

What to Expect from Your Psychiatry Clerkship

By: Joshua T. Thornhill IV, M.D.

The first thing to expect about your psychiatry clerkship is not to expect anything.

When I was asked to write about what to expect on the psychiatry clerkship from the perspective of a clerkship director I figured this will not be too bad. After all I've been a clerkship director for almost ten years now and surely in that time I've learned something that is worthwhile to pass on. However as I began this essay I am faced with the fact that there are over 125 psychiatry clerkships in the United States alone. Thus instead of specifics, I am going to try and discuss in general what to expect on your psychiatry clerkship. I hope you find it useful.

The first thing to expect about your psychiatry clerkship is not to expect anything. Any preconceived ideas about psychiatry and psychiatric patients should be put aside until you really find out what things are like. Unfortunately popular culture rarely portrays psychiatrists or psychiatric patients in a positive light. We are all not comedians or idiots, our patients have real problems, and working with psychiatric patients can be one of your most rewarding experiences in medical school. I've stopped counting the number of students who are continually amazed when they go to an Alcoholics Anonymous meeting, a requirement of my own clerkship, by the diversity of people from all walks of life that they see there.

The second thing to expect is that seeing patients with a mental illness is hard work. Working with psychiatric patients can be emotionally and mentally draining. Learning to "be there" with a patient and share some of their emotional pain while at the same time maintaining a perspective on the situation can be quite exhausting. I've had many a student ask me how I can sit and listen to someone talk about their problems without becoming depressed myself. I explain that like every medical specialty psychiatry is part art and part science. The art of psychiatry is not allowing oneself to become caught up in others problems, but at the same time being able to understand how problems impact a patients' illness and their lives. So while your working hours will more than likely be less than your surgery clerkship, don't underestimate the mental tiredness you may feel at the end of the day.

While clerkships across the country vary in length between four and eight weeks, whatever the length the third thing to expect is time. Time to get to know your patients. Psychiatrists are experts at interviewing patients and getting patients to tell them about their lives. Use this time and take advantage of their expertise to get to know your patients. I tell my students that time will not be available in their busy primary care practices to spend large amounts with their patients and they need to take advantage of the time now to learn how to be comfortable talking to patients.

Finally, what are going to be the expectations of your clerkship director and clinical attendings. Other than the obvious like showing up on time and expressing an eagerness to learn you will be expected to keep an open mind about your patients and their problems. Focus on learning how to take a good psychiatric history and mental status exam that will enable you to formulate a differential diagnosis and treatment plan based on the biopsychosocial model. In general you will be evaluated not only on the depth of your knowledge base, but how you apply it, and how you interact with patients in a clinical setting.

In closing while reviewing your psychopathology and psychopharmacology notes is helpful before you begin your psychiatry clerkship, if you find some time in your busy schedule think about reading one of the following: either An Unquiet Mind by Kay Redfield Jamison which tells the story of her battle with Bipolar Disorder or A Beautiful Mind by Sylvia Nasar from which last years popular movie was based. Both will give you insight into the lives of those with mental illness and will serve to make your clerkship experience richer. I think I can speak for all clerkship directors in that we look forward to having you on the rotation!

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What to Expect from a Psychiatry Clerkship

By: Stacey Bernstein, MSIV

As a third year medical student at The Finch University of Health Sciences/The Chicago Medical School, I began my third year psychiatry clerkship with a well-established interest in the field. I thought that the six weeks I was going to spend at the North Chicago Veteran's Administration Hospital would simply reinforce my long-standing interest in becoming a psychiatrist. What I experienced turned out to be much more.

No matter what field of medicine you ultimately enter, the psychiatry clerkship offers the chance to hone your interviewing skills, to learn to write descriptively about your patients, and to apply the psychopharmacology that you memorized as a second year medical student. To be successful, one must have patience and compassion, and of course, a sense of humor always helps. Where in other rotations your stethoscope will be your most essential tool, in psychiatry the questions you ask of your patients and the way in which you listen and interpret their answers will be your means of diagnosis.

As with most rotations, the psychiatry clerkship is generally divided into inpatient and outpatient experiences. Some students may have the chance to also take part in their department's Emergency Psychiatry or Consult-Liaison services. In my case, I spent two days each week in a Child and Adolescent Psychiatry clinic, which is an interest of mine, but which also took me away from the continuity of the inpatient floors. Regardless of where you are placed, familiarize yourself in the first days with your environment, including the computer system, the patient charts, the security protocol of the floor or clinic you are working in, and the on-call rooms. Don't be afraid to introduce yourself as a new third year student doctor to the nurses and the other staff. These people will become your most essential allies.

Some medical students see the psychiatric evaluation as nothing more than simply talking. It is, in this way, deceiving, as it is really the medical examination of the human brain. You will learn that despite the conver-

sational tone of a good examination, it is actually structured, and proceeds logically and in a standardized manner. You will want to get the big picture first with open-ended questions and then move on to more close-ended questions as you begin to narrow your diagnosis. This is the skill you will be trying to work towards during your entire rotation. It is challenging, and at times I even felt like the patient was interviewing me. I remember in particular a patient with manic behavior that wouldn't let me get a word in. I greatly appreciated the suggestions of my resident who let me conduct the entire interview myself, and later gave me feedback as to what I did well and what I could have done differently.

Some essentials to have with you at all times during your rotation is a list of the main psychopharmacologic drugs, with both trade and generic names, their mechanism of action, and common side-effects and drug interactions. You may find yourself, as I did, performing cognitive testing on patients. I found it very helpful to keep a note card with the Mini-Mental Status Exam written down, which is used to screen for dementia. I also found keeping an outline of the Mental Status Exam in my pocket useful. This routine exam is the means by which you will communicate in the patient's chart elements of his or her appearance, motor skills, affect, mood, and speech and language, among other things. You will become very familiar with this exam, eventually becoming comfortable with words like, "catatonic features" and "labile mood", to describe what you mean.

Finally, pick up on how patients make you feel. Does he or she make you sad or energized or frustrated? Such an intuitive response may influence the questions you ask during your interview, in turn leading you towards a diagnosis. In this way, the field of psychiatry is an innately human one. You will be challenged during your rotation by the extremes and subtleties of human behavior. In doing so, you will begin to expand your skills as a clinician, while gaining insight into the workings of the human mind.

"No matter what field of medicine you ultimately enter, the psychiatry clerkship offers the chance to hone your interviewing skills, to learn to write descriptively about your patients, and to apply the psychopharmacology that you memorized as a second year medical student."



Stacey Bernstein is a fourth year medical student at the Finch University of Health Sciences/The Chicago Medical School. She has an undergraduate degree in Art History from UC Berkeley, and worked for several years as a journalist before entering medical school. She is applying for residency in psychiatry.

Reflections of an Educator—Career in Academic Psychiatry

By: Leah J. Dickstein, M.D., M.A.

I was asked to write an article on education having chosen to close my faculty career at the University of Louisville after more than 27 years.

I left teaching sixth graders at inner-city Public School 110 in Greenpoint, Brooklyn in 1964 to complete pre-med classes for medical school. I entered University of Louisville in 1966 and I could not have known what opportunities and challenges I would meet and accept.

I loved teaching—an opportunity to relearn and learn more—whether English in the Ghent, Belgium Berlitz school or inner-city bright children or medical students. Each of the prior experiences enabled insights gained which I incorporated into the Louisville programs I created. In 1975, I joined the faculty to establish its first University-wide student mental health service, with trainees from all mental health fields rotating through my supervision. Beyond medical students and psychiatry residents, I welcomed pastoral counselors and expressive therapists from programs (the first such program in the US) established by theologian Wayne E. Oates, PhD and Sandra Kaplan, PhD. I had the good fortune to meet Cornelia B. Wilber, MD, who treated “Sybil,” and supervised me when I diagnosed a gifted and anxious student with MPD in 1977. In 1978, two first year medical students, Judith Axelrod and Michael Saag, came and demanded that I “do something so the next entering class wouldn’t be so stressed.” Thus, I began a multi-disciplinary and voluntary support group, the “Student Hour.” It is still ongoing and has expanded greatly.

When former Hopkins chair, Joel Elkes, MD, joined our faculty, he came to see me at the request of dean Arthur Keeney, MD. At Joel’s suggestion, I moved the Student Hour to four days before classes begin. Again, a voluntary health promotion program for students, their significant others and family members (including dogs!), remains a nationally recognized support program run with the wonderful energy of the medical students and selected faculty. For decades, students continued to thank me for helping them to realize first that they are people to be cared for and to care for each other and their significant others.. One of the greatest satisfaction has been the elective “Physicians and the

Arts” program which I established in 1983. This elective offers preclinical and senior students opportunities to try first time creative projects. Classes, which averaged 80 to 90+ students annually, met weekly to share with each other and learn a variety of new things such as playing an instrument, piloting a plane, climbing to the base of Mt. Everest, sewing quilts, writing poems, plays, etc.

In 1978, I started a seminar, for second year residents, of 50-minute demonstrations of psychodynamic psychotherapy with the same patient for an entire academic year. It was followed by a 40-minute discussion after the patient left and a monograph I wrote of reading assignments.

To say that I have hopefully matured and gained insights into human behavior is clearly an understatement. I have been honored to treat more than 800 medical students as a psychiatrist. This has definitely decreased stigma toward psychiatry as a specialty and as a treatment modality. In fact, many of these medical students became wonderful psychiatrists.

Earning the trust, respect and gratitude of students, residents, faculty, staff and patients for teaching, supervision, advocacy and psychiatric care has been an immeasurable award and reward.

I recommend this career opportunity without hesitation. I would, however, add that simultaneous to learning how to be professionally responsible, one must also learn the politics of academic medicine. This is in order to maximize your opportunities to help others as you dedicate yourself simultaneously to your professional achievements. Furthermore, I have also appreciated students, residents and faculty who have mentored me.

Teaching is the best way to learn. I have been enormously fortunate to have taught others in various schools for more than four decades. I also took appropriate advantage of colleagues’ knowledge I didn’t possess. With a call, I always received wonderful answers. Finally, I could not have accomplished any of these and other programs without the indirect and direct assistance of my family: Dr. Herb and three wonderful sons, two of whom are now colleagues.

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prior to examinations and military personnel engaged in battle. It is also seen with most individuals, who tend to curtail sleep on weekdays and make up for it on weekends. On the other hand, **chronic sleep deprivation** typically refers to partial sleep deprivation over prolonged periods of time, commonly years. While the effects of the former type of sleep deprivation are more easily perceived by the sufferer and understood by laypersons, chronic, partial, sleep deprivation can be as devastating.

Closely related to sleep deprivation is the process of **sleep fragmentation**. This refers to a loss of sleep quality (vs. quantity), which, over time, can lead to the same degree of daytime impairment as sleep deprivation. This is more common than sleep deprivation and is the primary process operant in illnesses that are associated with daytime sleepiness such as sleep apnea syndrome, periodic limb movement disorder, and depression.

II. Sleep Needs

How much sleep do we need? Although most sleep researchers and clinicians prescribe 8 hours per night, which is the average nightly sleep duration, individual needs may vary. A recent National Sleep Foundation poll of more than 1,000 American adults indicated that their average sleep time was between 7 and 8 hours. However, 22% of those surveyed indicated that they were significantly affected by daytime sleepiness, suggesting that their sleep needs were greater. Sleep duration is also highly affected by age. Children above the age of 3 obtain about 10 hours and the elderly less than 7 hours. As the elderly obtain less sleep during the course of a typical night yet spend more time in bed than their younger counterparts. Other studies suggest that seniors have a greater tendency to nap during the course of the day, and have greater complaints regarding daytime sleepiness. Thus, the elderly may actually have a need for sleep that is similar to their younger counterparts, yet may

have greater difficulty obtaining it during the course of the night due to circadian and qualitative deterioration in their sleep. Sleep lengths vary even within similar age groups, with some individuals requiring as little as 5 hours of nightly sleep. Given the great discrepancies in sleep needs, the most prudent answer to the question of "how much sleep do I need?" is that amount of sleep which results in optimal daytime alertness and a sense of mental alertness and well-being over prolonged periods of time.

III. Impact

Many physiological effects have also been demonstrated in human subjects undergoing sleep deprivation. Neurological changes include mild nystagmus, slurred speech, hyperactive gag and deep tendon reflexes, hand tremor, ptosis, and a decrease in nocturnal alpha sleep and an increase in delta and theta sleep. In addition, sleep loss has been shown to lower the seizure threshold in patients with seizure disorders and is often utilized to induce seizures in diagnostic settings. Autonomic variability has also been noted, yet the majority of human studies have reported no significant changes in autonomic parameters such as systolic blood pressure, diastolic pressure, heart rate, respiratory rate, and finger pulse volume. Nevertheless, a recent study revealed a 20% reduction in response to hypoxia and hypercapnia (White, 1983). Apneas, or pauses in ventilation, become more frequent and prolonged (Brooks, 1997). There are subtle decrements in exercise ability and recovery from exercise may be slowed.

Biochemical tests in humans have shown an increase in thyroid activity as measured by thyrotropin, thyroxine, and triiodothyronine. Noradrenaline, prolactin, and growth hormone, which depend on circadian rhythms, lose their periodic or cyclical pattern with sleep loss. Several human studies show changes in immune function as well. A few studies for example found decreases in natural killer T-cell activity.

The changes associated with sleep curtailment that have received the greatest attention on a societal level are those associated with mental function and performance. The most obvious of these is daytime sleepiness. Sleep curtailment is also associated with decrements in mood, irritability, fatigue, decreased concentration and disorientation. Misperceptions and even visual hallucinations can also occur. Other studies have shown impairment in cognition, discernment, visual/auditory vigilance and rapid eye-hand coordination.

The effects of sleep deprivation are seen in a variety of occupations. The report of the National Commission on Sleep Disorders Research (1992) estimates, for example, that 200,000-auto accidents/year are directly caused by sleepiness. In addition, sleepiness accounts for one third of all fatal trucking accidents. The finding that one truck driver death is associated with four innocent deaths magnifies the impact of this difficulty. Sleep deprivation has been implicated as a causal factor in a number of catastrophes, including the Three Mile Island nuclear reactor meltdown (1979), the erroneous launch of the space shuttle Challenger (1986), and the grounding of the oil tanker Exxon Valdez (1989).

Significant concern has been expressed regarding the potential impact of sleep deprivation on physicians and their patients. While results of controlled studies have been highly variable, eleven of 14 studies that examined various types of performance or mood in physicians who had slept an average of 2.6 hours compared with recent baseline sleep of 7.1 hours found significantly worse performance on at least one test (Bonnet, 2000). Studies suggest that performance decrements are more likely in physicians with less experience, on reasoning tasks, and on nonstimulating tasks. Housestaff were also more likely to have fallen asleep

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Ten Medical Students Complete 1st APA/CMHS Summer Fellowships

2002 Summer Fellows

Ama Terasha Nkumah Arthur
Meharry Medical College

Mary Ann Castro Barnovitz
University of California, Davis

Michael Choi
University of Southern California

Laura Louise Deon
University of Tennessee

Dauda Griffin
George Washington University

LeDamien Myers
Wright State University

Falguni Patel
Northeastern Ohio Universities

Ann K. Shinn
UC San Francisco

James H. Suh
Brown Medical School

Brian Gee Tang
University of Vermont

By summer's end, ten medical students became the first cohort to complete the new APA Summer Fellowship, a program that provides practical experiences for ethnic minority medical students interested in psychiatry. Said one fellow, "The fellowship strengthened my resolve to pursue a career in psychiatry," a sentiment which pithily sums up the intent of the program. The Summer Fellowship, an expansion of the APA/CMHS Minority Fellowship Program for residents, was created to give minority medical students hands-on exposure to psychiatric practice in real-life settings in an effort to steer them to a career in psychiatry. The program enables medical students to spend one month during their summer break with a psychiatrist-mentor, who devises an agenda of experiential exercises in patient care and research. Fellows' living, transportation, and other expenses related to the conduct of the fellowship are paid for by the fellowship.

The 2002 summer fellows were ten medical students from California, Illi-

nois, New York, Tennessee, and Washington, DC. They trained at urban facilities which gave them access to the fellowship's target patient groups, underserved and minority patients. Their daily schedules were full and varied. They took patient histories. They observed Grand Rounds. They recommended treatment options. They helped formulate research projects. They attended group therapy sessions. They shadowed interns and residents. "I was really able to get in there and see patients, ask questions, and learn what things were all about," recalled one fellow of her experience.

Applications for the 2003 fellowship year are due on February 14, 2003. Application forms can be downloaded from www.psych.org/students or by following the link to the APA/CMHS Minority Fellowship Program site. For more information and eligibility requirements, contact Alison Bondurant, APA Department of Minority and National Affairs, 202-682-6239; abondurant@psych.org

Chair's Message, cont. from page 1

decreasing Medicare reimbursement, and a downward trend in federal support for residency teaching. Some medical schools find themselves in the unenviable position of cutting faculty members and removing infrastructure. If educational funding is reduced at a *greater* percentage than clinical funding, it could constitute *unethical* institutional behavior. This observation is grounded in the notion that teaching of students is a primary function of medical schools.

- Educators and students can make a difference in being vigilant about the quality of the educational experiences and the availability of resources. ADMSEP, a liaison organization to the Committee on Medical Student Education,

is planning a survey to review resources available to directors of medical student education. The data will be important in the ongoing discussions with chairs and deans about maintaining quality educational programs.

I am encouraged by the determination and quality of psychiatric educators. If you wish to comment on the observations presented, please contact me at cgreiner@unmc.edu

Dr. Carl Greiner is a professor of psychiatry and vice chair for education at the University of Nebraska. He has recently become Assistant Dean for Clinical Affairs with a focus on risk management issues.

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while driving and had increased traffic citations and accidents. Studies that did not reveal negative effects of sleep deprivation have received criticism for methodological issues, such as not controlling for time of testing. Additionally, many compared housestaff who were, to those who were not, acutely sleep deprived, yet did not account for the chronic levels of sleep deprivation in both groups which may have obscured differences between groups. Indeed, the most consistent finding in residents and students regarding sleep has been its paucity; one study of 26 internal medicine residents found that they spent an average of 5 hours per call night in bed, and obtained an average of 3.7 hours of sleep during this time as measured by ambulatory polysomnographic recordings (Richardson, 1996).

In 1989, the Bell Commission report cited sleep deprivation in medical house officers as a major contributor to the death of a young woman in New York (Asch, 1988). In response, the New York State Legislature enacted New York State Code 405, reducing the total work hours for house staff from 100 or more to 80 hours maximum. Despite these minimal restrictions on work hours, a third of residency programs violate them. It is curious that while other professions where human error could also lead to catastrophic consequences, such as the airlines and trucking industries, have imposed strict

guidelines regarding work and rest schedules, this issue has been generally neglected by the medical profession.

IV. Quantification and Assessment

Sleep deprivation can be assessed through the commonly used test, "multiple sleep latency" (MSLT; Mitler, 1982). The patient is studied in a sleep lab and urged not to resist the urge to fall asleep. Daytime sleepiness can be assessed with the "maintenance of wakefulness test (MWT). The test measures the ability to stay awake while engaged in sleep inducing activities of daily life such as driving or reading. If you wish to review sleep medicine in greater depth, the textbook *Principles and Practice of Sleep Medicine* (Saunders, 2000) by Kryger, Roth, and Dement is recommended.

V. Countermeasures

The best remedy for sleep deprivation is more sleep! Thankfully, a short nap ("power nap") can temporarily restore daytime alertness for those who suffer from sleep deprivation. However, the effects of napping are transient and cannot be relied upon for sustained and dependable relief from sleepiness. The most effective treatment of sleep deprivation is prolonged nocturnal sleep over a few weeks or months, followed by the maintenance of adequate sleep times. The adherence to proper sleep hygiene measures is also recommended.

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EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

0=never 1=slight 2=moderate 3=high

- Sitting or reading
- Watching TV
- Sitting, inactive in a public place (eg, a theater or a meeting)
- As a passenger in a car for an hour without a break
- Lying down to rest in the afternoon when circumstances permit
- Sitting or talking to someone
- Sitting quietly after a lunch without alcohol
- In a car, while stopped for a few minutes in traffic

SLEEP HYGIENE EDUCATION

- Maintain regular wake time
- Avoid excessive time in bed
- Short, timed naps
- Expose yourself to bright light while awake
- Avoid nicotine, caffeine, alcohol and OTC sedatives
- Avoid sedating medications
- Exercise regularly early in the day



Medical Student Newsletter

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APA's New Medical Director

We are delighted to announce that James Henry Scully, M.D., has accepted the Board of Trustees' invitation to be Medical Director of the American Psychiatric Association. Jay is a native Washingtonian, former APA Deputy Medical Director and an APA member since 1976. He will begin his new responsibilities as Medical Director effective January 1, 2003.

Jay brings an unusual mix of talent and experience to the Medical Director position. His present job is Professor and Chair of the Department of Neuropsychiatry at the University of South Carolina (USC) School of Medicine in Columbia, SC, and he serves as one of APA's delegate to the AMA HOD.

Jay has always advocated for psychiatry's future - the young psychiatrists of tomorrow. While at South Carolina he spearheaded an aggressive residency training program which now attracts trainees from all over the country. As a result of his leadership, nearly 10 percent of USC's graduating medical students choose

psychiatry as a career, one of the highest percentages in the country.

Jay brings a wealth of experience to the role of APA Medical Director. He served as an interim director of the South Carolina Department of Mental Health and was Residency Training Director at the University of Colorado before becoming vice chair for education. He has also been a hospice consultant and, while in the Navy, served as medical officer aboard the USS John Adams.

While serving as Deputy Medical Director for Education at APA from 1992 to 1996, Jay held appointments as clinical professor of psychiatry at Georgetown University School of Medicine and in the George Washington University Department of Psychiatry, and the Uniformed Services and in the University of the Health Sciences.

Please join us in welcoming Jay Scully back to APA.



James Scully, M.D.