Clinical Excellence in Psychiatry: A Review of the Psychiatric Literature

Margaret S. Chisolm, MD; Matthew E. Peters, BS; Kathleen Burkhart, MPA; and Scott M. Wright, MD

ABSTRACT

Objective: The provision of excellent patient care is a goal that physicians would like to achieve in caring for all patients, all of the time. Until recently, *clinical excellence* had not been defined, and the extent to which this recently published definition applies to the care of patients with psychiatric illness is not known. This article sets out to consider how the paradigm for clinical excellence applies to the field of psychiatry.

Data Sources: PubMed, Ovid MEDLINE, and PsycINFO were searched (1962 through December 2010) combining the keywords *psychiatry* (or *psychiatrist*) and *clinical excellence*, limiting the output to English-language case reports. In subsequent searches, the term *clinical excellence* was replaced by each of the components of the definition: *communication* and *interpersonal skills*, *professionalism* and *humanism*, *diagnostic acumen*, *skillful negotiation of the health care system*, *knowledge*, *scholarly approach to clinical practice*, *exhibiting a passion for patient care*, *explicitly modeling mastery to medical trainees*, and *collaborating with investigators to advance science and discovery*.

Study Selection: The search yielded 218 case reports. All of the case reports were reviewed, and a consensus was reached on the 8 exemplars and 1 teaching model to be presented in the article. Careful consideration was given as to whether any aspects of the framework for clinical excellence were missing or not applicable for psychiatry.

Results: Every case report reviewed touched on 1 or more of the domains of clinical excellence. None of the case reports uncovered new aspects of clinical excellence that were not described in the existing definition.

Conclusion: This review of the case reports published in psychiatry reveals that the definition of clinical excellence described in this article may be highly applicable to those caring for patients with psychiatric illness.

Prim Care Companion CNS Disord 2012;14(2):doi:10.4088/PCC.11r01179

Submitted: *March 10, 2011; accepted September 13, 2011.*
Published online: *April 5, 2012.*
Corresponding author: *Scott M. Wright, MD, Miller-Coulson Academy of Clinical Excellence, Johns Hopkins Bayview Medical Center, Johns Hopkins University School of Medicine, 5200 Eastern Ave, Mason F. Lord Bldg, Center Tower, Ste 2300, Baltimore, MD 21224 (swright@jhmi.edu).*

As a public trust, the medical profession has a responsibility to provide clinically excellent care to patients. The research mission at academic health centers often overshadows the commitment to patient care. This prioritization of scholarship and discovery ahead of patient care can result in a failure to recognize the clinically excellent academic physician.[1] It is difficult to value constructs that are not readily measurable, and this might at least partially explain why researchers, whose accomplishments can be measured in grants secured and articles published, may be regarded more highly than skilled physicians. Before measurement of clinical performance can be considered, defining clinical excellence is a mandatory first step.

The Miller-Coulson Academy of Clinical Excellence at Johns Hopkins Bayview Medical Center (Baltimore, Maryland) was established to recognize and promote clinical excellence.[2] The Academy's members currently hail from 9 clinical departments, and, in addition to providing outstanding patient care, the Academy seeks to teach clinical excellence and advance what is known about clinical excellence. To this end, this article seeks to build on earlier qualitative studies wherein analysis resulted in a definition for clinical excellence.[3] While the resultant domains of clinical excellence appear to apply broadly to all fields of medicine, questions have arisen as to how well they relate to a specific discipline such as psychiatry.

Although clinical excellence as a scientific construct is beginning to receive attention in some medical specialties,[2–6] little has been published about this subject matter in psychiatry.[7] Core competencies for psychiatry have been established[8,9] and elements of high-quality care in psychiatric subspecialties have been described,[10–12] but there is little guidance in the literature that might help an individual to discriminate between good and great psychiatrists.[13] With increasing interest in the patient-centered medical home model of primary care and with the advent of accountable care organizations, an understanding of the qualities desirable in clinical psychiatrists, involved either as consultants or in collaborative models, is now especially relevant for addressing mental health effectively in primary care settings.

This article describes a process wherein published case reports were reviewed to explore whether the core domains of clinical excellence are represented in the literature and to look for elements that might be missing from our framework.[2]

DEFINITION OF CLINICAL EXCELLENCE IN ACADEMIA

Multiple methodological approaches were used to define clinical excellence in academia over a 12-month period by those tasked with developing the Miller-Coulson Academy of Clinical Excellence. After conducting a systematic review of the literature,[2] our team met with internal organizational leaders (including deans, the university president, promotion committee chairs, and department chairs) and solicited input to understand perspectives from leaders at national

Clinical Points

- Clinical excellence comprises several domains, all of which are applicable and relevant to psychiatric patient care.
- Mastery of these domains enables clinicians to provide the best possible care for all patients, including those with psychiatric illness.
- Excellent patient care can be fostered in the academic medical setting by recognizing those clinicians who exemplify clinical excellence.

organizations (including Association of American Medical Colleges, American Board of Internal Medicine, and American Medical Association). We then conducted a qualitative research project with master clinician informants from across the country.[3] As part of this iterative process, we finally arrive at the following definition for *clinical excellence in academia*:

- Achieving a level of mastery in the following 6 areas as they relate to patient care:
  1. Communication and interpersonal skills
  2. Professionalism and humanism
  3. Diagnostic acumen
  4. Skillful negotiation of the health care system
  5. Knowledge
  6. Scholarly approach to clinical practice
- Exhibiting a passion for patient care
- Explicitly modeling mastery to medical trainees
- Collaborating with investigators to advance science and discovery.

The last 2 domains are of relevance to clinicians in academic medical settings, whereas the other domains are applicable to clinicians in any setting.

METHOD

Rather than describing local examples of clinically excellent individuals and programs in psychiatry at our institution, it was decided that the proof of concept for this article would come from case reports of psychiatric care delivered elsewhere.

A senior medical informationist from the Harrison Medical Library at Johns Hopkins Bayview Medical Center was enlisted to help with the case finding. A search of PubMed, Ovid MEDLINE, and PsycINFO for the years 1962 through December 2010 was performed. Initial broad searches combined the keywords of *psychiatry* (or *psychiatrist*) and *clinical excellence*, limiting the output exclusively to case reports. Searches were also narrowed by using the limits of *humans* and *English*. In subsequent searches, the term *clinical excellence* was replaced by each of the components of the definition above (eg, *diagnostic acumen*). Using these parameters and limits, a total of 218 unique published case reports were identified across the databases. The abstracts or summaries were used to screen the articles. Those articles showing promise were then read in their entirety to fully understand the patient's story and the psychiatric care that was delivered. At team meetings, the authors discussed candidate case reports and decided by consensus upon the cases to serve as exemplars. The authors discussed and considered the extent to which each case represented high-quality performance in 1 of the domains in the definition, while also deliberating about whether extreme cases adequately demonstrated the nuances required in psychiatry.

In reviewing the many cases, the authors carefully considered whether there were any aspects of the framework for clinical excellence that were missing or not applicable for psychiatry.

APPLICATION OF THE DEFINITION OF CLINICAL EXCELLENCE TO PSYCHIATRY

To illustrate how mastery in each of these domains relates to the care of patients with psychiatric conditions, the authors selected 8 case reports and 1 teaching model from the extant literature. Each case or model report demonstrates how mastery of a particular domain of clinical excellence enables clinicians (including psychiatrists, non-MD psychotherapists, and internists) to expertly diagnose and provide the best possible care for psychiatric patients.

Communication and Interpersonal Skills

Communication and interpersonal skills may be considered to be at the heart of excellent care of patients with psychiatric illness. A report of successful psychotherapy in a woman with schizoaffective disorder highlights the importance of this domain to psychiatric care.[14] In this case, the patient, Ms A, was a 30-year-old woman with schizoaffective disorder who did not talk to or make eye contact with her treatment team for the first 6 months in an acute psychiatric hospital.[14] The report relays a breakthrough moment when, in an attempt to reach Ms A in the seclusion room, her therapist lay down on the floor next to her mattress and spoke to her calmly and soothingly. After 180 sessions, Ms A finally conversed with the team, telling them how grateful she was and thanking them for trying to "save" her from her terrifying world.[14] From that point on, Ms A was able to talk openly and freely with the team. She was eventually discharged from the psychiatric unit, continued to meet with her psychotherapist, and never required another psychiatric hospitalization for the 15 years of follow-up described in the case report. The persistent, undaunted efforts at meaningful communication between the treatment team and Ms A were viewed as essential for her recovery.[14]

The psychiatrist Jerome Frank described features common to successful psychotherapies—in both religious and medical settings—worldwide using empirical research methods.[15] One of Frank's most important findings was that the success

of all techniques rests on the healer's relationship with the patient, an alliance that is best predicted by the healer's ability to convey empathy, and the skill of "conveying" empathy rests on communication and interpersonal skills (while the empathy itself is at the core of humanism,[16] which is discussed in the next section). Communication and interpersonal skills allow psychiatrists to connect in a meaningful way with patients. These proficiencies are obviously a central domain of clinical excellence in every branch of medicine, but they are even more critical in psychiatry. This is especially true when working with psychiatric patients with severe communication barriers, such as mutism, as illustrated in the case above.[14]

Professionalism and Humanism

Because of the potential vulnerability of patients with psychiatric illnesses, only practitioners with profound commitments to professionalism and humanism can be considered to be clinically excellent. While there are many conceptualizations for professionalism in medicine, The Physician Charter, endorsed by many organizations including the American Board of Internal Medicine, stresses 3 principles: (1) the primacy of patient welfare, (2) patient autonomy, and (3) social justice.[17] The Arnold P. Gold Foundation is dedicated to humanism in medicine, which they describe as "relationships between physicians and their patients that are respectful and compassionate. It is reflected in attitudes and behaviors that are sensitive to the values, autonomy, cultural, and ethnic backgrounds of others."[16]

The case of Mr B, a 37-year-old patient who presented to an emergency room after being struck with a bottle and losing consciousness, illustrates how physicians can be exemplary in this domain.[18] During his hospitalization, the team discovered that, over a span of 14 years and 27 cities in 3 states, Mr B had 33 criminal arrests and 72 prior hospital visits. Mr B was ultimately diagnosed with Munchausen's syndrome, defined by a self-induced syndrome for which medical/surgical treatment is sought. The team consciously and deliberately continued to treat Mr B with empathic concern and intellectual curiosity despite their growing awareness of his lies. This hospitalization ended in an outcome that is not different from that of many patients with Munchausen's syndrome: Mr B fled the hospital and was lost to follow-up.[18]

Tolerance and compassion are essential in the treatment of any patient. Those psychiatric conditions that involve deception and poor prognoses may engender antipathy from the psychiatrist and challenge his/her ability to connect with the patient as an individual. This is especially common in patients with Munchausen's syndrome.[19] Nevertheless, a clinically excellent clinician, as seen in the case of Mr B, will appreciate that each patient deserves to be heard, respected, and valued. Mr B's treatment team found him to be extremely interesting and educational, so they elected to present his case at grand rounds and to write a case report.[18] Professionalism and humanism with patients are of paramount importance for the realization of the meaningful and trusting relationships that are essential for effective psychiatric treatment. This need for trusting relationships is especially true of patients with highly culturally stigmatized behavioral disorders, such as patients with pedophilia, repetitive self-injurious behavior, injection drug abuse, and, as Mr B demonstrated, Munchausen's syndrome.

Diagnostic Acumen

Many psychiatric signs and symptoms are diagnostically nonspecific and can only be distinguished by a thorough and detailed approach to the patient's history and mental status examination. Although a full discussion of the nature of a clinically excellent patient assessment is beyond the scope of this article, we want to emphasize the fundamental role of a systematic patient assessment in psychiatric clinical reasoning; it is the foundation for all that follows. This type of evaluation may take several hours, which in a real-world inpatient or outpatient setting may require more than 1 visit to complete. But a careful and personalized assessment will reap rewards for the patient in the form of a more accurate understanding of the individual and his/her condition. This type of assessment may allow for the formulation of the most appropriate plan and the delivery of effective therapy.

Borderline personality disorder and bipolar affective disorder share many criteria, as can be seen in the *DSM-IV-TR*. The case that follows is presented to illustrate the role that diagnostic acumen plays in distinguishing between these 2 psychiatric conditions.[20] Ms C, aged 22 years, was seen by a consulting psychiatrist regarding ongoing management of bipolar disorder diagnosed at the age of 16 years. The psychiatrist agreed that Ms C displayed most signs and symptoms of bipolar disorder, including periods of apparent mania, but given the chronic rather than episodic nature of her illness, a cluster B personality disorder was suspected.[20] Ms C showed evidence of splitting, a classic sign of borderline personality disorder, including an instance of severe rage against her "lying" psychiatrist who was out of town on vacation. Given this new diagnosis, her therapy was changed from a mood stabilizer to the combination of an antidepressant and weekly individual psychotherapy with excellent results.[20]

The *DSM* classifies psychiatric disorders entirely on their outward appearances—the signs and symptoms they produce. There is no doubt that this way of looking at mental illness has moved the field of psychiatry forward. This atheoretical approach has provided a vernacular that may be used by any psychiatrist to describe a collection of the signs and symptoms displayed by a patient and reliably assign a diagnosis based on the syndrome observed. This method has also allowed researchers to study reliably similar subsets of patients on the basis of a set of displayed symptoms and signs, thereby advancing our understanding of optimal therapy. However, as this case illustrates, it is a superficial appearance-based classificatory system that, in the hands of an inexperienced and/or harried psychiatrist, can result in missing diagnoses that require more skill and time with the patient to diagnose. A clinically excellent formulation and

treatment plan does not simply entail writing down the *DSM* multiaxial diagnoses. Although not shown in its entirety here, the unabridged version of Ms C's case[20] demonstrates her physician's meticulous attention to detail in building the observation-based history and mental status examination, which is essential to one's proficiency as a diagnostician in working with patients with psychiatric conditions.

Skillful Negotiation of the Health Care System

Coordination of medical care for individuals with psychiatric illness can be challenging because of myriad factors, including the potential for ambivalence, impaired cognition, lack of insight, poor judgment, poverty, limited treatment resources, and stigma. Those aspiring to deliver excellent patient care to individuals with psychiatric illness must be effective advocates who are knowledgeable about the resources available for patients. Presented here is the case of Ms D, a 47-year-old homeless woman with a diagnosis of paranoid schizophrenia followed by an Assertive Community Treatment (ACT) program.[21] ACT programs are community-based treatment programs for individuals with severe and persistent mental illness and are sometimes viewed as "hospitals without walls."[22,23] ACT teams straddle the ethical line between autonomy and beneficence and often perform services otherwise carried out by family members. In this case, after trying all other treatment engagement avenues without success, including relocating Ms D to an apartment building with a night staff and curfew, the ACT team decided to offer Ms D a global positioning system (GPS) device.[21] Long-term hospitalization was seen as the only safe alternative. A consultation from the ethics team was solicited to assist in the shared decision-making process. Although it was decided that a GPS-enabled device would be the less restrictive solution, ultimately this device was not used.[21] When caring for patients who are sick and complex, clinically excellent psychiatrists, like all masterful clinicians, seek input from and consult trusted colleagues.

Because a fundamental aim of all ACT programs is to enable patients to remain in community-based treatment, ACT teams must be quite resourceful across the spectrum of health care delivery options. Skillful negotiation of the health care system was modeled creatively by the ACT team in caring for Ms D.[21] The team's consideration of technology to extend their coverage to support Ms D wherever she may travel is an example of clinically excellent psychiatry.

Knowledge

Many consider knowledge to be the cornerstone of clinical excellence in medicine, as deficits here can render all other domains of clinical excellence moot. Although traditionally prized as the coin of the realm, knowledge is now increasingly searchable on Google from almost anywhere given the advances in smartphone technology. With that said, clinically excellent physicians are extremely knowledgeable, and, perhaps even more importantly, they know what they don't know and know how to find what they need.

The case of Ms E, a 30-year-old woman, 6 weeks postpartum and breastfeeding, with signs of postpartum depression, is presented for illustration.[24] This new mother described classic symptoms of depression and confided to the psychiatrist that she often felt unsure of her ability to care for her baby. Since his birth, Ms E had neglected her own hygiene and housekeeping duties, although according to her husband, she was taking good care of the baby.[24] With the support of her husband and the pediatrician, the patient and her psychiatrist decided to initiate therapy with medication. Because of Ms E's desire to continue breastfeeding, the physician called upon his knowledge of psychopharmacology as it relates to concentrations of drug in breast milk, and sertraline was selected. Communication with the involved pediatrician ensured close monitoring of the baby over the ensuing weeks.[24]

This case was selected because it nicely demonstrates how knowledge is critical for effectively taking care of patients suffering from psychiatric conditions. Psychiatrists treating women of reproductive age must stay current with the rapidly evolving evidence base in the scientific literature as it relates to risks, benefits, and alternatives. In such instances, psychiatrists must consider the efficacy and safety of treatments as they pertain to the mother and her child. In this case, the focus is on postpartum depression, a condition that affects 10%–20% of women.[25] Although not included in the case excerpt above,[24] the excellent psychiatrist remains alert to the possibility of postpartum psychosis, which although rare, is associated with increased risk of suicide and infanticide.[26] This clinically excellent care of a relatively common, yet potentially life-threatening, disorder is predicated upon the psychiatrist's expert knowledge about postpartum depression's prevalence, clinical features, and treatment options and the need for a team approach involving the patient's husband and pediatrician.

Scholarly Approach to Clinical Practice

Clinically excellent psychiatrists are not only knowledgeable but they also keep up-to-date with new discoveries, and they understand how to apply this new knowledge as evidence-based practitioners to the care of their patients. Another aspect of the domain scholarly approach to clinical practice involves generating new knowledge through scholarly collaborations with investigators and even publishing case reports like those highlighted in this article.

Ms F, a 70-year-old woman, presented to a geriatric psychiatrist following 12 months of progressive memory decline.[27] Her Mini-Mental State Examination (MMSE) was 26/30, losing 3 points on short-term recall and 1 point on orientation. Armed with knowledge of the prevalence of mild cognitive impairment, 19% for individuals over 75 years of age with incident rates of 1%–1.5% annually, the psychiatrist gave this diagnosis strong consideration early in the evaluation.[27] The psychiatrist followed the diagnostic algorithm and ultimately confirmed the diagnosis of mild cognitive impairment. The psychiatrist was aware of the lack of effective pharmacotherapy for mild cognitive impairment

(based on critical appraisal of several randomized controlled trials) and did not prescribe a medication, as this would be unnecessary, costly, and potentially harmful.[27]

In this case, the psychiatrist's scholarly approach resulted in clinically excellent care of the patient.[27] The psychiatrist used empirical methods to arrive at the definitive diagnosis of mild cognitive impairment and also applied the principles of evidence-based medicine when reviewing the scientific literature for the discussion with Ms F and her husband about the likelihood of progressing to dementia. Proven behavioral approaches were also stressed as strategies for reducing this risk.[27]

Exhibiting a Passion for Patient Care

No case reports ever written capture a clinician's passion for treating patients with psychiatric conditions more fervently than those composed by Sigmund Freud. In the "Wolf-Man," Freud presents the case of Sergei Pankejeff, a 23-year-old Russian aristocrat severely disabled by pervasive anxiety and phobias.[28,29] Although Pankejeff's religious neurosis is the main focus of his 4-year treatment with Freud, the case report centers on the analysis of Pankejeff's terrifying dream of a pack of wolves sitting in a tree outside his bedroom window. Pankejeff completed treatment, was apparently cured, and only returned to Freud briefly following the Russian revolution and dissolution of his fortune.[28,29]

Freud's major case studies are not only vivid and compelling narrative achievements in their own right but also detailed psychological studies that demonstrate Freud's authentic engagement in his patients' treatment. Although Freud's clinical excellence in other domains may be a matter of controversy, his intense intellectual and emotional engagement with his patients and their stories are indisputable.

Explicitly Modeling Mastery to Medical Trainees (relevant for psychiatrists in academia)

Apprenticeship from novice to master is the basis and ambition of medical training. To demonstrate the domain of explicitly modeling mastery to medical trainees, a report of a psychiatric teaching model is presented.[30] This model includes 3 specific methods for the teaching of psychiatry to medical students and residents: the lecture, the tutorial, and the recitation. Explicit modeling is most evident in the recitation, a process that involves a questioning instructor and a responding student. In the recitation, a psychiatry resident presents a patient's history, an experienced faculty member examines the patient, and then the students are questioned by the teacher about what they observed during the faculty member-patient interaction and what conclusions can be drawn on the basis of these shared observations. Led by a master psychiatrist, this group experience provides a model of clinical excellence that has advanced learning for generations of psychiatry trainees at multiple institutions.[30] Explicit modeling wherein the faculty member explains and draws attention to their behaviors is believed to be a particularly effective method for influencing trainee behaviors.[31]

This teaching paradigm, centered on the teacher's examination of a patient, provides opportunity for modeling of excellence in patient care. The observation of masterful psychiatrists' interactions with patients offers students a standard of excellence to which they can aspire.

Interface With Researchers to Advance Discovery (relevant for psychiatrists in academia)

Academic psychiatry demands that faculty members contribute in ways that are above and beyond the delivery of high-quality clinical care. Dissemination of clinical scholarship is usually an expectation at our academic institutions.[32] While there are several ways to accomplish this task, one strategy is for academic psychiatrists who spend a majority of their time delivering clinical care to interface with researchers in hopes that such partnerships may result in the advancement of discovery.

The exemplary case selected for this section describes Mr G, a morbidly obese man (body mass index > 55 kg/m^2) who decided to enroll in an experimental deep brain stimulation trial for hypothalamic stimulation after failing multiple medication and behavioral therapies for weight reduction.[33] The treating team was multidisciplinary, consisting of a psychiatrist and a psychologist, neurologists, and neurosurgeons, all who collaborate with additional researchers to develop novel treatments for overeating. In this report, a psychiatrist's ability to interface with clinical researchers led to a novel treatment for overeating.[33] This particular procedure has been shown to control appetite in animals, including nonhuman primates. Under local anesthesia only, deep brain stimulation electrodes were implanted bilaterally in the ventral hypothalamus of Mr G to stimulate potential appetite suppression sites. Mr G perceived vivid and colorful déjà vu sensations and felt 20 years younger. However, he did not sense subjective, reproducible changes in hunger sensation from any of the contact sites.[33]

The case report illustrates the patient's increased limbic activity (as evidenced by the déjà vu experiences) and hippocampus-dependent memory function after continuous electrical hypothalamic electrical stimulation.[33] Although this was not the objective of the intervention for this patient, the observations may prove helpful for other patients with psychiatric conditions, including those with emotional dysregulation and memory impairment. The psychiatrist physician who is a part of a research team is involved in an aspect of clinical excellence that is at the foundation of academic psychiatry's effort to create new knowledge. Clinically excellent academic psychiatrists are integral to advancing scholarship and discovery.

CONCLUSIONS

The definition of clinical excellence that has served as the starting point for the Miller-Coulson Academy of Clinical Excellence at Johns Hopkins Bayview Medical Center[3] appears to be applicable to and to have relevance for those who are caring for patients with psychiatric illness. While the case

reports and examples presented above are each pigeonholed under a single domain of the definition, reflection about every example clarifies the interconnectedness and compounding nature of the individual components. While each specific category appears to apply to psychiatry, some might contend that it would be a faulty assumption to assert that the sum of the parts (domains of the definition) can therefore be held up as the framework to determine who is a clinically excellent psychiatrist. In carefully reviewing the case reports and the literature related to excellence in psychiatric care, our team failed to identify any major themes that were not captured by our definition. This article should be viewed as a starting point for thinking about clinical excellence in psychiatry and not the end of the discussion. Because all primary care physicians engage in the practice of psychiatry in caring for many patients with mental health illnesses, the examples presented in this article may help them to be more effective when taking care of similar patients.

Analogies that underscore the need to master multiple domains to achieve overarching excellence are plentiful. One example can be found in music for which knowledge of the score is necessary to perform an orchestral piece; however, other skills such as communications with the conductor and other musicians, emotional interpretation of the score, and stage presence are all necessary components. It is extremely difficult to deconstruct the domains that contribute to the definition of clinical excellence into specific behavioral terms that characterize the threshold between competence and excellence. The Miller-Coulson Academy of Clinical Excellence has used these domains to guide the development of a "clinical portfolio" that serves as the vehicle that determines which faculty members are granted membership in the Academy on the basis of reviews by extrainstitutional and internal review committees.

One limitation of this article may rest in the methods by which the case reports were identified and selected. We acknowledge that if other teams with content expertise in clinical excellence were assembled, each team would choose different cases to highlight the domains. This is not a fatal flaw but merely a reality accepted by those who engage in qualitative types of scholarship. As mentioned in the Method section, and compounded by the relative lack of case reports of the most prevalent psychiatric conditions, some of the cases we selected to illustrate high-quality performance in a particular domain of clinical excellence represent relatively uncommon and/or extreme presentations. Nevertheless, this deficit demonstrates that the domains of clinical excellence are relevant to a range of cases, from the seemingly simple to the simply overwhelming. When reflecting upon the cases that were highlighted in this article, readers working in primary care may also consider role model psychiatrists with whom they have consulted and collaborated or challenging patients who brought out the best in them so that the way in which that specific domain relates to clinical excellence may be more deeply imprinted into consciousness.

The impact of the Miller-Coulson Academy of Clinical Excellence, which now includes physicians from numerous departments including psychiatry, hopes to go beyond merely recognizing clinically excellent physicians. By highlighting the value of excellent clinical care to an academic medical institution, it hopes to retain and nurture these clinicians. For psychiatry, this will result in increasing the number of academic psychiatrists who continue to engage in excellent patient care, serve as masterful role models for psychiatry trainees and other clinicians, and promote scholarship—all such activities may improve psychiatric patient outcomes. Thus, recognizing excellent psychiatric care may serve to strengthen all 3 arms of the tripartite mission (education, clinical care, and research) of academic psychiatry and academic medical centers.

Drug name: sertraline (Zoloft and others).

Author affiliations: Departments of Psychiatry and Behavioral Sciences (Dr Chisolm) and Medicine (Dr Wright, Mr Peters, and Ms Burkhart), Johns Hopkins Bayview Medical Center, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Potential conflicts of interest: **Dr Chisolm** is a member of the Miller-Coulson Academy of Clinical Excellence. **Dr Wright** is a Miller-Coulson Family Scholar. **Mr Peters** and **Ms Burkhart** report no conflicts of interest related to the subject of this article.

Funding/support: This initiative is supported by the Miller-Coulson family through the Johns Hopkins Center for Innovative Medicine.

Acknowledgments: The authors thank Cheri Smith, MLS (Johns Hopkins Bayview Medical Center, Baltimore, Maryland) for her assistance with this project. Ms Smith reports no conflicts of interest related to the subject of this article.

REFERENCES

1. Durso SC, Christmas C, Kravet SJ, et al. Implications of academic medicine's failure to recognize clinical excellence. *Clin Med Res*. 2009;7(4):127–133.
2. Wright SM, Kravet S, Christmas C, et al. Creating an academy of clinical excellence at Johns Hopkins Bayview Medical Center: a 3-year experience. *Acad Med*. 2010;85(12):1833–1839.
3. Christmas C, Kravet SJ, Durso SC, et al. Clinical excellence in academia: perspectives from masterful academic clinicians. *Mayo Clin Proc*. 2008;83(9):989–994.
4. Kapur N, Wilson BA. Aiming for excellence as an applied psychologist. *Psychologist*. 2010;23:36–39.
5. Sutkin G, Wagner E, Harris I, et al. What makes a good clinical teacher in medicine? a review of the literature. *Acad Med*. 2008;83(5):452–466.
6. Reed DA, West CP, Mueller PS, et al. Behaviors of highly professional resident physicians. *JAMA*. 2008;300(11):1326–1333.
7. Kramer TL, Glazer WN. Best practices: our quest for excellence in behavioral health care. *Psychiatr Serv*. 2001;52(2):157–159.
8. Miller SI, Scully JH Jr, Winstead DK. The evolution of core competencies in psychiatry. *Acad Psychiatry*. 2003;27(3):128–130.
9. Scheiber SC, Kramer TA, Adamowski SE. The implications of core competencies for psychiatric education and practice in the US. *Can J Psychiatry*. 2003;48(4):215–221.
10. Dietz PE. The quest for excellence in forensic psychiatry. *Bull Am Acad Psychiatry Law*. 1996;24(2):153–163.
11. Hamilton JD. Concluding the series on evidence-based practice: the spread of excellence in child and adolescent psychiatry. *J Am Acad Child Adolesc Psychiatry*. 2008;47(11):1222–1227.
12. Jayaram G, Triplett P. Quality improvement of psychiatric care: challenges of emergency psychiatry. *Am J Psychiatry*. 2008;165(10):1256–1260.
13. Bhugra D, Sivakumar K, Holsgrove G, et al. What makes a good psychiatrist? a survey of clinical tutors responsible for psychiatric training in the UK and Eire. *World Psychiatry*. 2009;8(2):119–120.
14. Schmitt F, Lahti I, Piha J. Does attachment theory offer new resources to the treatment of schizoaffective patients? *Am J Psychother*. 2008;62(1):35–49.
15. Frank JD, Frank JB. *Persuasion & Healing*. Baltimore, MD: The Johns Hopkins University Press; 1991.
16. The Arnold P. Gold Foundation. Working to keep the care in healthcare. http://www.humanism-in-medicine.org/index.php/aboutus/what_is_humanism_in_medicine. Accessed January 13, 2012.

17. ABIM Foundation, ACP Foundation, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. http://www.abimfoundation.org/Professionalism/~/media/Files/Physician%20Charter.ashx. Accessed January 13, 2012.
18. Ireland P, Sapira JD, Templeton B. Munchausen's syndrome: review and report of an additional case. *Am J Med*. 1967;43(4):579–592.
19. Shaw RS. Pathologic malingering: the painful disabled extremity. *N Engl J Med*. 1964;271(1):22–26.
20. Johnson AB, Gentile JP, Correll TL. Accurately diagnosing and treating borderline personality disorder: a psychotherapeutic case. *Psychiatry (Edgmont)*. 2010;7(4):21–30.
21. Trinh NH, Moore D, Brendel DH. Ethics consultation to PACT teams: balancing client autonomy and clinical necessity. *Harv Rev Psychiatry*. 2008;16(6):365–372.
22. Stein LI, Test MA. Alternative to mental hospital treatment, 1: conceptual model, treatment program, and clinical evaluation. *Arch Gen Psychiatry*. 1980;37(4):392–397.
23. Weisbrod BA, Test MA, Stein LI. Alternative to mental hospital treatment, 2: economic benefit-cost analysis. *Arch Gen Psychiatry*. 1980;37(4):400–405.
24. Payne JL. Antidepressant use in the postpartum period: practical considerations. *Am J Psychiatry*. 2007;164(9):1329–1332.
25. Campbell SB, Cohn JF. Prevalence and correlates of postpartum depression in first-time mothers. *J Abnorm Psychol*. 1991;100(4):594–599.
26. Sit D, Rothschild AJ, Wisner KL. A review of postpartum psychosis. *J Womens Health (Larchmt)*. 2006;15(4):352–368.
27. Rosenberg PB, Johnston D, Lyketsos CG. A clinical approach to mild cognitive impairment. *Am J Psychiatry*. 2006;163(11):1884–1890.
28. Freud S. From the history of an infantile neurosis. In: Huish LA, trans. *The "Wolfman" and Other Cases*. London, England: Penguin Classics; 2002:203–320.
29. Freud S. Therapy and technique: from the history of an infantile neurosis (Wolf Man). In: Gay P, ed. *The Freud Reader*. New York, NY: W W Norton & Company; 1995:400–428.
30. McHugh PR, Slavney PR. The education of psychiatrists. In: Gelder MG, Lopez-Ibor JJ, Andreasen N, eds. *New Oxford Textbook of Psychiatry*. New York, NY: Oxford University Press; 2000:41–47.
31. Wright SM, Carrese JA. Excellence in role modeling: insight and perspectives from the pros. *CMAJ*. 2002;167:638–644.
32. Grigsby RK, Thorndyke L. Perspective: recognizing and rewarding clinical scholarship. *Acad Med*. 2011;86(1):127–131.
33. Hamani C, McAndrews MP, Cohn M, et al. Memory enhancement induced by hypothalamic/fornix deep brain stimulation. *Ann Neurol*. 2008;63(1):119–123.