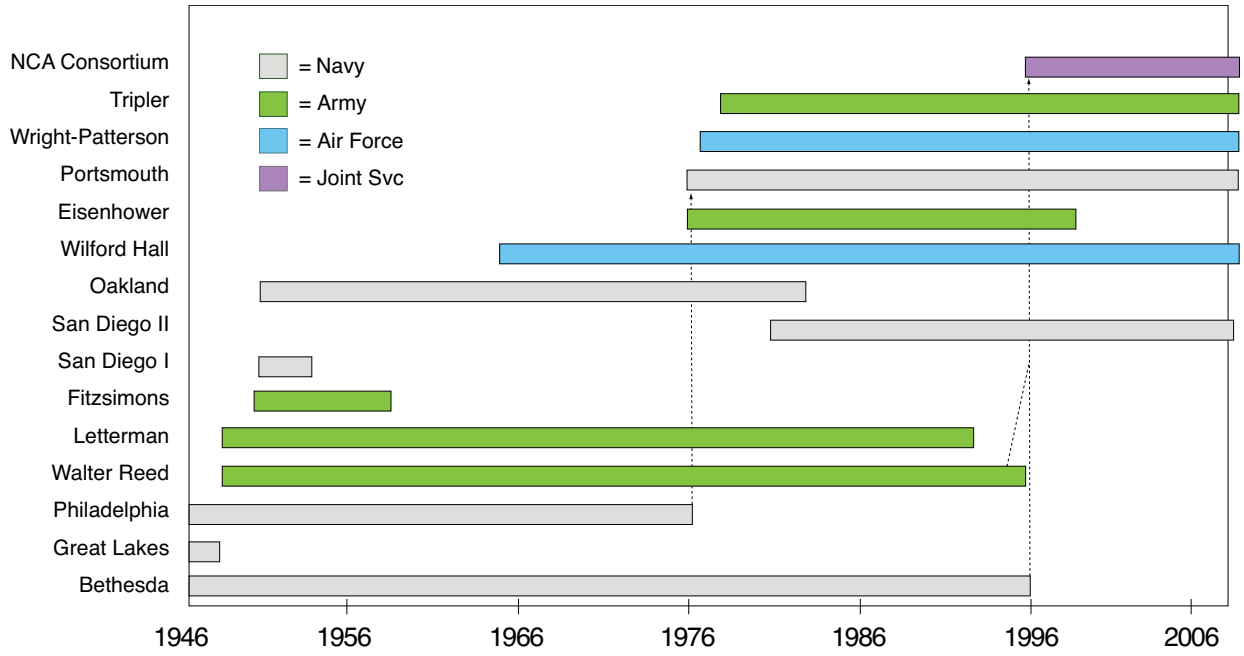

Figure 42-1. A graphic timeline of accredited US military psychiatry programs. The dotted lines represent when programs were either transferred to another location or merged.
NCA: National Capital Area; Svc: Service

was identified for closure in 1988.[19] Its final cohort of psychiatry residents graduated in 1993, and the hospital closed 1 year later.[20] The training program at Eisenhower Army Medical Center in Augusta, Georgia, although not an official casualty of the BRAC, was closed preemptively by the Army in 1999 because of a dwindling pool of applicants.[21] Similarly, although Oak Knoll Naval Hospital in Oakland, California, was not identified for closure until the 1993 BRAC, the Navy had already relocated the psychiatry training program from Oakland to San Diego in the mid-1980s.

In 1995, in an effort to fortify their programs against the threat of closure, the three DoD hospitals in the national capital area—Walter Reed Army Medical Center in Washington, DC; the National Naval Medical Center in Bethesda, Maryland; and Malcolm Grow Air Force Hospital in Prince George's County, Maryland—combined forces, creating the National Capital Area Consortium. Affiliated with the Uniformed Services University of the Health Sciences (USUHS), in Bethesda, Maryland, the consortium program is currently the largest active military psychiatry training program.

A new BRAC initiative in 2005 has called for the closure of Walter Reed by 2011,[22] but the consortium psychiatry residency program is expected to remain intact and headquartered at what is currently the National Naval Medical Center. The 2005 BRAC initiative also called for the consolidation of Wilford Hall Air Force Medical Center with Brooke Army Medical Center in San Antonio, Texas. By 2011, only a San Antonio Military Medical Center is expected to exist, with the north campus (Brooke) being primarily an inpatient facility and the south campus (Wilford Hall) having only outpatient services.[23] As in Washington, DC, the Air Force psychiatry residency program in San Antonio is expected to remain intact.

The global war on terror (GWOT) has contributed to an increase in behavioral health problems among active duty personnel and their families, as well as among veterans and civilians in the United States. Interest in psychiatry as a career field also appears to be on the rise, perhaps as a direct result of this GWOT-influenced increased demand.[24] The future of military psychiatry GME will likely continue to parallel the need for services during times of war, as has been the case for the past century.

PROGRAM LEADERSHIP

The military stresses competent leadership as an essential factor in successful completion of the mission. Much of an officer's military education is composed of development and utilization of proper leadership techniques.[25] Although the majority of military medical officers will never serve in command positions,

many will become service, section, or department chiefs, directly responsible for delivering high-quality medical care in addition to promoting the professional development of subordinates. A fortunate few will be appointed to lead GME programs, taking on the responsibility of training future military clinicians to excel in varied environments.

The department chairperson performs diverse roles in a military psychiatry GME program. Besides the requirements established by ACGME, the chairperson must also meet the standards expected of a military leader.[7] Essential attributes include articulating a clear vision, prioritizing the mission, managing personnel, and overseeing the budget, all while supporting the goals of the MTF commander. As the military healthcare system evolves into a managed care model emphasizing clinical productivity as a measurement of fiscal success, GME leaders are challenged with demonstrating financial success while maintaining a quality training program. GME-related activities such as clinical supervision, didactics, trainee performance assessments, medical education committees, psychiatric clinical report reviews, and research-related activities do not produce workload credit, resulting in a lower productivity standing compared with other MTFs that do not have GME programs.

Success of a military psychiatry program is predicated on the department leadership being able to incorporate GME into four essential tasks: (1) direct patient care delivery, (2) deployment cycle support, (3) operational readiness of personnel, and (4) research activities. Until the mid-1990s, military psychiatry GME programs were relatively insulated from external influences such as managed care and operational taskings. Programs readily focused on psychiatric education, utilizing direct patient care, clinical supervision, didactics, and research, augmented by a military psychiatry curriculum, to prepare trainees for success as clinicians in an MTF practice or as a garrison-based division psychiatrist. GME leaders were not pressured by the requirement to formulate intricate business plans to predict and subsequently demonstrate clinical productivity. Specific military psychiatric curriculum consisted of several didactic courses and focused on familiarization with basic military organization structure and function, dual-agency issues, performing military-unique administrative mental health evaluations, interacting with operational leadership, and operational military mental health doctrine, much of which was from the Vietnam era and in the process of being updated. The operational experience for trainees was limited to a rotation during the final year of residency to a post with a large troop population, and in many instances such rotations lacked formal structure or stated goals and objectives.

As the evolution of managed care within the military healthcare system of the late 1990s coincided with the changes in defense strategy after September 11, 2001, conducting military GME became much more complex and challenging. Leaders of GME programs wer no longer able to dedicate resources exclusively to the training mission but were forced to balance multiple requirements while devising methods to maximize the learning experience of trainees. GME programs became directly affected by the GWOT through deployment of faculty and taskings to participate in deployment cycle support at locations serving as deployment platforms. Advantageously, trainees were given the opportunity to participate directly in many deployment cycle support activities, as well as to provide treatment for casualties evacuated from the theater of operations. A challenge for the GME leadership was to ensure that adequate supervision and training occurred during the provision of such services.[26]

With the extended GWOT-related campaigns of Operation Iraqi Freedom and Operation Enduring Freedom in the first decade of the 21st century, most graduates from Army psychiatry GME programs deployed to a combat zone within 2 years of completing training, requiring the programs to provide comprehensive instruction and practical experience in operational psychiatry. Faculty at the two Army GME programs became part of the psychiatry deployment pool and served in diverse assignments throughout both theaters of operations, directly enhancing the quality of the operational psychiatry curriculum. Prior deployment experience became a determining factor for prospective faculty, and by the end of 2006, over 75% of the active duty staff psychiatrists at the two Army psychiatry programs had deployed to a combat theater.[27]

Role of the Program Director

A residency program's existence and viability critically depends on a program director who is fully engaged and active in the program's daily activities. In the field of psychiatry, such active participation is even more paramount in running a successful residency program. The field of psychiatry requires that residency graduates not only be skilled in diagnostic assessments and treatment modalities, but that they also be capable of engaging patients and systems to construct realistic individualized treatment plans. Such capabilities can be utilized effectively only if the psychiatrists are fully aware and in control of their own personal mental health. Therefore, a quality psychiatry residency program encourages trainees to develop an

awareness of how their own histories can potentially affect their ability to engage patients in clinical service delivery and program faculty in their educational pursuits. The psychiatry residency program director must therefore possess skills as an effective parent, colleague, arbitrator, visionary, and leader when interacting with residents and faculty.

When groups are formed in which some have power and control over other members, acting out behaviors will inevitably follow. In a residency program, the program director must anticipate these behaviors and develop methods of preventing them when possible, in addition to maintaining proper boundaries when challenged. The faculty and program director are expected to avoid leveraging their power differential while guiding the trainees through a process of personal growth and learning. The program director must learn to respond appropriately to acting out behaviors with the requisite amount of action, while redirecting residents with such behaviors toward more constructive use of their energies.

Psychiatry residency training evolves along a developmental continuum. The beginning section usually involves encouraging residents to apply newly learned knowledge in patient care and to develop clinical instincts in evaluation and treatment procedures. During the middle phase, the program director helps residents consolidate basic skills and begin developing more advanced skills in therapeutics through treatment of challenging and treatment-resistant cases. Finally, during the end stage of training, the program director develops situations for the resident to become a leader of junior colleagues and begin taking on independent responsibilities as a credentialed provider.

The visionary program director must be aware of the future of psychiatry as an evolving medical specialty while remaining cognizant of how the military plans to address its future behavioral health challenges. The latter requires the program director to maintain connections with military behavioral health leaders so the needs of the military system can quickly be built into the training of future military psychiatrists. These changing needs force the program director to continually refine the vision and mission of the program, articulating these refinements clearly and concisely to the faculty and residents. Program directors must also stay current with the latest developments and research in psychiatry, which is rapidly developing from a field of general syndromes to a complex specialty containing significant advances in neuroscience and therapeutics.

Leaders of organizations are tasked with many responsibilities that can quickly become overwhelming and burdensome, and those whom they lead look to them for mentorship and guidance. Leaders' behaviors set the tone for the entire organization and are naturally scrutinized by subordinates. Program directors must therefore be aware of the significance an action can have across the residency training program. The fundamental operating principles of a residency must be repeatedly articulated so that residents and faculty can understand the rationale and potential outcomes of certain decisions. Faculty and trainees may not agree with a decision, but they need to be made aware of how decisions are consistent with the stated principles of the program. With so many ongoing issues to incorporate into a residency program, the program director must balance being open to feedback at all levels with making decisive and timely decisions to keep the program current with psychiatry as a specialty and also with the needs of the military.

Faculty Development

In addition to capable GME leadership, recruitment and selection of appropriate faculty is a critical element to program success. Besides uniformed clinicians, the teaching staff is composed of civilian faculty employed by the federal government, clinicians on personal service contracts, and possibly faculty members from local civilian psychiatry GME programs.

As with any enterprise, the recruitment and retention of bright, experienced, and energetic supervisors directly affects program success. A psychiatry GME faculty member should possess the inner drive for personal growth, passion to promote learning in trainees, and professional experience to provide capable supervision and guidance.[7] The composition of a military psychiatry GME faculty should be a mix of established clinicians with significant experience in academic settings and midcareer psychiatrists with an interest in further development of teaching and mentoring skills. In many instances, the more professionally mature members of the faculty are retired military clinicians who possess a wealth of practical military psychiatric experience.

Retention of military physicians beyond completion of initial active duty service obligation has been a challenge since the conclusion of Operation Desert Storm. The potential of prolonged operational deployments combined with dwindling resources and the evolution of managed care within the military healthcare system has produced a less attractive environment for prolonged service. However, one extremely favorable aspect of military medicine is the wide scope of career tracks available.[28] Within several tours of duty post-training, active duty psychiatrists are in a position to mold their careers in a single area, such as a clinical,

operational, command, academic, or research-based concentration, with the flexibility to shift between these tracks. For the academically oriented military psychiatrist, the potential to become faculty at one of the military GME programs is a tremendous incentive to continue practicing medicine on active duty.

Potential faculty members are identified throughout the entire career path of the military psychiatrist. Occasionally, an outstanding trainee demonstrating a talent for academic psychiatry may be recruited to remain on staff as a junior faculty member while further refining teaching and mentoring skills under the guidance of senior faculty. More likely, promising graduates with an interest in teaching and academics will serve at least one tour as an MTF or operationally based psychiatrist to gain practical clinical and administrative experience as an independent healthcare provider. Another group consists of clinicians who initially were not recognized as future faculty members, but through a combination of experience, reassessment of career aspirations, and possibly attaining specialized skills such as forensic or addictions psychiatry training, may be deemed faculty material at midcareer or later.

No codified requisite criteria exists for consideration for faculty appointment to a military psychiatry GME program, but the candidate should demonstrate superior clinical, leadership, management, scholarship, and military skills with an underlying passion to develop future military psychiatrists. A search committee composed of current faculty members should be formed to identify and interview candidates. One method to screen potential faculty is using ACGME competencies to predict a resident's level of performance as an independent practitioner.[7] The potential faculty member should markedly exceed the baseline standard for each of the competency areas, with focus on the ability to provide mentorship and guidance (Exhibit 42-1). Additional data to be assessed are performance during GME training, scope of assignments post-GME, input from supervisors and colleagues, and unique skills to enhance the training program.

Recruitment of a dedicated and multitalented faculty is essential for the success of a military psychiatry training program. The increased frequency of operational deployments since September 11, 2001, has necessitated frequent shifting and restructuring of faculty duties. To provide future military psychiatrists with the necessary skills to thrive in multiple complex environments, the GME faculty must be dedicated to the mission of being teachers, mentors, and role models.

EXHIBIT 42-1

AMERICAN COUNCIL OF GRADUATE MEDICAL EDUCATION COMPETENCIES

1. Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
2. Medical knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care.
3. Practice-based learning and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care.
4. Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals.
5. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds.
6. Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of healthcare, as well as the ability to call effectively on other resources in the system to provide optimal healthcare.

Data source: Accreditation Counsel for Graduate Medical Education. Psychiatry program requirements. ACGME Web site. Available at: http://www.acgme.org/acWebsite/RRC_400/400_prIndex.asp. Accessed October 28, 2009.

CURRICULUM

During the last 2 decades, the establishment of the core competencies and the psychotherapy competencies as the basic evaluation tools has brought significant changes to psychiatry GME. Training requirements are gradually shifting to an outpatient-centered treatment model as the inpatient rotation standard has been steadily reduced. Specific didactic requirements have also been expanded with the evolution of psychiatric subspecialties such as forensic, geriatric, and psychosomatic medicine, as well as with advancements in psychopharmacology. Training programs must also provide residents with adequate exposure to the challenges of managed care, because most psychiatrists-in-training will not have a practice

composed exclusively of direct-payment patients. In addition to the elements unique to psychiatry training, military programs have unique training requirements pertinent to the diverse role of the uniformed psychiatrist.

Core Competencies

The core competency movement within ACGME began with the "outcomes movement" by the US Department of Education in the 1980s and accelerated in Canada in 1996 through the publishing of the Canadian Medical Education Directions for Specialists (CanMEDS) 2000 Project report.[29] This movement grew out of a recognition that the role of the physician has changed from a paternalistic medical expert model to a model in which the medical expert is part of a medical decision-making team that includes the patient. Also, the rapid pace of advancement of medical knowledge has repeatedly emphasized the need for physicians to be avid life-long learners and for residency training programs to teach new physicians how to develop life-long learning skills. In response to the change in the mechanism of healthcare delivery, ACGME and the American Board of Medical Specialties launched the core competencies program for all American residencies in 1999.[30] In 2001, the psychiatry residency review committee (RRC) became the first RRC to change its official program requirements. The following year, site reviewers began assessing whether or not programs had begun to implement the core competencies. Similar to the overall emphasis in healthcare on the ability to assess quality in medicine by such certifying organizations as the Joint Commission, ACGME mandated outcome measures to assess competency in the core areas.[31]

The core competencies consist of six main elements: (1) medical knowledge, (2) patient care, (3) interpersonal and communication skills, (4) practice-based learning and improvement, (5) professionalism, and (6) systems-based practice.[7] Medical knowledge and patient care emphasize the traditional elements of physician medical education over the past century. Medical school and clinical experiences in residency form the foundation of medical knowledge that physicians use to perform competent, safe patient care. The patient care competency focuses on interactions with patients, including the psychiatry-specific psychotherapy core competencies. Interpersonal and communication skills have become increasingly more important as fully informed consent and a focus on patient choice have steadily increased throughout the past 60 years, since the passage of the Nuremburg Code in 1947.[32] Practice-based learning and improvement emphasizes the ability to understand and grow from clinical experiences in addition to keeping current on recent advances. The goal is to instill such abilities during training so that practitioners continue the process throughout their entire medical careers.

Professionalism is an essential aspect of any occupation, encompassing the requisite skills and sense of commitment needed to function in a competent and safe manner. No amount of medical expertise can overcome the requirement for strict standards of behavior that define professionalism and serve as the backbone for a strong physician-patient relationship. In addition to acting professionally with patients and healthcare colleagues, the military clinician has an additional obligation to maintain the high standards of a military officer.[33] Finally, advances in medical practice have resulted in effective management and control of many chronic illnesses in the outpatient setting, which in turn has created a need for increasing collaboration with many different organizations to maximize the well-being of patients. The systems-based training competency emphasizes this ability to operate within systems of care, in coordination with many types of healthcare professionals, thereby maximizing quality of life for patients. By training within a systems-based environment, the military psychiatry resident gains an appreciation for the importance of utilizing primary, secondary, and tertiary prevention.[34]

Implied in the competency model is the idea that length of time in training alone is insufficient to establish competence. Rather, a consistent ability to use a specific set of knowledge, skills, and attitudes must be demonstrated by the trainee prior to clearance for graduation. Further development will produce a longitudinal assessment tool for competence as opposed to completion of a set of timed requirements. However, little evidence exists on what outcome measures can reliably assess the psychiatric core competencies. Currently, many programs use some form of standardized assessment tool in conjunction with subjective input from multiple sources such as supervisors, instructors, and mentors to assess overall competency of trainees.[35]

Medical Students and Core Competencies

The core competencies of interpersonal and communication skills, professionalism, and systems-based practice in particular require trainees to demonstrate the ability to interact effectively with persons other than patients. Because they are so crucial to successful medical practice, development of these competencies begins very early in the medical education process. At the heart of these competencies is the theme of working

cooperatively within multidisciplinary teams of other medical professionals in a manner that synergizes efforts to provide the best care for patients. With nurses, occupational therapists, medical technicians, and administrative staff, medical students are often members of these multidisciplinary teams.

At USUHS, the only US federal medical school and the principle source of future military physicians, military medical students are introduced to the concepts of team learning, practice, and interpersonal communication through a variety of small-group laboratory exercises based on clinical vignettes. Students also participate in Introduction to Clinical Medicine small-group courses, where they learn and practice medical interviewing and physical examination skills with patients from the treatment facilities in the national capital area.

Psychiatry residents from the National Capital Consortium's psychiatry GME training program are actively recruited and encouraged to participate as co-instructors with full-time university faculty members in these exercises and courses. In this manner, residents are afforded opportunities to demonstrate their medical knowledge, to discuss principles of systems-based medicine, and to role model professional relationships with junior medical officer students and senior co-faculty.

Third-year USUHS medical students currently participate in clinical clerkship rotations on psychiatry wards and clinics at the three medical centers within the National Capital Consortium; at Tripler Army Medical Center, Hawaii; and at Wilford Hall Air Force Medical Center (soon to be known as the San Antonio Military Medical Center–South). Additionally, 3rd- and 4th-year students from USUHS and other medical schools may also rotate at civilian treatment facilities and other military medical centers. At these sites, residents (under the appropriate guidance of military GME faculty) also hone their skills as mentors, teachers, supervisors, role models, and team leaders.

GME program faculty members appointed by the USUHS Department of Psychiatry as clinical site directors at each of these sites assure that residents contribute to the core knowledge and competency requirements of the Liaison Committee on Medical Education for psychiatry clerkship students. Students are responsible for learning the fundamentals of psychiatric assessment, differential diagnosis and treatment, mental status examination, safety assessment, treatment planning, and case presentation to multidisciplinary teams during these rotations. In providing both didactic and "hands-on" training for medical students, GME residents also develop and demonstrate the RRC-required core competencies, as well as honing the professional and leadership skills necessary for the practice of psychiatry in military medical settings.

Psychotherapy Competencies

Psychiatry residency programs have had to restructure their training strategy to meet the competency requirements for various psychotherapies, including supportive therapy, psychodynamic therapy, brief therapies, cognitive-behavioral therapy, and combined medication and psychotherapy. The evolution of managed healthcare converging with marked advancement in psychopharmacology shifted the emphasis of psychiatry GME away from long-term psychotherapeutic treatment and toward a crisis intervention model. In response, many psychiatry residency programs experienced a shift in culture away from emphasis on psychotherapy skills toward a more neurobiology-based approach that led to increased reliance on safer, less burdensome medications for treating mental illnesses. By the end of the 1990s, numerous programs around the country were struggling to find the financial resources necessary for robust psychotherapy training.[36] In contrast, military residency programs faced less financial pressure to demonstrate productivity and thus were able to maintain a strong emphasis on psychotherapy skills development.

In 2001, the psychiatry RRC mandated not only that residencies must start implementing the six core competencies, but additionally that they must develop assessment tools to certify that their graduates are trained and competent in all five psychotherapies.[37] No directives have been written on how to teach, develop, or assess each of these psychotherapies, and development of competencies was left to individual programs to design and implement.

General Psychiatry Residency Curriculum

An accredited psychiatry residency program must be 48 months in length, including the postgraduate year 1, also known as internship. Graduation from medical or osteopathic school is a prerequisite to enter such a program. The psychiatry internship usually consists of approximately 6 months of basic medical training in primary medicine areas, such as internal medicine, family medicine, or pediatrics, and about 6 months of neurology and psychiatry training. Postgraduate year 2 typically involves mostly inpatient psychiatry rotations, as well as rotations in addictions, consultation-liaison, geriatric psychiatry, and other clinical experiences. The majority of outpatient psycho-

therapy and medication management training occurs during postgraduate year 3. Finally, postgraduate year 4 involves consolidating medication management and psychotherapy skills, mentoring junior trainees, and learning administrative skills necessary for interacting in the larger system of medical care.[7]

Requirements for completion of GME training in psychiatry have evolved over time. During the past 2 decades, focus has shifted from inpatient psychiatric experience to outpatient rotations, mirroring the medical industry's evolution of an outpatient-based treatment model. For example, the required time for inpatient psychiatry rotations in 1984 was 12 months, compared to a minimum of 6 months in 2007.[7,38] ACGME mandates specific time requirements for certain rotations, and others are left to the discretion of the training program (Exhibit 42-2).

Three other aspects to psychiatry residency training are unique and increase the complexity and cost of executing a training program. First, much of psychiatric care occurs in one-on-one sessions with a patient. The duration of a typical appointment can be from 30 to 90 minutes, with a low reimbursement rate compared to other medical specialties. Because of the very sensitive nature of topics discussed and the structure of psychotherapy sessions, there are significant barriers to having a supervisor directly observe a trainee's interactions with patients. Some programs in the military are beginning direct observations via video links to offices with consent by the patient as a means to observe but not intrude on the patient-physician interaction.

Secondly, as mandated by ACGME, psychiatry trainees must meet with supervisors individually at designated times to review clinical encounters that have already occurred.[7] Each trainee must have 2 hours a week of individual time with faculty supervisors to discuss recent evaluations and therapy cases. Therefore, if a program has 25 residents, faculty must spend 50 hours a week of nonclinical time reviewing cases with the trainees, leading to a large amount of fiscally nonproductive time for both residents and supervisors.

Third, much of psychiatry training involves trying to understand the enormously complex field of human behavior. Residents need to understand human development across the lifespan and how it manifests differently at various points in development. For example, a 5-year-old girl might be displaying normal developmental behavior when she states that she sees an invisible friend standing next to her, whereas such behavior would be abnormal for a 13-year-old child. In addition to learning through clinical experiences and case supervision, psychiatry GME training requires a greater amount of didactic learning than any other medical specialty. The total time spent participating in didactics does not include advanced preparation or individual reading and research pertinent to the resident's cases. Learning how to distinguish normal behaviors from mental disorders, understanding various medication and therapy treatment modalities, and learning how to develop realistic treatment plans necessitate a large reading and didactic program.[7] To satisfy all of the academic requirements, most psychiatry GME programs have developed didactics schedules of about 3 to 5 hours per week per year level, resulting in an overall didactic schedule of approximately 13 to 15 hours per week for the entire program, all of which is nonbillable time for faculty and resident participants.

EXHIBIT 42-2

SUMMARY OF AMERICAN COUNCIL OF GRADUATE MEDICAL EDUCATION RESIDENCY REVIEW COMMITTEE REQUIREMENTS FOR PSYCHIATRY RESIDENTS, AS OF 2007

Timed Experiences

- Primary Care Medicine: 4 months in internship year
- Inpatient Psychiatry: minimum of 6 months
- Outpatient Psychiatry: 12 consecutive months
- Neurology: 2 months
- Consult-Liaison Psychiatry: 2 months
- Child and Adolescent Psychiatry: 2 months
- Addiction Psychiatry: 1 month
- Geriatric Psychiatry: 1 month

Untimed Experiences

- Forensic Psychiatry
- Community Psychiatry
- Family/Couples Therapy
- Group Therapy
- Electroconvulsive Treatment
- Psychological Testing

Research and Scholarly Activity

Although not specifically mentioned as a GME core competency, the ACGME RRC requires that involvement in scholarly activity or research be incorporated into residency training.[7] All military psychiatry GME programs require participation in a research project or scholarly endeavor as a requirement for graduation.

Historically, such scholarly endeavors have included literature reviews presented at department-wide or hospital grand rounds. Increasingly, however, general psychiatry residents have been paired with research mentors—GME faculty members with specific skills and interest in research. As a result, many GME residents graduate with a sophisticated understanding of study design, institutional review board procedures, and research report writing skills. In addition to numerous book chapters, military residents have authored or coauthored publications accepted in the *American Journal of Psychiatry, Journal of the American Academy of Psychiatry and the Law, Jefferson Journal of Psychiatry, Psychosomatic Medicine, Military Medicine,* and *American Journal of Disaster Medicine,* among others. These efforts have not only advanced the practice of psychiatry within the military, but have also expanded the knowledge and understanding of specific military psychiatric issues within the larger civilian community.

Military Psychiatry Curriculum

In addition to satisfying all of the standard ACGME requirements for a psychiatry residency program, military GME programs must prepare trainees to function as capable leaders immediately upon completion of training. New graduates can be placed into various leadership positions, such as chief of a division mental health clinic or officer-in-charge of a brigade combat team mental health section.[39] The staff of a mental health clinic or section may include other officers, several enlisted personnel, and possibly civilian employees. New graduates can also be assigned to combat stress control units or to other medical units in a deployment setting, where they will be expected to serve in leadership roles.

A well-executed military psychiatry curriculum spans the entire 4-year training cycle. Issues emphasized in the military psychiatry curriculum include dual-agency issues, utilizing the military structure to support soldiers in need, and ways to reduce stigma and perform primary prevention efforts. Dual-agency issues arise more often in military psychiatry because Army psychiatrists serve simultaneously as physicians and Army officers.[40] Most of the time these two roles do not conflict, but in some situations duty to the mission may be of higher priority than the immediate best interest of the soldier. Especially during combat operations, the needs of the group and the mission may sometimes trump the needs of the individual, potentially creating a dilemma for physicians trained and sworn to act in the best interests of the patient.[41] This dual-agency issue is addressed frequently in the training of military psychiatrists.

One benefit of the military structure is the ability to develop and execute a comprehensive biopsychosocial formulation and treatment plan for a service member. Military psychiatry GME programs provide trainees with practical experience in performing clinical psychiatry while addressing pertinent military issues. Applying an occupational health model by working closely with the service member's chain of command, the military psychiatrist has influence in structuring a soldier's work environment via the scope of work, physical setting of work, and even duty hours.[6] An in-depth understanding of the challenges and constraints faced by military units is essential for the military psychiatrist when consulting with service members' chains of command to develop realistic treatment plans. To promote familiarity with the practice of psychiatry in a military environment, trainees participate in rotations at posts and bases with large cohorts of operational units. Through such interactions, the psychiatrist-in-training gains practical experience in military group dynamics and learns to develop realistic treatment plans within the constraints posed by the unit's mission.

Many military psychiatry GME graduates deploy to an operational environment shortly after completion of training, so familiarity with unit structure and dynamics is tremendously important to the psychiatrist aspiring to be of optimal service to both active duty patients and unit leaders. Learning about the critical role of mental health in the entire deployment cycle support process prior to completion of residency training will greatly aid the military psychiatrist in the initial assignment.[42]

Unlike most civilian occupations, military service does not impact solely upon the service member, but affects the entire family unit. The high percentage of married service members makes adequate knowledge and experience in managing family dynamics, particularly in the face of deployment, necessary for military psychiatry trainees. The mental health needs of military children have been recognized through research and practical experience.[43] Military psychiatry trainees should have experience with programs that address such needs outside of the traditional office setting, such as in school-based mental health programs.[44]

Over the last 5 to 10 years, increasing emphasis has been placed on early identification of mental health problems through education and primary prevention efforts. After the September 11, 2001, terrorist attacks, the Army instituted Operation Solace to offer assistance to Pentagon employees. Military psychiatry trainees played a prominent role as members of the assistance team.[45] Boundaries of traditional methods of patient care had to be crossed to allow survivors easy access to mental healthcare providers while si-

multaneously decreasing the stigma to seeking help. For example, mental health teams of various types of providers were assembled to bring outreach efforts directly to employees in work areas, creating the term "therapy by walking around." Outcome data suggest that such efforts may have resulted in a smaller-than-expected incidence of mental illness at the Pentagon following the attack.[46]

Combat operations since then have provided multiple opportunities for mental healthcare providers to further improve educational activities, to refine screening of service members during the entire deployment cycle, and to minimize the traumatic effects of the combat experience. Further advances in military psychiatry curricula will result in graduates being better prepared for the complex military mental health treatment mission.

Postresidency Fellowship Training

Postresidency psychiatric subspecialty education and training (fellowship programs) are currently offered at several military medical centers.[47] These programs provide the Army and Navy Medical Corps with the majority of their military psychiatric subspecialists. Historically, the Air Force has opted to permit relatively few of their psychiatrists to complete fellowship training (and these primarily through civilian channels), but Air Force physicians have also participated in the training programs described below. The opportunity to apply for and, if selected, receive subspecialty training in child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, and addictions psychiatry serves as a retention incentive for physicians who might otherwise terminate their active duty service. Military psychiatrists with subspecialty training continue to primarily practice adult general psychiatry in most operational billets. However, those assigned to tertiary care facilities and teaching hospitals are often assigned duties specifically related to their subspecialty skills (eg, working several days a week at the child psychiatry service, or as a medical review officer for the base substance abuse program). Those assigned to smaller clinics or medical detachments are given duties that utilize their expertise. For example, although military regulations do not require a forensic psychiatrist for the evaluation of competency and criminal responsibility,[4] forensically trained psychiatrists are called upon to conduct these assessments by commanders or medical service chiefs whenever possible. Thus, the opportunity to practice specialized psychiatric skills also serves as a retention incentive for specialty-trained psychiatrists.

Fellowship programs in child and adolescent psychiatry accredited by the ACGME RRC are presently offered at Tripler Army Medical Center and Walter Reed Army Medical Center (as part of the National Capital Consortium). Walter Reed also offers RRC-accredited fellowship training in forensic and geriatric psychiatry, and Tripler offers addictions psychiatry fellowship training. Army GME plans currently permit two Army psychiatrists to enter forensic training each year, five psychiatrists to enter child and adolescent training, and one to enter geriatric or addictions training in alternate years. The programs also offer training to Navy and Air Force psychiatrists on a space-available basis, provided their parent service agrees to permit their matriculation. In this way, the training programs generate a pool of psychiatric subspecialists sufficient to fulfill forecasted needs and to justify continued program accreditation.

The US Army, Navy, and Air Force have also recently established annual training billets for the National Capital Consortium's Disaster Psychiatry Fellowship at USUHS. This military-unique training opportunity combines a competitive master's in public health program with research and clinical mentorship in military operational response to disasters, war, and terrorism, as well as rotating internships at various federal agencies involved in disaster response. Disaster psychiatry subspecialty training, though not formally recognized by the ACGME through an accreditation process, has emerged to fill a need within the military for psychiatrists specifically trained in public health interventions, health surveillance, and principles of disaster mental health research and practice. Because the military is uniquely positioned and often tasked to provide medical and mental healthcare in natural and human-caused disasters, military psychiatrists with subspecialty training in this arena can augment the response of general psychiatrists and behavioral health specialists.

The opportunity to apply subspecialty skill sets in military operational environments—whether addressing the mental health needs of child victims of the southeast Asian tsunami or the medico-legal issues surrounding the mental health of service members accused of war crimes—often encourages specialty-trained psychiatrists to remain on active duty beyond their contractual obligations.

RELEVANCE IN MISSION PERFORMANCE

The delivery of mental health services in a military environment differs in multiple ways from civilian mental healthcare. Just as an attorney who relocates to a new state must learn the laws and culture of that state

before establishing a practice, military mental health providers must thoroughly understand their service branch's laws and culture to be effective caregivers. Military GME provides trainees with necessary exposure to the knowledge, skills, and attitudes required of military mental healthcare providers. Additionally, trainees in military programs receive guidance and supervision from experienced military supervisors while providing healthcare directly to service members and their dependents. Instruction and training in military-unique mental health issues is not available in civilian training, and being comfortable practicing in a military environment may be a major determinant of the length of time a military psychiatrist will ultimately remain in the service.[8] As the Society of Medical Consultants to the Armed Forces emphasized in a 1987 white paper, "[Military] graduate medical education is the chief guarantor of quality medical care and an unmatched incentive for the recruitment and retention of active duty medical officers. It is the essential prop supporting the entire voluntary military medical structure."[48]

The material presented in this section focuses on Army psychiatry GME training. Although the other mental health disciplines such as psychology, social work, psychiatric nursing, and occupational therapy may also offer graduate training programs in military healthcare facilities, psychiatry training is the longest and the most comprehensive. The authors of this chapter, all Army psychiatrists, are most familiar with Army standards and procedures. However, all branches of the US armed forces currently endorse a similar approach to evaluating, treating, and managing service members with psychiatric conditions. Additionally, each service recognizes the importance of addressing the issues of the entire military family when developing a mental healthcare delivery strategy. Each service also follows the same regulatory guidance, albeit with different nomenclature. Most of the information presented in this section is applicable to all mental health disciplines and all branches of the armed forces. Regardless of specialty or uniform, exposure to military systems as a trainee greatly contributes to the development of confidence and competence in caring for service members and their families during peacetime and war.

The military mental health field is unique, with many inherent challenges that are not addressed in civilian residency training programs. Besides simply offering cultural immersion, military residencies include both didactic and experiential training opportunities that appropriately prepare trainees for the jobs they will enter following graduation. These programs are a crucial component of military medicine and have been identified as the largest guarantor of provider longevity in the military. Additionally, appropriate implementation of the aforementioned knowledge, skills, and attitudes by well-trained military mental health providers will enhance overall unit readiness and improve mission performance by the units they support.

Military psychiatry is distinguishable from civilian adult psychiatry by two major constructs, both requiring years of experience to master. The first is the aforementioned dual-agency role, referring to the psychiatrist's constant but necessary struggle to balance the best interest of the patient with the best interest of the patient's unit, which includes overall unit health and successful completion of the military mission.[45] The second construct is the extensive amount of technical, military-specific knowledge required to practice successfully within the military culture (Table 42-2).

As mentioned above, all US military psychiatry programs are accredited by ACGME. Like psychiatrists trained in civilian programs, military psychiatrists are expected to demonstrate competence through successful development of specific knowledge, skills, and attitudes.[7] Thriving as a military mental health provider requires the nurturing of career-specific knowledge, skills, and attitudes that can be gained only by repeated clinical encounters within military systems under the direction of an experienced supervisor. This section will introduce and explain these elements of competence as they relate to military psychiatry, accompanied by case examples pertinent to each.

Knowledge

Knowledge begins with a basic understanding of the military culture, such as appropriate wear of the uniform, rank recognition, salutations, customs, and courtesies.[49] It also involves an appreciation of the mindset of military leaders, who are responsible for the safety of hundreds of service members and millions of dollars worth of equipment, and whose success depends on their ability to motivate their troops to accomplish potentially life-threatening tasks under adverse conditions for minimal pay. Leaders often have neither the time nor the incentive to make special accommodations for service members who are not mentally fit for the mission at hand. Additionally, knowledge consists of understanding military occupations in terms of education, content, scope, typical duty environment, and inherent stressors. For example, the military psychiatrist should know that cooks and infantry soldiers require one of the lowest entrance examination scores,[50] that recruiters have one of the most stressful jobs,[51] and that aviation crew members are prohibited from taking certain types of medications.[6]

TABLE 42-2

OFFICIAL DOCUMENTS WITH WHICH US ARMY PSYCHIATRISTS SHOULD BE FAMILIAR

Number	Title
Army Regulations and Pamphlets	
AR 40-1	*Composition, Mission, and Functions of the Army Medical Department*
AR 40-66	*Medical Record Administration and Documentation*
AR 40-400	*Patient Administration*
AR 40-501	*Standards of Medical Fitness*
AR 380-67	*Personnel Security Program*
AR 600-8-4	*Line of Duty Investigations*
AR 600-8-22	*Military Awards*
AR 600-8-24	*Officer Transfers and Discharges*
AR 600-85	*Army Substance Abuse Program*
AR 608-18	*The Army Family Advocacy Program*
AR 623-3	*Evaluation Reporting System*
AR 635-40	*Physical Evaluation for Retention, Retirement, or Separation*
AR 635-200	*Active Duty Enlisted Administrative Separations*
AR 670-1	*Wear and Appearance of Army Uniforms and Insignia*
DA Pamphlet 600-24	*Suicide Prevention and Psychological Autopsy*
Department of Defense Directives and Instructions	
DoD Directive 1332.14	*Enlisted Administrative Separations*
DoD Directive 1332.30	*Separation of Regular and Reserve Commissioned Officers*
DoD Directive 6490.1	*Mental Health Evaluations of Members of the Armed Forces*
DoD Instruction 6490.4	*Requirements for Mental Health Evaluations of Members of the Armed Forces*
Army Field Manuals	
FM 4-02.51 (formerly FM 8-51)	*Combat and Operational Stress Control*
FM 6-22.5	*Combat Stress*
Other Documents	
DoDSER	*Department of Defense Suicide Event Report*
Air Force Instruction 41-307	*Aeromedical Evacuation Patient Considerations and Standards of Care*

Furthermore, knowledge includes familiarity with community resources and programs available to assist troubled service members and their families. Each branch of the armed forces has its own service-specific support agencies, several of which psychiatrists are required by regulation to contact under specific circumstances, and others that are simply available for anyone who needs them. The first category includes substance abuse education and treatment programs,[52] child and family welfare programs,[53] patient administration offices,[54] physical evaluation board liaison offices,[55] other mental health treatment programs in the community, and law enforcement agencies. The second category includes organizations such as the command chaplain group, local community service agencies (eg, Army Community Service, Fleet and Family Services, Airman and Family Readiness Centers), the staff judge advocate (legal), the inspector general, Military One-Source, and the Veterans Administration.[56,57]

Another aspect of knowledge is the military psychiatrist's ability to predict the effect of clinical decisions and administrative recommendations on service members, their command, and the military as a whole. For example, military psychiatrists must have an idea of realistic alternative duties available to a service member who is given a mental health

profile or is prescribed sedating medications. They must proactively liaison with unit leaders to minimize stress on the service member, to help the unit accommodate the service member's duty limitations, and to limit adverse effect upon the unit's mission. Military psychiatrists must have an appreciation for how long it takes an individual to be administratively or medically separated from the service and how peers are likely to treat that individual during the separation process. An additional concern for commanders is that a recommendation for an administrative separation may trigger a flurry of requests for separation from other service members. This is especially concerning during times of high operational tempo, when a unit's attrition rate is a critical factor that can degrade the unit's ability to accomplish its mission. Additionally, the psychiatrist should know something about financial compensation and other benefits available to veterans upon leaving active duty service.

Finally, and perhaps most importantly, knowledge refers to being intimately familiar with a host of military regulations and instructional manuals.[2] Because of their obligation to protect units as well as individual service members, military psychiatrists must know the medical conditions that disqualify recruits from entering military service, as well as those conditions that require a recommendation for medical discharge.[6] They must be familiar with the regulation that addresses the medical disability program and know how to conduct a separation history and physical examination.[55] In addition to knowing which mental health conditions warrant medical separation, military psychiatrists must be familiar with regulations pertaining to administrative (nonmedical) separations, which differ for officer and enlisted personnel, and some of which require an evaluation and recommendation for discharge by a doctoral-level mental health professional. During these separations, knowledge of the psychiatrist's role as either a patient advocate or a neutral evaluator is essential.[58,59]

As part of a safeguard to prevent coerced mental health referral of service members, military psychiatrists must be very familiar with the tenets of the DoD policy on command-directed mental health evaluations, including service members' rights in such proceedings, the limits of confidentiality, the psychiatrists' obligations, the personnel involved, specific time limits, and required documentation.[3] This policy was implemented in 1993 in response to congressional-level concern that service members were being inappropriately referred for mental evaluations after blowing the whistle on suspicious activities within their commands.[60] Deviation from the prescribed process could result in significant administrative sanctions against the military psychiatrist.

Additional administrative duties that do not have a correlate in civilian mental healthcare include security clearance evaluations,[5] participation in suicide investigations and appropriate documentation of suicide attempts,[61–64] and transportation of patients via the military aeromedical evacuation system.[65] Regulations pertaining to basic charting standards, maintenance of military medical and mental health records, and dispositioning of retired records are other duties required of a military psychiatrist.[54,66] Since September 11, 2001, having an understanding of service-specific medical and mental health units, their placement on the battlefield, and the behavioral health officer's specific roles and obligations during wartime has become even more critical for the military psychiatrist.[67–69] Such knowledge could conceivably be acquired through a concentrated training period shortly after entering active duty,[8] but the depth and scope of such training would not remotely approach the training and experience gained from a 4-year military training program. The following case studies, as well as the others in the chapter (all from the clinical experience of one of the authors [WW]), demonstrate the benefits of such a program.

Case Study 42-1: A deployed Army psychiatrist identifies a number of immature and maladaptive coping skills in many of the soldiers she evaluated. Concerned about their ability to successfully complete the deployment, she recommends most of them for personality disorder separations under Chapter 5-13, Army Regulation 635-200.[59] Even though some of these soldiers are aggressive and unpredictable, the majority of them are not separated. The frequency with which the psychiatrist recommended separation reduced her credibility with the unit's commander, who ultimately stops following through on any of the psychiatrist's recommendations whatsoever.

Case Study 42-2: A 25-year-old deployed Army aviation soldier comes to the mental health clinic requesting treatment for insomnia. The soldier describes initial insomnia related to worries about upcoming missions that involved flying into hostile territory. In addition to clarifying the soldier's psychiatric symptoms, the psychiatrist asks him about his job and work schedule. Knowing that aviation personnel are grounded while using psychotropic medications, as well as realizing that the soldier's job could require him to wake up in the middle of the night and quickly perform an equipment check prior to flying, the psychiatrist does not feel comfortable prescribing a sleep medication for the soldier. Instead, she provides him with instructions in deep breathing and progressive muscle relaxation and schedules him to attend a sleep hygiene class offered by the clinic.

Case Study 42-3: A soldier walks into the mental health clinic with a memorandum stating that he needs a psychological evaluation to get his security clearance renewed. Having just graduated from a civilian residency program, the

psychiatrist is unaware that he should have received additional documents pertaining to the soldier's background prior to the appointment and that the memorandum's questions must be answered in a very specific fashion. He conducts a one-on-one assessment of the soldier and types up a letter stating that he thinks the soldier should be granted a security clearance. His letter is rejected by the requesting security agency because it does not address a key question raised during the background check and was not submitted in the proper format.

Skills

Many of the skills required of military psychiatrists, including assessment, formulation, crisis management, consultation, and various psychotherapies, are taught in civilian training programs. Other skills, however, are required uniquely by military psychiatrists, and can only be learned by working within a military environment. Such skills are mastered through successful completion of a military psychiatry GME program followed by experience at the initial duty assignment. Military-related skills include the specific interpersonal skills required for interacting with individual patients as well as their patients' commanders and military support personnel. Additionally, numerous technical and administrative skills related to both patient care and career management are required of military psychiatrists. Even unique clinical skills are required, particularly during times of overseas deployment (Exhibit 42-3).

EXHIBIT 42-3

UNIQUE SKILLS REQUIRED OF MILITARY PSYCHIATRISTS

Military psychiatrists must possess the ability to

- connect with service members who are patients;
- connect with service members who are not patients;
- connect with unit leaders;
- be a "salesperson" and an ambassador for the field of mental health;
- provide appropriate interventions following traumatic events;
- interact within and among various military agencies;
- access pertinent regulations;
- format and write military memoranda;
- prepare official reports;
- provide quality care in austere environments;
- counsel subordinates; and
- prepare counseling statements, award recommendations, and performance reviews.

Military psychiatry is not unique in requiring good interpersonal skills. However, the specific interpersonal skills required of a military psychiatrist are unique and vary depending upon the setting. For example, because some service members feel uncomfortable interacting with providers who do not maintain the decorum they expect of a military officer, the psychiatrist must maintain appropriate military bearing, yet not be so formal and rigid as to negatively influence the formation of a therapeutic alliance. Like patients in the civilian sector, service members will open up in a supportive, somewhat relaxed environment. A military psychiatrist who is too authoritative may have difficulty connecting with a service member who is having trouble with one or more supervisors, and thus may inadvertently create a barrier to care. Conversely, a style that is too casual may give service member patients permission to behave unprofessionally or spend excessive amounts of time at the mental health clinic—behaviors that will inevitably lead to or worsen preexisting occupational difficulties.

Working with unit commanders requires an entirely different interpersonal skill set, consisting of a business-like attitude, a focus on data and regulations, emphasis on mission success, and a willingness to accept that the commander will not always seem appreciative of the psychiatrist's efforts to help the unit or the soldier. Commanders often have preconceived negative opinions of mental health providers secondary to prior personal or family contacts with mental healthcare professionals, a perceived adversarial role, and a skewed opinion of the ability of mental health to enhance mission readiness.

As clinicians, psychiatrists are expected to maintain their clinical skills and to keep up with current medical literature. As military officers, they are expected to maintain their physical fitness and be familiar with current military tactics, procedures, and regulations. Often, the most challenging interpersonal skill required of a military psychiatrist is expert marketing to a population that may be resistant to receiving psychiatric assistance. Unlike their civilian counterparts, military mental health professionals must actively participate in primary prevention activities through education and outreach efforts for the units they support. By proactively getting to know their post's units and commanders, they can reduce stigma associated with mental health interventions, an identified barrier to care.[70] The ability of military psychiatrists to establish themselves as viable members of a unit's healthcare team will enhance access to mental health-

care for soldiers. Enhanced access to care is vital in an era of repeated combat operations when a large percentage of service members self-report operational mental health issues.[71]

Military psychiatry also requires a number of unique technical skills, many of which include researching and writing official correspondence and reports of various types (Exhibit 42-4).[2] Failure to take the appropriate course of action or failure to document recommendations or actions in the correct manner could reduce the psychiatrist's credibility, negatively impact the effectiveness of the unit, and potentially have lifelong consequences for uniformed patients. The military psychiatrist must be familiar with pertinent regulations, how to access the regulations, and how to apply them while providing high-quality mental healthcare for service members and commands. In the US Army, regulations dictate how a medical chart is prepared,[54] what elements of the physical examination are required for a disability evaluation,[55] how to schedule a command-directed mental health evaluation,[3] what information must be provided to commanders after a command-directed evaluation,[72] how to communicate recommended duty limitations to soldiers and their commanders,[6] how to dispose of closed behavioral health charts,[54] and even how to write in the "military style."[73] Significant failure to practice in accordance with these regulations could adversely affect a provider's reputation, credentials, and medical license.

EXHIBIT 42-4

DOCUMENTS AND REPORTS PREPARED BY MILITARY PSYCHIATRISTS

- Clinical notes
- "Sick slips"
- Extended sick slips (eg, physical profile, limited duty board)
- Safety precaution recommendations to commanders
- Security clearance evaluations
- Medical review officer findings
- Medical board narrative summaries
- Suicide line-of-duty statements
- Sanity boards
- Psychological autopsies*
- Military memoranda
- Standard operating procedures
- Counseling statements
- Officer evaluation report support forms
- Officer evaluation reports
- Award recommendations
- Line-of-duty investigations

*In the US Army, as of 2001, these are completed only by forensically trained psychiatrists.

Technical skills required of military psychiatrists also include those relevant to their career progression and to that of their subordinates. If conducted appropriately, the military's performance evaluation system ensures that service members are provided with timely feedback and ample opportunities to improve upon their deficits.[74] Similarly, the military's award system recognizes exceptional performance, providing incentives for exceeding the standard.[75] Both mechanisms to recognize performance are complex and can be quite confusing, even to individuals with years of experience. Promotions and accompanying pay raises depend upon the ability to successfully navigate these two systems. All military leaders, including most military psychiatrists, are responsible for counseling and rating their subordinates, as well as for submitting award requests months before they will be presented. The psychiatrist must be familiar with subordinates' accomplishments, know what level of award such accomplishments warrant, and what language to use to ensure the requested award is approved. Procedure and language is of equal, if not greater, importance when preparing performance reports, and information on these elements is not available in any official document. It is available primarily through mentoring and guidance by senior officers and supervisors.

Military psychiatry GME programs provide trainees the opportunity to learn about the military performance rating system because trainees, like all military officers, require an annual evaluation report. Through formal instruction and individual guidance by a supervisor, trainees learn how to document personal goals and accomplishments.[74] They also become familiar with the process of mentoring and evaluating subordinates, which they will most likely have to perform at their initial postresidency duty station. Trainees in civilian psychiatry GME programs do not have the same opportunity to experience the military rating system and thus are at a great disadvantage when evaluating other mental health professionals upon completion of residency training.

Military psychiatry also requires unique clinical skills during deployment or other duty in austere environments. The practice of "combat psychiatry" requires the ability to conduct problem-focused interviews in suboptimal clinical settings with little privacy, loud ambient noise, extremes of temperature, and unreliable computer and telephonic support. Interventions must be brief (two to four sessions) and

solution-focused. Long-term psychotherapy is not an option. The military psychiatrist must learn to trust the clinical capabilities of staff members, which often include enlisted mental health specialists with less than a year of training. Laboratory services are often very limited, commonly consisting of basic serology and urine screens only. The results of liver and thyroid function tests, drug levels, and advanced drug screens may take weeks to return, if they are available at all. Stocked medications are sometimes limited to one or two selective serotonin reuptake inhibitors (SSRIs), bupropion, one sleep agent, one benzodiazepine, and a first-generation antipsychotic such as haloperidol. Mood stabilizers, atypical antipsychotics, non-SSRI antidepressants, and stimulants may not be available at all. Subspecialty consultants are also difficult to access, and at times a military psychiatrist may be the only actual physician at the location. Such topics are integrated into the curriculum of military residencies to prepare trainees for successful practice in diverse and challenging environments. The following vignettes, as well as those elsewhere in the chapter, are illustrative of materials prepared for military physicians in training.

Vignette 42-1: A psychiatrist is treating a soldier who is extremely angry with his chain of command. He claims that his commander "plays favorites" and fails to take care of his subordinates' basic needs. The soldier mentions several unsafe practices allegedly occurring in the unit and gives the psychiatrist permission to investigate. The psychiatrist discovers that an unusually high number of individuals within the soldier's company are being seen at the mental health clinic, their charts all documenting similar complaints. He requests a meeting with the company commander to discuss the allegations. At the scheduled appointment time, the psychiatrist arrives in a pressed uniform, prepared with a briefing that includes specific data about recent behavioral trends in the unit, evidence-based information about how unsafe and unfair practices could contribute to reduced unit readiness, and very specific recommendations on how to improve the situation. The company commander states that he's interested in trying to implement the recommendations.

Vignette 42-2: A new military psychiatrist was active in his residency's psychotherapy interest group and authored several publications on dialectical behavioral therapy. One of his first patients as a division psychiatrist is a young woman with a very troubled past whom he diagnoses with borderline personality disorder. Intrigued by the case, the psychiatrist begins to see the patient for 50 minutes twice a week. Enlisted mental health specialists in the clinic complain to their noncommissioned officer in charge that the psychiatrist is always in session and is never able to staff cases. The patient herself seems to be getting worse and insists that she needs a sick slip excusing her from her upcoming field training exercise. At the end of the 4th week, the patient's first sergeant accompanies her to the appointment and angrily asks the psychiatrist whether or not he understands the impact that her absence from the training exercise will have on the rest of the unit, and whom he expects to look after her while the unit is in the field.

Vignette 42-3: A deployed Army psychiatrist is working at a small base at a hostile location in Iraq. Late one night, he is sleeping in his cot at the back of his clinic tent when he is awakened by a weary-appearing soldier requesting help. The soldier is dirty, malodorous, and exhausted. Earlier in the day, he returned from a long convoy during which his platoon was attacked with small-arms fire and rocket-propelled grenades. He claims to be tense and worried about his wife, whom he has been unable to call in 2 weeks. He tearfully tells the psychiatrist that he is scheduled to go out again the next morning, but that he doesn't feel like his "head is in the game," and that he questions his ability to defend his comrades. The psychiatrist conducts a brief assessment and contacts the soldier's commander to recommend he be removed from convoy duty for a couple of days and be allowed to participate in a "restoration" program offered by the clinic.

Attitudes

The development of appropriate attitudes may seem less essential than the acquisition of sufficient knowledge and skills in the field of military psychiatry. However, psychiatrists who approach clinical and administrative tasks in the military with the wrong attitudes may inadvertently make their lives more stressful and find it difficult to achieve job satisfaction. They must adopt an attitude of selflessness and advocacy for patients while maintaining a skeptical eye for malingering. They may have to treat a patient while simultaneously providing support for the patient's unit. They must adopt an attitude of flexibility and humility, including a willingness to take on challenging tasks for minimal recognition. Finally, they must excel in their role as a leader to ensure their subordinates receive the recognition and promotions they deserve.

The dual-agency role discussed earlier perfectly demonstrates the importance of having the right attitude for the job. Military psychiatrists must be willing to adopt a utilitarian viewpoint.[76] They must regard the entire population of service members as their "patient" and endeavor to protect that "patient" from harm, even at the cost of violating the confidentiality of individual service members. Unforeseen violations of doctor-patient confidentiality are rare, but are necessary and appropriate if the identified patient is experiencing symptoms that could compromise the safety of the unit. Depending on the patient's job, such symptoms might include poor concentration, sleep deprivation, errors in judgment, severe anxiety, profound depression, delusions, hallucinations, cognitive deficits, impaired impulse control, and of course, suicidal and homicidal fantasies.

Military psychiatrists must be flexible and creative, satisfied with limited available resources and treatment capabilities, and moderately comfortable as the sole psychiatrist serving troop populations as large as 15,000.[77,78] They must accept the inability to help everyone, a difficult concept to acknowledge for many psychiatrists, who presumably entered the field to help their patients live happier, more productive lives. Because of the high service-member-to-psychiatrist ratio, military psychiatrists must also believe in the power of primary prevention and commit themselves to the concept that psychiatric care begins in the foxhole, where troops help one another overcome adversity.

Psychiatrists in the military should maintain an air of humility and understand that a caring friend, a chaplain, or a commander may be more effective and therapeutic than a mental health professional in certain situations. They must also accept that the title of "captain" or "major" is sometimes preferable to "doctor" in military units, because the former more clearly identifies them as a part of the military team. Additionally, they will come to realize that most of the troops they serve have no idea what the difference is between a psychiatrist, a psychologist, and a social worker.

The military psychiatrist must be willing to work under and alongside other mental health professionals, such as psychiatric nurses, social workers, and occupational therapists. They must also be willing to place a great deal of trust in the clinical abilities of their enlisted mental health specialists, who are often the first providers to make contact with service members seeking treatment. These personnel serve a crucial role in triaging patients, performing and documenting initial assessments, conducting educational groups, providing supportive counseling, and managing acute crises, often with fewer than 12 months of mental health training.[79] Mental health specialists in the Reserves and the National Guard may have completely unrelated civilian jobs, requiring an extensive amount of training prior to providing patient care. Military psychiatry training programs incorporate into the curriculum specific experience working with other mental health professionals and paraprofessionals.

Operating in a military environment under close scrutiny also creates a number of unique challenges. Military psychiatrists must always remember they are representatives of the US armed forces. Many military bases are relatively small, and psychiatrists commonly encounter patients and their families at various locations on post and in the surrounding communities. Many military psychiatrists have had the experience of sharing a lunch table, a medical waiting room, and even a shower area with their patients. Such situations, while essentially unheard of in a civilian setting, are commonplace in today's military environment, and uniformed psychiatrists must be capable of maintaining good military bearing and a professional demeanor at all times.

Case Study 42-4: A military psychiatrist is seeing an intelligence analyst who has had difficulty sleeping since she was switched to the night shift 4 weeks ago, and has had a limited response to sleep medications. Her energy and concentration have reached dangerously low levels and she has already made a couple of mistakes on the job. While recognizing the soldier's right to seek treatment confidentially, the psychiatrist has valid concerns that his patient's ability to accurately report important intelligence data may be compromised. He contacts the soldier's commander to recommend that she be given a day shift job because of her compromised ability to perform her duties, knowing that her security clearance may be suspended as a result.

Vignette 42-4: A military psychiatrist graduated with honors from an esteemed medical school on the East Coast and completed a civilian residency before joining the Army. She was used to wearing a white coat to work and having a large administrative staff to assist her. She was also accustomed to calling her staff by their first names and to joining them regularly at educational dinners sponsored by pharmaceutical companies. She has a very difficult time adjusting to the Army and feels disrespected by the other members of her department, whom she regards with an air of contempt. Her department chief, a psychologist, counsels her multiple times on the importance of being a team player and interacting regularly with the local commands. She ultimately deploys to Iraq, and as soon as possible following her miserable 15 months in the desert, elects to resign from the Army.

Vignette 42-5: A young soldier in Afghanistan walks into the combat stress control clinic in the middle of a chaotic afternoon. The psychiatrist, who is finishing up with one patient and has two more waiting to see him, just learned that a patrol from the base was attacked and that a unit is requesting a critical event debriefing. He missed lunch and has three phone calls to return, plus a tobacco cessation class to teach in 30 minutes. Noticing the new soldier standing in the entryway, he snarls at her and tells her she'll have to come back unless it's an emergency. The next morning the psychiatrist goes to the motor pool to catch a convoy to a neighboring base, and discovers that this soldier will be his driver.

FUTURE OF GRADUATE MEDICAL EDUCATION

Military psychiatry GME faces numerous pressures on different fronts. As emphasis on efficiency in the direct care side of the military healthcare system increases, a decision on whether GME should be financed within the system or contracted out to the civilian side may become necessary. Because the field of military

psychiatry is distinctly different than its civilian counterpart, the training of psychiatrists outside the Army is less tenable than in other medical specialties. The large shift into the core competency movement will directly affect the structure and content of all training programs. The current conflicts in the Middle East and the GWOT will have direct effects on the future of GME in psychiatry as issues involving behavioral health gain even more national attention.

The viability of GME within the military, because of its high costs, has always been debated. As medical services inside and outside the military strive for optimal efficiency, medical education is placed under increasing pressure because of the costly general apprenticeship model of medical education, which emphasizes personal experiences with teachers, mentors, and patients. Only through personal relationships with teachers and mentors and plentiful patient care experiences can a clinician develop sophisticated synthesizing capabilities. Traditionally, military GME was not affected as much as civilian training programs by the managed care model, but MTF commanders are now assessed by workload productivity via the relative value unit. GME-related tasks do not produce relative value units and therefore have no workload credit, a critical factor in whether the military decides to continue supporting GME with military and civil service faculty or contract the mission to nongovernment organizations.

The competency movement carries some promise for transition from time-based experiences toward a competency standard independent of time. Although more applicable to procedure-dominant medical specialties, the development of treatment portfolios of medication and psychotherapy cases will benefit psychiatry, allowing more longitudinal, rather than cross-sectional, evaluations. The competency movement will also leverage psychiatry to develop more relevant clinical outcome measurements, enabling programs to start objectively measuring their trainees' patient care skills.

The current conflicts in the Middle East and the ongoing GWOT will necessitate an elevated operational tempo for years to come and require that the mental wellness of all service members receive attention from the military. Added emphasis on treatment of posttraumatic stress disorder and traumatic brain injury must be incorporated into training programs. As proximity, immediacy, expectancy, and simplicity (PIES) principles and force sustainment and resetting efforts take on increasing importance in behavioral health force-shaping in all environments, further emphasis on military psychiatry doctrine in GME programs will become paramount. Because the overall number of matriculates from USUHS and the Health Professions Scholarship Program has decreased in recent years, increased recruitment efforts will be necessary to ensure adequate numbers of future psychiatrists.

SUMMARY

GME is an essential aspect of ensuring safe, high-quality healthcare in the United States. Training programs for each medical specialty must abide by a specific set of requirements and guidelines and maintain available faculty to provide adequate physician-in-training supervision and mentoring. Psychiatry GME has very extensive didactic, clinical, and supervision requirements, resulting in the development of a comprehensive skill set over the course of the training period. Military psychiatry GME programs observe all of these requirements, in addition to providing education in military-specific behavioral health skills, which are essential for psychiatrists to function adequately in both garrison and operational environments.

Lessons learned from military conflicts over the last 40 years indicate that psychiatric trauma from war is a significant medical issue; this issue has become a prominent concern for American society. Service members returning from combat deployments can carry psychological scars that make reintegration into society challenging and stressful, affecting both veterans and their families. Military psychiatry GME programs have enhanced training in all aspects of the deployment cycle support process to ensure that military psychiatrists are prepared to address the varied needs of the military family during the deployment cycle. With behavioral health issues secondary to military service receiving extensive scrutiny in the media and by government agencies, military psychiatrists must be comfortable practicing in potentially high-profile environments, necessitating a comprehensive training experience.

With the anticipated long-term duration of the GWOT, military psychiatry GME will continue to be an essential aspect of military readiness. Ongoing refinement of behavioral health screening throughout the deployment cycle, treatment of psychiatric conditions related to combat stress, and deployment-related interventions for military families will require military psychiatry GME programs to be flexible in modifying military-specific training while complying with the standard requirements mandated by ACGME. Retention of qualified military GME program faculty

as mentors, role models, and subject matter experts will ensure the continued development of competent military psychiatrists prepared to support US service members and their families.

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