

MILITARY UNIQUE CURRICULUM FOR PSYCHIATRY RESIDENCY PROGRAMS

Background: Psychiatrists cannot function in the military without understanding of military requirements, environments, cultures, and policies as they impact on practice. Our approach was to first determine the competencies expected of a military psychiatrist. In so doing we determined that these competencies are met through clinical experiences unique to our programs, operational medicine rotations during the residency, and formal didactic courses which occur throughout the residency.

Due to variance among the programs, each program has its own means to accomplish the training. For example, some programs have residents involved in disaster management as part of a community rotation while others may rely on seminar discussions or grand rounds presentations. Training in the administration of medical boards and sanity boards is a routine part of military clinical rotations and may occur during inpatient or outpatient years. Command interactions and an understanding of the unique aspects of the military community will occur throughout the course of the residency.

Attachment A is a listing of general competencies. As mentioned above, each program can determine how its residents attain these competencies. By having the competencies for each trainee reviewed routinely by the program director, areas of strength and weakness can be assessed. The trainee's clinical work can be adjusted to meet the requirements or alternative means of meeting the requirement can be developed. Attachments B and C are sample course outlines which provide some of the material in a didactic format. The National Capital and Wilford Hall programs send their residents to a week long training exercise (USUHS Bushmaster). All programs also send residents to the Combat Casualty Care Course.

Defined Competencies:

Command Interface: Residents in military psychiatry programs have routine interactions with unit commanders at all levels of training. Beginning in the PGY2 year residents contact command to obtain collateral information concerning job performance and other behavioral observations of patient prior to service member hospitalization. This interface is vital in determining whether service members are likely to be able to return to a duty status. Military members also face unique stressors as a function of their duty

assignments and direct interface with command is essential in understanding how these matters may have contributed to the onset of illness and the likelihood of outcome if members are returned to duty.

Residents at all levels of training will prepare correspondence to commands concerning recommendations of suitability for further service and instructions for management of service members returned to duty for further service or administrative separation. Attending physicians instruct residents in the proper use of the chain of command in line and medical units to ensure optimal communication at the most effective level of command. PGY3 and PGY4 residents will have operational rotations in which they will interact with line commanders directly and will have the opportunity to discuss mental health issues and brief commanders in effective mental health preventative practices. These topics are also discussed in didactic seminars, grand rounds, and lectures.

Community Psychiatry / Prevention: Residents and fellows are educated and interact with the unique aspects of the military community throughout their training. The military has specific programs for the management of family members with specific physical and emotional problems (such as the exceptional family member program - EFMP). These programs have an impact on the availability of service members for deployment and for the integration and coordination of medical and psychiatric care for family members. Often times these programs have very specific and stringent criteria for enrollment and continued involvement. Since military members and their families are often assigned to remote locations with limited medical resources, there are also programs of overseas screening for service members and their families. Psychiatry residents are trained in understanding the availability and capabilities of medical and psychiatric services in these locations and are taught to assess whether service members and their families are appropriate for assignment to these isolated areas.

Substance abuse and dependence have historically interfered with the ability of military units to function optimally. In recognition of these problems, the military has specific programs for the identification, treatment, and monitoring of individuals with substance abuse and dependence problems. Residents must be familiar with these rules and interact with military unique administrative and treatment guidelines. During all phases of training residents are taught how to identify substance use problems and to refer service members to the appropriate level of care. They interact with the line community in determining which service members are likely to be able to complete their service commitments based on their response to substance use treatment programs.

Community psychiatry and prevention strategies are also taught in the course of didactic lectures, grand rounds, seminars, and clinical rotations which address how military psychiatrists educate and provide liaison services to line commands. Residents are taught methods of providing education of suicide prevention, stress management, and critical incident stress debriefing. Such educational outreach programs are usually not available in civilian training programs.

Confidentiality / Ethics / Dual Agency: Military psychiatrists are somewhat unique in that they serve both the patient and the parent military command. One of the most difficult areas for our physicians is understanding the interaction of these roles. A primary example of this is would be the military's position on individuals with homosexual or bisexual preferences serving on active duty in the military. Often times these individuals will disclose their sexual preferences in the course of psychotherapy or during a psychiatric evaluation. It is important for the psychiatrist to be able to distinguish the difference between disclosure in that setting compared to a disclosure or discovery made in the course of routine military service. Military psychiatry residents are trained in ways of obtaining important clinical information without compromising the patient's right to privacy and to protect the patient's ability to remain on active duty if that is their desire.

The military also has very specific rules on the degree of confidentiality of medical records and specific procedures for the release of those records under conditions of formal investigations or legal proceedings. Residents are educated on these specific guidelines through the course of their didactic courses, and also in day-to-day clinical supervision with experienced military psychiatrists who have previously faced these situations. Residents are taught to include in their medical records only the documentation necessary to provide appropriate medical care of the patient, thereby protecting, to the maximum degree possible, the confidentiality of information disclosed.

Due to the isolated nature of many military based throughout the world, there are often issues of privacy with regard to treating patients with whom other relationship exist. For example, military psychiatrists may be called upon to provide psychiatric treatment to their medical colleagues or to their family members. They may even be required to provide psychiatric care for officers superior to them in the military chain of command. These situations raise inherent ethical concerns. Residents in military psychiatry residency programs are exposed to these situations during a period of time in which they have

appropriate senior supervision. Residents in non-military psychiatry residency programs do not have this opportunity, as most people with a psychiatric condition would elect to seek psychiatric care other than from their professional colleagues.

The military has unique issues of confidentiality and patient privacy. Military rules of evidence for legal proceedings are different than state and federal rules of evidence. There is no physician/patients confidentiality of information contained in active duty and non-active duty records maintained by military medical treatment facilities. There are, however, specific safeguards which control the release of records to appropriate authority. Psychiatrists not trained in military programs are unaware of these conditions and have erred at both extremes of illegally suppressing records and releasing information without due process.

Medical Systems Issues: Military members are expected to perform their duties in diverse and often rigorous environments throughout the world. Individual members in combat units face unique biological, psychological, and environmental factors which are never seen in comparable civilian populations within the continental United States. Psychiatric conditions in these environments may present in a significantly different fashion than in a routine clinical setting. Exposure to toxic agents or infection may result in symptoms which mimic psychiatric conditions. Patients with psychiatric problems may also develop physical symptoms which are suggestive of other etiologies. Our residents are taught a systematic process for evaluating patients in operational settings. This occurs through formal didactic courses throughout the course of the residency program. It also occurs during a unique operational experience that the residents from Wilford Hall and the National Capital Area attend during their third year of psychiatry training. Operation Bushmaster is a field training exercise conducted at Camp Bullis in San Antonio, Texas. During the course of this training exercise residents serve as instructors for senior medical students. They instruct the students in the specific aspects of operational medicine which modify the perspective of a psychiatric evaluation. Students evaluate simulated psychiatric patients under the supervision of the resident. Sample conditions include patients with atropine intoxication who present as being psychotic, patients in the midst of substance withdrawal, patients with amnesia probably secondary to traumatic brain injury, and patients with routine adjustment disorders as a result of being assigned to a combat theater. In addition to assessing and diagnosing these simulated patients, the students and residents are also challenged in how to manage them in an operational setting. Medications will be limited and psychiatric support staff and support facilities are extremely limited. A determination must be made whether the individual can be reconstituted to the point of returning to duty, or whether they must be evacuated from the battlefield.

An additional unique aspect of psychiatric practice in the military is the utilization of non-physician provider-extenders. The military has uniquely trained enlisted personnel who serve as psychiatric technicians on inpatient units, in outpatient clinics, and in operational assignments. Newly graduated residents from military psychiatry residency training programs are often assigned to positions as division psychiatrists or as commanders of combat stress center detachments. These assignments require that the psychiatrist be able to appropriately supervise and train the enlisted psychiatric technicians. Instruction in how to approach this responsibility is included in the didactic courses of the residency programs. More importantly, from the beginning of their training, and throughout the course of their residency, psychiatry residents in the military programs work side-by-side with the enlisted psychiatry technicians. In this manner, they become aware of the capabilities and limitations of these personnel. While civilian residency programs train residents in hospitals which utilize paraprofessional staff, the working relationship between the residents and the paraprofessional staff is not nearly as close as it is in the military treatment facilities.

Fitness for Duty/Administrative/Forensic Issues: Military physicians are called on to make determination of whether service members are fit or suitable for continued service. This responsibility is rarely seen in civilian practice. Members are unfit for duty if they manifest significant symptoms resulting from a primary acute psychiatric disorder such as depression, manic depressive illness, or schizophrenia. In the event that members develop such disorders and their symptoms are not quickly manageable with appropriate treatment, the individual is separated by means of a medical board. Throughout the course of their training, military psychiatric residents assess and treat patients with consideration of the possibility of the need of a medical board. They must take into consideration the severity of illness, the nature of the stressors of which precipitated the illness, and the patient's response to treatment. Additional factors include the patient's military specialty and the environment to which they will likely be returned. Medical boards are extremely important documents in that they will influence the ability of the service member to remain on active duty. They also influence the amount of medical care and financial support provided the service member. Medical boards must therefore be prepared with great accuracy and detail. Residents in our programs learn to prepare these documents in their first and second years of training under close staff supervision. The medical board system is extremely complex and in that it includes options for service member rebuttal and appeal of the initial recommendation and ultimate findings. Only by experiencing this system can psychiatrists be aware of its complexities and possible pitfalls.

Service members who suffer from long-standing psychiatric conditions such as personality disorders, or substance abuse disorders which are refractory to treatment available within the military may be deemed unsuitable for continued military service. Under these conditions service members do not receive medical boards; they are administratively separated by the line commander. In this regard, residents are required to carefully assess the nature of the patient's symptoms and causes. They must then determine whether the patient is likely to be able to return to a level of function appropriate to their military responsibilities. If this is not likely, then the resident must prepare a letter of recommending administrative separation. Each of the military services is somewhat unique with regard to the terminology and regulations related to administrative separations. Residents, through experience, gain an understanding and an appreciation for the differences between the services. Depending on the nature of the problem, there are also priorities for separation ranging from expeditious to routine. In making their recommendation, a resident must determine whether the patient poses a significant risk to himself or others if maintained on active duty, or whether he can tolerate the weeks to months of delay associated with a routine separation. Contact and consultation with line commanders at this point is essential to ensure that the resident has a full understanding of the patient's prior behavior. Line commanders must be provided full understanding of the consequences of their acceptance or rejection of the medical recommendation for separation. There is new legislation referred to as the "Boxer Act" which deals with military unique aspects of involuntary admission and retention on inpatient status, as well as management of potentially dangerous service members. These rules and regulations are unique to the military and differ significantly from civilian practice and training which residents receive in civilian training programs.

Unlike their civilian counterparts, military physicians are often called upon to serve as forensic experts and to provide administrative review of complex psychiatric cases. In this regard, military psychiatrists often times are called to assess the competency of patients to stand trial and to determine whether they are able to properly engage in the defense of their case. They must also determine whether there are mitigating factors of a psychiatric etiology which might influence the court in making its determination of guilt or punishment. In the civilian sector, this is an area of sub-specialty training and of a dedicated career path. In the military, all psychiatrists regardless of their ultimate assignment may be called upon to perform these evaluations. An integral part of the training program is that residents, while under supervision, perform sanity board evaluations and formal reviews for boards of correction of records. Once again, these evaluations and procedures related to them fall under strict regulations which are unique to the military. By performing these evaluations while in training, our residents become familiar with these

regulations. In addition, military psychiatrists may be called upon as expert witnesses in administrative appeals or in courts martial. Our residents are taught approaches to skillfully provide expert testimony and to avoid pitfalls into which novice witnesses can fall. They are also taught the principles which distinguish expert testimony from legal consultation.

Professionalism/Military Bearing/Physical Readiness: Military psychiatrists are also military officers and are expected to maintain the same professional standards as their line counterparts. To accomplish this, residents in training are subjected to physical fitness tests twice per year. Failure to meet weight standards or to pass the physical fitness test can be cause for discontinuation of training and for other disciplinary or administrative actions. Military residents are also expected to wear their uniform in the proper fashion and to display appropriate military etiquette and personal grooming standards. By living this lifestyle throughout the course of their residency graduates of the military psychiatry programs are comfortable in fulfilling these professional standards on assignment to their first duty station. By living in a military environment throughout the course of their residency, the residents also develop an understanding and appreciation of leadership issues and the management of active duty and civilian employees within the structure of military hospitals. Leadership and personnel management within the military and federal system is significantly different from that found in civilian training institutions. Residents trained in military psychiatry residency programs are therefore much more capable leaders and personnel managers following their graduation.

Operational Readiness/Organizational Issues: The Department of Defense and the component services branches of which it is comprised are extremely complex organizations. Each of the military services has a unique organizational structure and a unique role within the national security strategy. Under the Goldwater-Nicholes Act of 1985, the services function in joint command structures for most operational assignments and military operations other than war. All military psychiatrists must be aware not only of the structure and organization of their own service, but that of the other services as well. Psychiatrists who do not understand these issues will be less competent and less credible when interacting with line commanders. The curriculum of the military psychiatry residency programs includes an orientation to command organization structure and function, not only for the service to which the individual is assigned, but to the other services as well. Thus an Air Force psychiatrist is expected to have a general understanding and appreciation of the capabilities of a Marine expeditionary unit, a Navy task group and an Army division. Effective interaction with line commanders also requires that military psychiatrists have

an appreciation of the global national security policy. Military psychiatry residency programs include seminars which discuss national strategy utilizing documents such as the report on the Defense Quadrennial Review and White House papers which express the most recent changes in strategic planning and strategic policy. Other topics include a discussion of operations within a joint command structure. Residents are also expected to be conversant in discussions of how central unified commands function with regard to issues such as cultural differences among the services and the manner in which power and authority is distributed within these complex command structures.

In addition to their understanding of how the line units are organized and function, military psychiatrists must be aware of medical units and specifically how mental health assets are organized and deployed in peacetime in operational settings. Residents in the military programs are provided instruction in these organizational and operational topics as well as practical issues such as how to prepare for deployment and re-deployment. These topics are covered in a series of seminars, and are also the subject of Grand Rounds presentations throughout the course of the four-year residency programs. Residents are provided exposure not only to their parent service, but also to the other services as well, since they will be expected, upon graduation, to operate in a joint medical environment.

In summary, it should be clear that the unique aspects of the military psychiatry residency programs do not lie only in didactic courses. The military curriculum is taught through clinical experiences, administrative taskings and operational exercises, all under the supervision of trained and experienced military faculty. A successful military psychiatrist must also accept and adapt the cultural norms unique to the military. This occurs only through immersion and repetition over the entire course of the residency program.

RESIDENT MILITARY PSYCHIATRY COMPETENCY CHECK LIST

Resident Name: _____

Identified as
Competent for
Level of Training
Date

Identified for
Additional Work
Comments:

1. Command Interface (Example components: Consultation on organizational processes, Principles of avoiding group discrimination and harassment, Components of an effective briefing, Military correspondence and chain of command issues) _____
2. Community Psychiatry/Prevention (Example components: Roles of EFMP, Screening for overseas deployment of dependents, Suicide and stress management briefings, Rules and application of substance abuse policies) _____
3. Confidentiality/Ethics/Dual Agency (Example components: Nature of doctor/patient relationship in military, Practical issues related to “don’t ask/don’t tell”, Understanding of dual agency issues, knowledge of limits of confidentiality and regulations concerning release of records, Management of privacy in small command environments) _____
4. Medical Systems Issues (Example components: Identify biological psychological and environmental factors at individual and group levels as they affect the delivery of psychiatric and medical care in war and MOOTW environments. Describe evaluation and management of psychiatric and medical problems in diverse operational environments, Concepts of supervision and training of non-physician mental health providers. Principles of disaster management and consultation - CISD,) _____
5. Fitness for Duty/Administrative/Forensic Issues (Example components: Preparation of medical boards - letters to command regarding suitability, Performance of Sanity Boards, Review of Boards for Correction of Records packages, compliance with regulations concerning command directed evaluations, Understanding of principles of pre-deployment screening and evacuation for deployed operations, Principles of “expert testimony” versus legal consultation) _____
6. Professionalism/Military Bearing/Physical Readiness (Example components: Pass physical fitness/readiness tests, Proper wearing of uniform, Proper military etiquette, Personal grooming standards, Understand issues of leadership in operational units and in large military/joint service commands. _____
7. Operational Readiness/Organizational Issues (Example components: Organization of combatant and medical support units in the three services, Knowledge of joint operations in war and MOOTW environments, Understanding of national security and strategic concepts, _____

Signatures / Review Date (quarterly)

Resident _____

Program Director _____