



# THE MARYLAND PSYCHIATRIST

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## Perspectives on Alexander Hamilton

By: Jennifer Palmer, MD



Jennifer Palmer, MD

*Alexander Hamilton*, a 700-page biography -- combined with the award-winning musical, *Hamilton* -- catapulted this once relatively obscure founding father to cultural and historical prominence. In the book, Ron Chernow attempts to explain Hamilton's actions, failures and achievements in terms of his personality, as shaped by the traumas of his early life. As a student of Paul McHugh's and Philip Slavney's *The Perspectives of Psychiatry*, I cannot help but wonder whether disease states must also be considered in this story. The ever-shifting fortunes in Hamilton's life -- characterized by ambition, interpersonal conflict, infidelity, an unrelenting urge to write, and an untimely, violent death -- suggest to me that he had an underlying mood disorder.

At least two authors, John Gartner in *The Hypomanic Edge*, and John McManamy in *Hamilton: A Hypomanic Case Study*, have argued that Hamilton had hypomanic "genes" or "traits", but not the disease we call bipolar disorder. However, I would argue that he experienced hypomanic episodes that exaggerated his underlying personality traits, resulting in great achievements and tremendous losses. Therefore, Hamilton's spectacular life and career very well could

*(Continued on p. 2)*

### **The Disease Perspective**

In *The Perspectives of Psychiatry*, McHugh and Slavney outline four basic Perspectives to consider when formulating a case: Behavior, or what a person *does*; Dimension, or who a person *is*; Life Story, or what a person *encounters*; and Disease, what "broken part" a person *has*. Chernow depicts Hamilton in terms of his behaviors, dimensions of personality and early life history, but does not consider whether a psychiatric disease may have played a role. He does, however, describe Hamilton as physically frail and frequently ill. In his recent book, *The Geography of Genius*, Eric Weiner argues that illness in general correlates with genius, acting as a constraint that is necessary for its expression. Many authors have described a co-occurrence of mental illness and creative genius. In this context, Chernow's observation of Hamilton's overall poor health could support a correlation between the Disease Perspective and great achievement.

Chernow describes Hamilton as "a man of deep and often ungovernable emotions" who displayed periods of "superhuman stamina" punctuated by episodes of

significant melancholy. At time he was arrogant, combative and promiscuous, made "rash decisions" and demonstrated "needless indiscretion." Such descriptors are characteristic of patients with bipolar disorder. Further, Hamilton had "an unhealthy fascination with dueling" that led to his early demise in the famous standoff with Aaron Burr. It has been speculated that Hamilton provoked the quarrel as a suicidal act after the death of his eldest son, a stressor that could plausibly precipitate a depressive or mixed episode. A biological predisposition -- a family history of bipolar disorder -- must also be considered, given the turbulent life of his mother.

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## HAMILTON (Continued from front page)

have been the result of behaviors driven by disease, in addition to traits of personality and early life experience. I should note that when I was reading Chernow's text, I did not detect evidence of any frank manic or psychotic episodes, and would therefore consider a diagnosis of type II bipolar disorder.

*A few of my favorite examples of possible hypomanic states:*

It would be a vast understatement to call Hamilton a prolific writer. Lin-Manuel Miranda captures this drive in the play by asking: "How do you write like you're running out of time...every second you're alive?" For example, Hamilton wrote 51 of the 85 Federalist Papers -- 600 pages of essays written under strict deadline pressure -- in concert with two other defenders of the Constitution, James Madison and John Jay. He also wrote a 40,000-word tome about the new economy. Chernow reports that Hamilton slept no more than 6 hours per night when composing such texts.

Hamilton's sexual appetites have been noted by many, including Martha Washington, who is said to have named a feral male cat after him. Hamilton had a well-documented affair with Mariah Reynolds, a neighbor's wife. Once discovered, Hamilton paid large sums of money to keep the affair quiet. However, when accused of speculation, he volunteered the details of the affair publicly, without rational consideration of the effect on his family or career. It has also been speculated that he had an affair with his sister-in-law.

In addition, Hamilton tended to pick public fights, including with President John Adams, thereby creating many unnecessary enemies. He instigated a number of challenges well before the duel with Burr, including one that came close to fruition with James Monroe. (This event was depicted hilariously in an episode of *Drunk History* starring Tony Hale and Alia Shawkat, narrated by Lin-Manuel Miranda. Watch it if you haven't.)

Finally, Chernow considers how history might have been altered if Hamilton had made wiser decisions at times. He wonders, for example, if Hamilton had not undermined a political alliance between his father-in-law, Philip Schuyler, and the powerful Livingston family during the first Presidential election, might political dominance have ended for George Clinton, New York's anti-Federalist governor, and the "Jeffersonian incursion" failed. Such lapses in judgment gave Hamilton's rivals an impression he was dishonest, despite the fierce integrity of character Chernow takes pains to describe. These inconsistencies could be interpreted as evidence of mood instability.

I wonder -- given Hamilton's crucial role in creating our republic -- if his disease had been identifiable and treatable at the time, what might -- or might not -- have become of the American colonies.



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## Interview: Jimmy Potash, MD, MPH

Chair, Dept. of Psychiatry & Behavioral Sciences Johns Hopkins

By: Bruce Hershfield, MD

November 10, 2017

### **Q.:“ What’s it like to come back to the department where you trained, to be the Chair?”**

Dr. P.:“ It’s really been delightful to be back, for all sorts of reasons. One is that it feels like home-- it’s where I was born. I was literally born in this hospital and then essentially grew up professionally here. I went to public health school and medical school here and did my residency and I was on the faculty for many years. I have lots of wonderful friends and colleagues around. It’s also been wonderful to see the place with fresh eyes. One of the things that struck me on coming back is how incredibly talented everybody is. I meet with one person after another and every single time I sit down with someone I just think to myself, ‘ My goodness! This person is so bright and so energetic, and so ambitious and is doing so many great things.’ It’s been very stimulating.”



Jimmy Potash, MD, MPH

### **Q. “What struck you as different, after having been away for several years?”**

Dr. P.:“ There were some obvious differences, like the fact that these acute care towers weren’t here -- the Zayed Tower and the Bloomberg Tower. Our Child Psychiatry group division is on the 12<sup>th</sup> floor of Bloomberg, which I can see looking out my window. On the structural front, there are all these developments. On the north side of the hospital, the East Baltimore Development Initiative has resulted in all these buildings going up. So, Kennedy Krieger has a new building going up and there is the Eager Park and 1810 Ashland. The Lieber Institute is another big change. That’s a 120 person research institute, entirely focused on psychiatric neuroscience, that was created after I left. It’s administratively separate, but very much related to the department in that 12 of the principal investigators there are primary faculty in our department and their leader, Dan Weinberger, who is in our department, is one of the leading biological psychiatrists-- one of the leading schizophrenia experts-- in the world.”

### **Q.:“ What was it like for you in Iowa? I’m sure that also changed your perspective.”**

Dr. P.:“ I enjoyed Iowa a lot. It’s a wonderful place. First

of all, it’s a lovely place to live. Life feels simpler there than it does in Baltimore. There is very little traffic -- it takes very little time to drive from one end of town to the other. There is a very strong sense of community. It has a lot of terrific people. It was very gratifying to work closely with the Chair of Neurology and the Chair of Neurosurgery to create a new neuroscience Institute.

We hired a fantastic basic neuroscientist and we got a \$45 million gift to get it going. That’s on the science side. But one of the big lessons that I learned as a leader there was to appreciate and show appreciation to clinicians. There was a clinical track there, in addition to the tenure track, which meant that a lot were wholly focused on clinical work. I think they sometimes felt under – appreciated. Of course, we couldn’t be the kind of place we wanted to be and deliver great care without them. So I learned that it’s important to show gratitude at every possible opportunity to the people really helping make the place work.”

### **Q.:“ I know that you also have done quite a bit of clinical work.”**

Dr.P.:“ I do. I did my residency here and then I did a fellowship with Ray DePaulo and that involved learning research in the genetics of mood disorders, but it also involved learning to be an expert mood disorder clinician and I saw lots of mood disorder consults, which I enjoyed immensely. Then I wound up doing inpatient attending for many years on the mood disorders service. So I have very strong feelings about the importance of high quality clinical care.”

### **Q.:“ You mentioned in your weekly message from the Chair, which I received today, that you had had dinner recently with Kay Jamison and Karen Swarz. They certainly know something about treating mood disorders patients, don’t they?”**

Dr. P.:“ They sure do. Kay had a long career as a clinical psychologist, focused on mood disorders. Of course, she is active in her career, but not in a clinical phase. Karen Swartz is our lead mood disorder psychiatrist and I think is as good a clinician as I’ve ever seen. She is a master clinician and it’s a thing of beauty to watch her in action.”

*(Continued on p. 4)*

**Q.:" It's certainly good for the students, to be able to see someone like that."**

Dr. P.:" I can't tell you how many medical students and residents have come away from experiences with Karen just raving about how inspiring it is to see her in action. She has a combination of intelligence and competence and wisdom, coupled with a warm and engaging manner and this tremendous love of teaching."

**Q.:" Would you tell us more about your research? I know you've done a lot of work on the genetics of mood disorders."**

Dr. P.:" I followed in Ray DePaulo's footsteps. I got involved in the genetics of bipolar disorder early on, with this idea that there might be commonalities between the genetics of severe forms of bipolar disorder and the genetics of schizophrenia. I guess that all of us who have taken care of seriously ill patients know that sometimes it can be hard to distinguish between those two. It's especially true in cross section. When you see acutely ill patients in the emergency room, it's hard to tell whether they are severely manic or having a schizophrenia exacerbation. It's interesting that this theme has become so important in the field. It's become completely clear in the last couple of years that there's a lot of overlap in the genetic susceptibility to bipolar disorder and to schizophrenia. It does not mean that they are the same, but there is a large chunk of overlap in the genetic variance that predisposes to the two illnesses."

**Q.:" So your research is centered on this topic?"**

Dr. P.:" That was one of the big themes, and then, more broadly, I got involved in looking at genetics of subtypes of bipolar disorder. I was helping other people who work on the genetics of suicide and bipolar disorder, and the genetics of postpartum depression, as a subset of a larger group of disorders. The other big thing that I started working on early on was epigenetics. That is sort of a less well-known area, though I think it's gotten a fair amount of attention in the last 10 years. This is the idea that our environment and experience can change the chemistry of our DNA. This would have an impact on what genes get turned on and what genes get turned off. It's an incredibly interesting area for those of us in Psychiatry -- something that has the potential to integrate between nature and nurture."

**Q.:" Are you planning to continue this work here? Do you have time to do that?"**

Dr. P.:" I'm going to have a lab. I have a graduate student from the University of Iowa who is coming over soon to start a postdoctoral fellowship. She works on epigenetics and the impact of stress on DNA chemistry."

**Q.:" What else would you like to accomplish here during your chairmanship?"**

Dr. P.:" I've been thinking a lot about what makes Hopkins really special. I'm quite persuaded that it is. One of the things that makes it special is that we provide incredibly high quality clinical care-- as good as any place in the country. My sense is that this has been true for 100 years. That was part of what this place was founded on. One of my goals is to maintain that. It seems like a relatively obvious and modest goal to have, but there are so many pressures that make it hard to maintain. There are financial pressures that make it hard to deliver high-quality care. Psychiatry is one of the least money -- generating fields in an academic center. So, across the country, leadership sometimes has a tendency to think, 'Maybe we should close beds and shrink inpatient units because they lose money anyway.' What we do is incredibly important in the context of the overall mission of providing great clinical care to patients. That recognition has allowed us to continue to do what we do. Another big pressure on us is the electronic medical record. That makes it harder to have the kind of time with patients that we want to have. I'm hoping that we can figure out how to optimize our use of that in a way that's consistent with great care."

**Q.:" That has been problematic in some ways."**

Dr. P.:" It has. We just had a Grand Rounds that focused on that this week. One of the messages, which I think is right, is that it will get easier over time. The question is how long it's going to take. I think technology will improve to the point where a kind of artificial intelligence component will do some of the time -- consuming things for us and allow us to interact more easily with patients."

**Q.:" How can the psychiatric community help you?"**

Dr. P.:" Lots of people in the community do a lot of really great teaching. I think that it's an enormous help to us. We want to provide both our residents and our medical students with fantastic teaching opportunities, and it helps that there are so many very capable people. They help make our educational enterprise robust. Another important piece concerns the whole 'continuum of care'. We all know that psychiatric illnesses often are long -- term. We try to take fantastic care of people here in the hospital, but that's only one small piece of a much larger picture. We want to have really good relationships with psychiatrists in the community and we want to have the kind of communication that allows for great transitions in both directions."





# REMEMBRANCE: Michael Kaminsky MD

By: Jimmy Potash, MD, MPH



Michael Kaminsky, MD

Dr. Michael Kaminsky left the full-time faculty of the Johns Hopkins Department of Psychiatry & Behavioral Sciences in 2010, after 34 years. During 13 of them he served as Clinical Director, and for eight he was the Vice Chair for Clinical Affairs. On December 17th, Mickey, as he was known, left this world, after 72 years in it. His loss is deeply felt by many of us who worked beside him, and under his tutelage.

Mickey was a master clinician whose compassion was vast, whose skills were finely honed,

and whose insights were revealing and often profound. He saw patients of all kinds, but he had a special commitment to the Community Psychiatry Program, and to the underserved and underprivileged who were the clientele there. He felt a connection with those patients whom he felt other mental health care providers at times scorned. When I worked under Mickey as his second-year resident, he taught me to have "sympathy for psychopaths," explaining that the negative feelings these patients sometimes provoked in others needed to be overcome if we were going to provide them with the same high-quality care that we always delivered, and that they too deserved.

I also recall Mickey's readiness to heed the call in times of crisis. For example, I took care of a young manic patient on Meyer 4 who had been admitted the day before after Mickey had seen him on a moment's notice, following a mother's panicked phone call. In another instance, in 2005, Mickey heeded the call and volunteered to join a Hopkins group that went to New Orleans, where he served the mental health needs of those who were traumatized by Hurricane Katrina.

Michael Jerome Kaminsky was raised in Memphis, Tennessee. I recall him saying that as a boy in the 1950s he saw Elvis Presley, who was similarly brought up in Memphis, perform there. He went to Yale as an undergraduate and majored in History. He obtained his MD degree at Cornell, where he met our former Department Chair, Dr. Paul McHugh. After a year of internship at Denver General Hospital, he followed Dr. McHugh to the University of Oregon for residency, and served as Chief Resident there. He then moved to Baltimore in 1976 to do a year-long fellowship in the Johns Hopkins School of Public Health's Department of Mental Health. He joined the faculty the following year. He served a stint as director of the Com-

munity Psychiatry Program. For 17 years he was Director of Psychiatric Emergency Services. And then, for 17 more, he was a beloved and admired inpatient Attending, serving on virtually every service. Along the way, he wrote papers on somatization disorder with Professor Emeritus Phillip Slavney in the *American Journal of Psychiatry* and in *Psychological Medicine* and others on the mental health of disaster victims.

Dr. Slavney, who was Dr. Kaminsky's close colleague and friend for about 45 years, said of him: "Mickey always spoke up for what he thought was right, even though it sometimes made things difficult for him. He was the only person I have known who was never afraid to do so, and he did it as a physician, as a colleague, and as a friend."

Mickey is survived by his wife Barbara, his son Joshua, and his son Zach, who was on the Johns Hopkins faculty from 2010 until this fall, when he secured an endowed Chair position at the University of Ottawa Royal Institute for Mental Health Research.

Earth receive an honored guest: Mickey Kaminsky is laid to rest.

## Elias Shaya, MD: New MPS Rep to the APA Assembly

By Elias Shaya, MD



Elias Shaya, MD

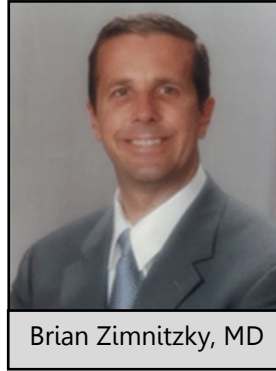
It has been a pleasure to have the opportunity to serve the remainder of Dr. Steve Daviss's term as an Assembly Rep. It is sure a tough act to follow, for Steve fulfilled this role in an exemplary way. He became very well-versed in the workings of the Assembly and he developed a network of support amongst the Assembly Reps, who recently elected him as its Recorder.

I am grateful to the Nominations Committee members for their trust in choosing me as one of the three MPS Assembly Representatives. My journey with the MPS has been a very gratifying one since I started my active involvement as a member of the Payer Relations Committee, under the leadership of Dr. Philip Dvoskin. I later joined the Executive Committee and served as the President at a time of major change in Maryland Psychiatry. That was when the state government, under the leadership of Secretary Josh Sharfstein, embarked on the integration of its departments of Mental Health and Substance Abuse under the newly integrated Behavioral Health Administration (BHA). The MPS played a role in the decisions that were made about the administrative structure of the BHA, ultimately leading to the continuation of the "carved-out" model. Soon after, the APA published DSM-5, the Center for Medicare and Medicaid Services (CMS) with the AMA published the new Evaluation & Management and Psychiatric billing codes, and the American Board of Psychiatry and Neurology continued to make changes to the Certification and MOC processes. These as well as many other issues continue to affect our work, shape our profession, and influence the care that we provide to our patients.

While we all need to do a lot more to improve access to care, reduce stigma, optimize parity, reduce administrative burdens, and foster innovation, I believe that Psychiatry as a whole is doing much better today than ever before, and its potential is great. In serving the remainder of Steve's term over the past few months, I have been learning how the Assembly sets the tone and helps develop the priorities for the APA and its Board. I look forward to the opportunity to continue to communicate the interests, preferences, and priorities of our members to the deliberations that take place in the Assembly.

## Brian Zimnitzky, MD: New MPS Rep to the APA Assembly

By Bruce Hershfield, MD



Brian Zimnitzky, MD

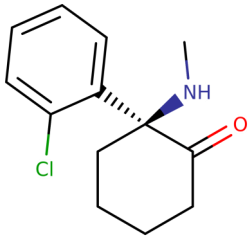
Dr. Brian Zimnitzky recently joined the MPS delegation to the APA Assembly. A native of Maryland, he knew from an early age he wanted to become a physician. He studied chemistry at the University of Delaware, then worked as a chemist at DuPont. He attended medical school at the University of Maryland, where he participated in the Combined Accelerated Program in Psychiatry (CAPP). In –

between his first and second years of medical school, he did a Psychiatry elective at Guy's Hospital in London – an experience he said he will always treasure. He then trained at the New England Medical Center and completed a fellowship in child and adolescent psychiatry at the Boston Children's Hospital.

Then, he said, the travel bug hit him again. He spent a year as a child psychiatrist in Wellington, New Zealand. He moved from there to San Francisco, where he lived for five years and developed an interest in forensic psychiatry. He returned to Baltimore in 2001 to complete a forensic psychiatry fellowship at University. He now practices adult, child, and forensic psychiatry in Annapolis.

He initially became involved with the MPS by working on the legislative committee. He was elected a member of the Council and eventually became our President. He continues to serve now on the Council, the legislative committee, and the nominations and elections committee.

He has already begun learning about the Assembly. He said it functions somewhat like a congress for the APA. Vital issues are presented for consideration, in the forms of "action papers" or "position statements". He commented that in the November, 2017 session the Assembly looked into subjects as varied as ethics investigations, women's issues, and physician – assisted suicide. He was impressed by the lively discussions he heard concerning them and said he looks forward to continuing to contribute to not only those, but other issues, as an MPS Rep.



# My Twenty-Month Ketamine Experience

By Brian Lerner, MD



**Brian Lerner, MD**

During my addiction fellowship, Steve Levine engaged me to provide ketamine infusions for those with a treatment-resistant major depressive disorder (TR-MDD) and bipolar depression. Since May, 2016 I have performed over 1300 infusions and consulted with about 200 new patients.

Over these twenty months, TR-MDD patients have had a 70 to 80% *response* rate, with 35% achieving *remission* during some interval in the course of treatment. It is obvious that some patients respond immensely, some improve more modestly, and others have no response. The heterogeneity of the disorders known as TR-MDD and MDD is fascinating. During my residency, TR-MDD patients typically presented as having a recurrent, episodic disease, and they were typically responsive to ECT. The treatment-resistant population has included those who have failed as many as two dozen medication trials. Some patients have failed to respond to TMS and/or ECT. Like patients who have substance use disorders, many depressed patients can benefit from a recovery program that requires them to take some initiative, when they are at least in partial remission.

The best dosing regimen for ketamine infusions remains to be established. The algorithm for episodic MDD is straightforward-- infusions until the episode resolves, followed by consideration for repeating them at the first signs of recurrence. More frequently, chronically depressed patients are infused twice weekly for two to three weeks, followed by a taper of a couple of weekly infusions. Subsequently, "maintenance" infusions are used when depressive symptoms return.

I was aghast when hearing a presentation by an academic anesthesiology practice at the 2017 APA meeting. It concerned me to hear the definitiveness with which they explained the exact mechanism by which ketamine cures depression. (Clearly, there are several unproven theories, with ketamine likely affecting a number of different circuits.) I was also alarmed because they seemed to see depression as a checkbox diagnosis. For patients who respond, but don't have complete remission, this is particularly concerning, as the post-infusion period is ripe for new learning and non-pharmacologic interventions-- including psycho-

therapeutic interventions that may not have been effective previously.

Many questions regarding ketamine use remain. It would be ideal to understand how ketamine acts, but of greater relevance is our need to identify the factors that predict successful treatment for both bipolar depression and MDD. While there are some objective measures we can use to assess improvement (especially with information from collateral observers), depression also has an incredibly subjective side. I have been asking patients to assess their mood, anxiety, irritableness and anger, as well as their sense of well-being, their functionality (physically and cognitively), the extent of their negative thinking and their resiliency to stress.

I am also aware of the need to collaborate with all my patients' providers to achieve the best care for each patient.

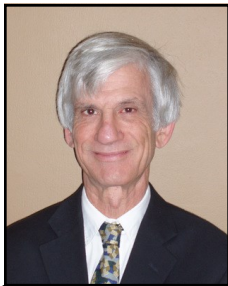
Safety of our patients is primary. Infusions are quite unlikely to lead to adverse consequences particularly if expectations are effectively communicated and understood. Our staff has become skilled at handling patients' anxiety, particularly as we have become more experienced. Because ketamine can elevate blood pressure and pulse, it's important to avoid prescribed stimulants before infusions. The safety record is consistent with its history in pediatric emergency departments and for when it is used to accompany wound dressing changes in burn units. I expect that safety and long-term efficacy will decline with the distribution of take-home ketamine preparations. The absence of ECT-induced memory issues or anesthesia risk can't be overstated. We are pleased to visit with patients who are suicidal, for possible prompt infusion, in order to decrease their need to visit an emergency room. Published data has shown an independent effect on acute suicidality.

I look forward to collaborating in any way possible to assist in the care of some of your most challenging patients. I can be reached at 410-844-3067.



# MPS Holds Psychopharmacology Symposium

By: Bruce Hershfield, MD



**Bruce  
Hershfield, MD**

On November 11th, about 125 psychiatrists attended the MPS psychopharmacology update – a series of five talks. All were excellent. Here are some of the highlights:

Scott Aaronson MD, who was the moderator for the day's activities, began with a discussion of why psychiatrists still make mistakes in diagnosing mood disorders. He pointed out that there are more than 100 different genes that

provide a background for mood disorders, so the clinical presentations may vary considerably. Patients who retain residual signs/symptoms after an episode run a greatly increased risk of having future ones. Mood disorders are chronically underdiagnosed – probably by a factor of 50%. Getting the pharmacy records will help determine whether prior treatments were of adequate dose and duration, but will not clarify diagnosis. In general, any collateral information, including family history, can be essential, given that many patients with bipolar disorder lack insight into their symptoms. It also needs to be kept in mind that 40% of patients are likely to be abusing some kind of substance at any one time.

It is estimated that psychiatrists are right about making a diagnosis of bipolar disorder about 48% of the time and primary care physicians are right about 23%. Dr. Aaronson is of the opinion that it is better to err on the side of over-diagnosing bipolar disorder than of under-diagnosing it. He closed with some "red flags"-- look for a history of "family drama" or violence -- in particular, any fights outside of the family, which can indicate mania. Also, keep in mind that substance abuse makes *everyone* non-responsive.

Lauren Osborne, MD gave the next talk -- the management of mood disorders during pregnancy. She pointed out that discontinuing medication during pregnancy may lead to a high relapse rate, which causes problems during the post-partum period. Prolonged stress -- including depression -- on the part of the mother can change the fetal behavioral system. Suicide is common in the post-partum period and may account for up to 20% of all post-partum maternal deaths. Assume that all women of reproductive age will get pregnant, when treating them with medication, she said. Try to limit the number of exposures to different medications, keeping the health of the baby in mind, and try to use the medications that we know more about, she told us.

Part of the problem is that we do not have good studies

about the usefulness of medication during pregnancy. There are also no studies that have lasted more than five years that were designed to see how medications taken during pregnancy affected the children who were exposed to them. Because of the interest in whether antidepressants cause malformations, Dr. Osborne spoke directly to that point, saying that there have been no significant findings of cardiac malformations when infants have been exposed to antidepressants, even though there have been 900,000 subjects. Another study, of almost 2 million, showed no significant heart defects from SSRI's. There is the "poor neonatal adaptation syndrome", with babies who are exposed to SSRIs in the third trimester, but it is not clear if this represents withdrawal or toxicity, or even that it is more common with SSRI's than with other known possible risk factors. We now know that there are no long-term developmental changes in children who are exposed to them and that these medications do not cause autism. Zoloft and Prozac have the most evidence that they are safe. It is unclear if taking Paxil in the first trimester is a risk factor; recent studies say that it is not.

She also talked about other possible teratogens. Valproate is known to be one, apparently playing a role in causing 7- 10% of infants who are exposed to it to have neural tube defects and also to reduce their IQ's. Tegretol leads to a 1% risk of spinal bifida. If you have to use antiepileptic medication in pregnancy, be sure to give 4 mg of folic acid per day along with it. Lithium causes only a 0.1% risk for Ebstein's anomaly. However, there is some risk for "floppy baby syndrome" when there is third-trimester exposure. Lamotrigine causes a 2.6% risk of birth defects, but this can pale when compared to the 3%-4% of birth defects in the general population. She pointed out that discontinuing it during pregnancy is very likely to cause relapse in the mother. She reviewed literature about atypical antipsychotics, pointing out that Risperdal might cause a cardiac problem. Benzodiazepines can cause pre-term birth and low birth weight. Almost all medications are safe in breast-feeding; only about 0.5% of Zoloft, for example, enters the milk. She suggests avoiding clozapine and lithium and large doses of long-acting benzodiazepines and prescribing with pregnant women. She pointed out that exercise helps as much as Zoloft does.

This was followed by a most interesting talk by Dr. Robert Post, who advised continuously treating someone who has a first episode of mania, to avoid the development of treatment re-

[\*\(Continued on p. 9\)\*](#)



sistance. He pointed out that in the USA two thirds of cases of bipolar disorder begin before age 19. He said that Americans are more likely to become psychiatrically ill, but have fewer hospitalizations, than Europeans, and that the offspring of Americans who have bipolar disorder are also more likely to become ill than in Europe. It has been true for the last four generations and is also true for unipolar depression. He said that children with bipolar disorder are often underdiagnosed and are not treated right. The advantage of treating continuously after the first episode of mania is that, although there is cognitive decline in bipolar disorder, patients recover completely from it if there are no more episodes. Lithium is better than Seroquel on every measure. A larger number of episodes, or rapid cycling, predicts poor subsequent response. Lithium has many advantages, including reducing the possibility of a diagnosis of dementia; it also has anti-suicide effects. It increases and normalizes the length of telomeres and increases both hippocampal and cortical volumes. He made it clear that it is not associated with end-stage renal damage. As is true for several other medical conditions, combining medications often works better than using only one of them by itself. He then talked about recent work with Keppra for insomnia in PTSD and said that n-acetylcysteine is often helpful in combination, including for OCD and for the irritability associated with PTSD. He suggested dispensing 500 mg BID for one week and then 1000 mg BID. Dr. David Pickar then spoke about psychosis. He pointed out that "nutraceuticals" are not regulated. He spoke about involuntary outpatient commitment. He stated that clozapine is better than the other antipsychotic medicines. He talked about Nuplazid, which was recently approved for treatment of hallucinations and delusions in Parkinson's disease, and Ingrezza, which was recently approved for tardive dyskinesia. He told us that the risk of psychosis is 70% inherited and that no single gene appears to be "key".

Finally, Dr. Aaronson gave his second talk of the day. He reviewed how drug "resistance" predicted post-ECT relapse. He went over the literature about whether trans-magnetic stimulation after ECT helps maintain the response. The *remission* rate for TMS is about 37% and the *response* rate is about 56%. Usually, the patient has 30 treatments over a six-week period. There is a better response rate in bipolar disorder than in unipolar depression. He said that TMS does not cause significant side effects, though it can lead to mania or a mixed state. He then went on to discuss vagus nerve stimulation, an under-utilized, aggressive intervention for severe treatment resistant depression. He is hopeful that there may be a home-synchronized TMS procedure available soon.

There was plenty to absorb, in the lectures and also in the lively question-and-answer periods. It was a good way to spend a Saturday morning and afternoon, learning from experts and surrounded by friendly colleagues.



# What CRISP Is Doing To Improve Behavioral Health Services

By: Sheena Patel, MD, CMPE



Sheena Patal, MD, CMPE

"CRISP"--the Chesapeake Regional Information System for our Patients-- was designated the statewide health information exchange (HIE) for Maryland in 2009. Since that time, it has played an integral role in sharing health information in Maryland, as well as in West Virginia and DC.

Its primary goal is to deliver the right health information to the right place at the right time, resulting in more efficient and higher quality patient care. It connects to, and receives data from, more than 100 acute care hospitals in Maryland, as well as from long term care facilities, radiology centers and-- more recently-- ambulatory practices.

It is committed to supporting the transfer of not only somatic data, but also behavioral health patient information, to the extent allowed by law. Much of that behavioral health data is protected by 42 CFR Part 2 regulations, which restrict the disclosure and use of patients' alcohol and drug records that are maintained in connection with any federally assisted individual or entity (other than a general medical care facility) providing drug abuse diagnoses, treatment, or referral for treatment. Because of these restrictions, CRISP has been limited in what behavioral health information it can share. However, recent updates make it possible for behavioral health providers, including psychiatrists, to have access to CRISP services. In the very near future, they should be able to contribute to the pool of shareable data within CRISP.

An explicit consent from the patient is required for sharing 42 CFR Part 2 covered data. The Substance Abuse and Mental Health Services Administration (SAMHSA) has worked to develop a consent management tool that allows for the sharing of this sensitive health information through the HIE. CRISP has leveraged this tool, Consent2Share, and is customizing it to work within our infrastructure.

**Prescription Drug Monitoring Program (PDMP)**  
The Prescription Drug Monitoring Program (PDMP) is a statewide effort to address [\*\(Continued on p. 10\)\*](#)

the ongoing opioid epidemic. The Maryland Department of Health (MDH) has partnered with CRISP to make controlled substance prescription information accessible to providers in real-time, at the point of care. Dispensers, e.g., pharmacists, of Schedule II through V controlled dangerous substances (CDS) must report each drug dispensed to CRISP within 24 hours. Practitioners authorized to prescribe CDS must have registered through CRISP by June 30, 2017.

Starting on July 1, 2018, practitioners must query CRISP for prescription data prior to initially prescribing an opioid or benzodiazepine AND at least every 90 days while the patient continues on that course of treatment. For more information regarding the PDMP, please visit <https://bha.health.maryland.gov/pdmp/Pages/Home.aspx>

### Clinical Query Portal (CQP)

Data available in the CRISP Clinical Query Portal can support patient follow up, transitions of care, and coordination of care. For psychiatrists, who may see patients much more frequently than primary care physicians, this information can be a powerful tool.

### Encounter Notification Service (ENS)

A common frustration for health care providers, especially those in the behavioral health community, is not knowing when their patients have been admitted or discharged from hospital settings. CRISP offers the Encounter Notifications Service, which sends real-time notifications to providers about their patients' hospitalizations. Not only do these help make transitions easier across the health care continuum, but the data itself can be extremely useful for identifying high-risk patients. This can help avoid unnecessary hospital utilization.

### CRISP Reporting Services (CRS)

It is often difficult to tell whether a specific intervention is effective. The CRISP Reporting Services "pre-post report" allows clinicians to submit a list of their patients, along with dates when they began treatment. Using this list, CRISP will give access to up to 12 months of aggregate hospital utilization data prior to, and after the "intervention date".

### Data Exchange Support Program (DESP)

CRISP has received federal and state funding to pay \$10,000 or more to ambulatory – including psychiatry – practices that choose to integrate their electronic health records with our agency. The payments would go toward offsetting whatever it would cost the practice to accomplish this. After integrating the data with us, and receiving Consent2Share credentials, a psychia-

trist would be able to create 42 CFR Part 2 compliant consent forms for their patients. CRISP will be able to check for consent profiles and data sharing preferences and display information only to providers whom the patient had authorized. The ability to share this sensitive information represents an important step. Behavioral health information is an important part of a patient's medical care. Because of new technology, we are finally able to share it safely and legally. We expect to begin enrolling practices in the program in late Spring, 2018.

CRISP offers multiple services that, when incorporated effectively into a psychiatrist's workflow, can improve patient care. We are working with hospitals and other organizations to improve the quality of data that we share, and are looking forward to being able to incorporate behavioral health data very soon. In the meantime, we are encouraging psychiatrists to enroll in CRISP services so that they can better access information about their patients and can safely share data about them in a way that should improve our system of health care..

For more information about any of these services, please contact me: [sheena.patel@crisphealth.org](mailto:sheena.patel@crisphealth.org) or visit our website at [www.crisphealth.org](http://www.crisphealth.org).

## Assessing Risk in Psychiatric Practice MPS CME Activity

On **Wednesday March 21<sup>st</sup>** Join us for an educational evening covering two very important topics. This risk management course is an interactive audience response lecture allowing you to engage with a risk management specialist to discuss real-life scenarios based on actual calls received by the PRMS risk management help-line. How would you deal with a law enforcement demand for patient records, a "Friend" request from a patient, pharmacist report of prescription alteration or an estranged parent demand for records? Next, we'll address PDMP use, which is mandated for CDS prescribing effective July 1st. Checking PDMP helps avoid the possibility of dangerous prescribing and adverse outcomes. The meeting will be held at MedChi and is only **\$20 for members** and includes **2 CME credits**. For information or to register please [CLICK HERE](#).



# Tick-borne Diseases & Mental Illness

By: Marilyn Williams, Executive Director  
Lyme Disease Association of Delmarva, Inc.



Marilyn Williams

Lyme disease and other tick-borne illnesses continue to be endemic in the mid-- Atlantic region. People now commonly encounter ticks not only while doing rural outdoor activities, but also in residential developments and city parks, thus increasing the need for psychiatrists to be suspicious of tick-borne diseases when evaluating their patients.

The Centers for Disease Control (CDC) states that 300,000 – 1,000,000 new cases of Lyme disease occur in the USA each year. Up to 20% - -or 60,000 to 200,000 - -of Lyme disease patients each year continue to have symptoms and to seek medical help after they have undergone the initial recommended treatment. There has been an increase in psychiatric manifestations. The intra-cellular nature of several of the more common tick-borne "co-infections" creates an opportunity for neurological infiltration. Depression, anxiety disorders, panic attacks, bipolar disorder, suicide, aggression, cognitive impairment, schizophrenia, dementia, autistic-like symptoms, and learning disabilities are among the more common neuropsychiatric symptoms that can be caused by tick-borne diseases (TBDs). I

would not say that tick-borne illness causes bipolar disorder, or any of the other disorders (different etiology)... rather it causes neurologic sequela with complex and diverse symptoms effecting mood and anxiety with the ability to impair cognition and produce psychotic phenomena. There is a real need to educate our colleagues that patients presenting with psychiatric symptoms/signs does not indicate that an organic etiology is absent.

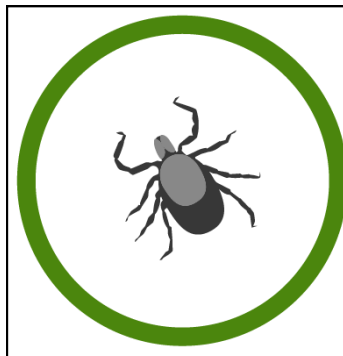
The organisms that ticks are now carrying are clearly evolving. A recent retrospective study identified 91 different tick-borne agents capable of creating disease in humans. *Borrelia* (which causes Lyme disease), *Bartonella*, *Brucella*, and *Mycoplasma* are among the more common causative tick-borne agents. Locally (define Maryland vs. Delmarva), *Bartonella* has been found to be more prevalent in our ticks than the *Borrelia* that causes Lyme disease. It has been linked to numerous psychiatric conditions (consider manifestations/ presentations); however, making the diagnosis is complicated by unreliable testing methods. *Bartonella* can also be transmitted from domestic and farm animals. Vectors include fleas, flies, and lice. People who work on veterinary staffs, veterans of

the Middle East, and outdoor workers are particularly vulnerable. The sudden onset of anxiety, panic attacks, or (symptoms that present as) depression, as well as a change in behavior and personality (without a causative event) should make one suspect an infectious process, as should a prior diagnosis of Lyme or other TBD (especially if there is no prior history of mental health diagnosis). A history of tick bites, fleas in the home, cat scratches, dog bites, head lice infestation, and spider bites can all be reasons to suspect *Bartonella*. It's prudent, as part of doing a physical exam, to look for "stretch marks" -- horizontal or vertical striae--since these skin markings can also be signs.

Depressive signs/symptoms or another psychiatric disorder that do not respond to treatment is another "red flag". In the past few years, we have seen a marked increase in the number of patients with TBD s who are suffering from depression without a causative life event. I have spoken with a few medical practitioners in our region whose practices focus on treating TBDs, and they indicated that depression (depressive symptoms) has (have) become a key symptom of TBD's. They also indicated that neuropsychiatric signs and symptoms are sometimes the only manifestations of TBD's in their patients.

Robert C. Bransfield, MD, a psychiatrist from Red Bank, NJ, who trained at Johns Hopkins, has long advocated that considering tick – borne illness should be part of a psychiatric evaluation. In "The psycho-immunology of lyme/tick-borne diseases and its association of neuropsychiatric symptoms" (*Open Neurology Journal*, Oct. 5, 2012), he explains that it is the inflammation and cytokine response to the infectious organisms that result in neuropsychiatric manifestations. On [www.mentalhealthandillness.com](http://www.mentalhealthandillness.com), Dr. Bransfield provides an Excel spreadsheet entitled, "Neuropsychiatric Assessment Database" that can be used by the psychiatrist to help determine if infections may be causing the patient's symptoms. The accompanying "Neuropsychiatric Assessment Article" provides the background information for the database form and instructions to psychiatrists.

[\(Continued on p. 12\)](#)





## TICK BORNE DISEASE (Continued from page 11)

Unfortunately, the reliance on laboratory testing and outdated treatment guidelines, which state that Lyme disease is easily treated with 2 to 4 weeks of antibiotics, has resulted in many patients going undiagnosed or under-treated. Also, emphasizing Lyme disease without considering the many other common TBD's can lead to patients not being tested and diagnosed for other commonly occurring vector-borne organisms.

(We recommend that) Anyone being tested for Lyme disease in Maryland or Virginia must be given a disclosure stating that the testing can be unreliable and a negative test does not necessarily mean that the disease is absent. Until more accurate tests are available, it's likely that Lyme and other TBD's will continue to be missed.

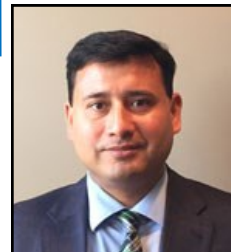
Training is available to mental health professionals in the diagnosis and treatment of Lyme and other TBD's at the Annual Scientific Conference hosted each Fall by the International Lyme and Associated Diseases Society (ILADS), where one afternoon track often focuses on neuropsychiatric manifestations of TBDs. Video presentations from past conferences are available for purchase at [www.ilads.org](http://www.ilads.org). Joining the organization provides an opportunity to join a members' blog where participants can seek guidance and support from experienced professionals.

A conference on April 20-21, 2018 at the Westin BWI Airport will offer important education on diagnosing and treating tick-borne diseases. The website for this event is [www.integrativelylyme.com](http://www.integrativelylyme.com).



## Our Nation's Health: A Matter of Grave Concern

By: Shobhit Negi, MD



**Shobhit  
Negi, MD**

Communities across the United States are being devastated by increasing prescription and illicit opioid use and overdose. About 91 Americans die every day from an opioid overdose. Recent data show that the average American can now expect to live 78.6 years on average--a decline of 0.1 years for 2016 over the figures from 2015, which also represented a drop. The back-to-back drops coincide with an average annual increase in opioid-related overdose deaths of about 20 % ; 64,070 people died from drug overdoses in 2016, and 75 % were caused by opioids. That's more deaths than the peak year for AIDS. More Americans died from drug overdoses in 2016 than from the Vietnam War.

This can be felt by all across the United States. We need to see the "invisible victims" of this epidemic. Nearly three quarters of the states have seen an unprecedented increase in the number of children entering foster care. Parental substance use is being cited as the primary reason. The number of babies born in the United States with Neonatal Abstinence Syndrome, which occurs shortly after birth, primarily among infants exposed to opioids such as prescription painkillers and heroin while they are in the womb, has quadrupled over the past 15 years. Toddlers and young children are increasingly being found unconscious or dead after consuming opioids. Children in households where parents struggle with substance use are more likely to experience long-term effects of neglect or abuse than others, including psychiatric disorders.

Thousands of parents continue losing sons and daughters across the country. In my clinical practice, parents often tell me experiences in looking for the right kind of support. The stigma related to substance use does not get buried when an opioid user dies; it continues to haunt their well-wishers for the rest of *their* lives, causing endless waves of sadness, guilt, and anger.

C. Everett Koop, the 13th Surgeon General, also known as "America's Family Doctor", championed the fight against AIDS. He was persistent in shifting the

*(Continued on p. 13)*



## OUR NATION'S HEALTH

(Continued from page 12)

terms of the public debate over AIDS from the “moral politics” – – of homosexuality, sexual promiscuity, and IV drug use – – to concern with medical care and the civil rights of AIDS sufferers. His efforts redefined the prevalent scientific model of the disease – – from a contagion akin to bubonic plague and yellow fever that required the strongest public health measures – – to a chronic disease that could be managed with medications and behavioral changes.

Dr. Koop once said that self-help brings together two central, but disparate, themes of American culture – – individualism and cooperation. Organizations such as Grief Recovery After Substance Passing (GRASP) and Broken No More, in addition to providing understanding, compassion, and support for those who have lost someone they love through addiction and overdose, reduce the stigma, thereby helping to stem the tide of addiction and overdose.

We have to adopt a pluralistic approach .The medical community, the legal community, social service agencies, faith-based nonprofits and neighborhood groups must form partnerships, meeting drug users “where they’re at” and addressing the conditions that breed them. “Harm reduction” is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. It incorporates a spectrum of strategies, such as substituting one opioid for another (Medication-Assisted Treatment [MAT]-Methadone, Naltrexone, Buprenorphine), or using an antidote (Naloxone), or engaging in safer use (Safe Injection Facilities), or abstinence. To ensure medication compliance, we have options, such as a monthly injection of Naltrexone (Vivitrol), a monthly injection of Buprenorphine (Sublocade), and a Buprenorphine implant inserted in the upper arm that lasts 6 months (Probuphine). The FDA recently approved NSS-2 Bridge, a device mimicking a hearing aid, to help reduce opioid withdrawal symptoms. According to Vivek Murthy’s 2016 Surgeon General Report, only about 10 % of Americans with a drug use disorder obtain specialty treatment. The report attributes the low rate to severe shortages in the supply of care, which can lead to waiting periods of weeks or even months. Further, over 40 % of addicts also have a mental health condition, yet fewer than half receive treatment for either disorder.

The CDC estimates that the total “economic burden” of prescription opioid misuse alone in the United States is \$78.5 billion a year. Policy makers need to conceptualize this deadly disease as a physical illness, rather than a weakness of willpower or morality. My hope is that, because the opioid epidemic was declared a national public health emergency by President Trump on October 26, 2017, policy makers will make evidence –based

treatments, such as MAT, readily accessible.

The Rolling Stones’, “Mother’s Little Helper”, related to the popularity of anxiolytic drugs, such as Valium and Meprobamate and the potential hazards of addiction and overdose. The lyrics, five decades later, continue reverberating- *“Doctor please, some more of these, outside the door, she took four more....Life’s just much too hard today....And if you take more of those, you will get an overdose no more running for the shelter of a mother’s little helper they just helped you on your way, through your busy dying day.”*

The American novelist, Chuck Palahniuk echoes the reasonable foreseeability of death associated with the first drug epidemic of the 21st century: *“I admire addicts. In a world where everybody is waiting for some blind, random disaster, or some sudden disease, the addict has the comfort of knowing what will most likely wait for him down the road. He’s taken some control over his ultimate fate, and his addiction keeps the cause of death from being a total surprise.”*

### How Can We Help?

- Ensure we regularly access tools designed to prevent unnecessary opioid prescribing.
- Educate patients about the risk of depression and of endocrine deficiency leading to sexual dysfunction associated with using opioids for a prolonged time. Many of us may falsely attribute low libido to a prescribed SSRI or SNRI.
- Teach patients how pain can be chronic, as it is in other common medical conditions such as hypertension and diabetes. We need to help our patients understand that psychological factors play a significant role in modulating chronic pain. We should emphasize noninvasive and non-pharmacological treatments for chronic pain. These include exercise and physical therapy, mind-body practices (Yoga, Tai Chi, Qigong), psychological therapies (CBT, bio-feedback, relaxation techniques), interdisciplinary rehabilitation, and mindfulness practices (meditation, mindfulness-based stress reduction practices). Osteopathic and spinal manipulation, acupuncture, and physical modalities (traction, ultrasound, transcutaneous electrical nerve stimulation [TENS], acupuncture, and functional restoration training) can also help.
- For patients with opioid use disorder, (Medication-Assisted Treatment [MAT]- should be readily accessible. We need to get to know other physicians in our communities who prescribe these medications. We need to form partnerships with them in order to instill hope and confidence in our patients that they have support in combating this epidemic.

We are confronting a serious problem. By working together with our patients, we can do a lot to improve the quality of life not only for them and for ourselves, but also for our communities.

The Maryland Psychiatric Society  
*presents*

# Assessing Risk in Psychiatric Practice

Rescheduled due to  
weather - new date!



MedChi's Osler Hall  
1211 Cathedral St  
Baltimore, MD 21201

2 CME Hours\*

This program covers two very important topics:

- The first **risk management** course is an interactive audience response lecture allowing you to engage with a risk management specialist to discuss real-life scenarios based on actual calls received by the PRMS risk management helpline. How would you deal with a law enforcement demand for patient records, a "Friend" request from a patient, pharmacist report of prescription alteration or an estranged parent demand for records?
- Next is **PDMP use\***, which is mandated for CDS prescribing effective July 1st. Checking PDMP helps avoid the possibility of dangerous prescribing and adverse outcomes.

Thursday,  
May 24, 2018  
6:30 - 9:00PM

## Agenda

**6:30-7:00PM**  
Registration, Coffee/Dessert

**7:00-8:00**  
What Would You Do?

**8:00-9:00**  
Maryland's Prescription Drug Monitoring  
Program (PDMP): Best Practice and Clinical Use

Registration is **\$20.00 for MPS Members**  
**Fees are non-refundable.**

**[REGISTER AND PAY ONLINE TODAY!](#)**

## Objectives

After attending this course, you will be able to:

- Describe the most frequent types of risk management concerns.
- Incorporate into clinical practice two risk management strategies to increase patient safety and reduce professional liability risk.
- Describe the Maryland Prescription Drug Monitoring Program (PDMP).
- Determine when PDMP will be required.
- Summarize what the PDMP query portal looks like.
- Confirm what other states' data can be accessed through the query portal.
- Establish how to use the PDMP as a clinical tool.
- Identify where to find safe opioid prescribing resources.

### \*Accreditation Statement

Professional Risk Management Services, Inc. (PRMS, Inc.) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

### AMA Credit Designation Statement


Professional Risk Management Services, Inc. (PRMS, Inc.) designates this course for a maximum of 1 *AMA PRA Category 1 Credits*<sup>™</sup>. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

### Accreditation Statement

MedChi, the Maryland State Medical Society is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

### AMA Credit Designation Statement

MedChi designates this live activity for a maximum of 1 *AMA PRA Category 1 Credits*<sup>™</sup>. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Thank you to our event sponsor:  PRMS  
Professional Risk Management Services, Inc.

# 2018 MPS Annual Dinner

**Thursday, April 26 at 6 PM  
Johns Hopkins Club**

Help up celebrate MPS achievements over the past year and turn the gavel over to Patrick Triplett, M.D., incoming MPS President. Marsden McGuire, M.D. will become President-Elect and Mark Ehrenreich, M.D. will become Secretary-Treasurer.

Winners of our Best Paper Contest and our new Resident/Fellow Poster Competition will be announced at the meeting. We'll recognize new lifer members, Fellows, Distinguished Fellows and 50 year members.

The evening will start with a cocktail hour complete with open bar, appetizers and live music. Dinner will be a plated meal featuring Petit Filet & Crab Cake.\*

Tickets are [\\$70 for MPS Members/Guests](#) and [\\$30 for Residents/Fellows/Guests](#). Tickets can be purchased online by clicking on the links above, or you can mail a check to the MPS office.

We have many Residents and Fellows who would love to attend! If you are interested in buying a ticket for a Resident or Fellow to attend this event at no charge, please visit the MPS website and [submit a payment](#) of \$30 via our PayPal site.

**You won't want to miss this fun event, live music, good food, and even better company!**

*\*If you have an allergy or special dietary restriction please email [mfloyd@mdpsych.org](mailto:mfloyd@mdpsych.org) or call the MPS office at 410.625.0232.*

*See you there!*

## Time is Running Out! Renew Your 2018 Membership THIS MONTH!

If you haven't already, please pay your 2018 dues now. Dues for calendar year 2018 were sent in October. Members who do not pay MPS and APA dues in full or schedule a payment plan will be dropped as of **March 31**. We want to help members in any way possible to remain in good standing! Please [contact the MPS](#) with questions, or to discuss dues relief options or payment arrangements.

## REMEMBER TO VOTE!

**The 2018 MPS election is underway!!**

Ballots were sent February 20 and returns must be postmarked no later than March 31, 2018. Candidate biography information is available online. Please [click here!](#)

## MPS Career Fair May 17 at 6:30 PM

Calling all Residents, Fellows and Early Career Psychiatrists! Plan to join us in Baltimore on May 17 for a fun, engaging career night. Meet with leaders in their respective fields, ask questions, and network with area employers looking to hire! The evening will also include heavy hors d'oeuvres with open bar.

Roundtable topics include:

- Child Psychiatry
- Private Practice
- Eating Disorders
- Public Health
- Academic Psychiatry





## LETTER FROM THE EDITORS

### What's To Be Done About MOC?

By: Bruce Hershfield, MD  
Jessica Merkel-Keller, MD

We are pleased to see that the American Board of Psychiatry and Neurology plans to offer a journal article – based assessment as an alternative way to keeping up with maintenance of certification, instead of relying on the once-every – 10-year proctored exam. Diplomates who are eligible can choose from articles selected by the ABPN pilot project test writing committees, which will include members from the APA. The exam will be “open – book”. Diplomates in this program who successfully complete 30 articles will still have to meet all other MOC requirements every three years to avoid being required to take the proctored “part III” exam. “Lapsed” and “lifetime” (certified no later than 1994) diplomates will not be eligible to participate in this project.

It is a step in the right direction, and the APA deserves credit for having worked with the ABPN to change one of its procedures. But we are concerned that it is simply not enough.

One of us is already doing the kind of CME called for by the Board, through “Audio Digest”. It is relatively easy to take the pre-test, then read the article and listen to the CD and then take the post-test, referring to the article for the relevant answers. It is hard to see how going through this process adds much to the practical knowledge base that helps psychiatrists function.

We believe that, in recent years, the ABPN is taking a disturbingly major role in deciding what is best for Psychiatry-- a role it was never designed to do. The ABPN was set up in 1934 to ensure that doctors who were calling themselves psychiatrists had finished accredited training programs. It was never supposed to ensure that psychiatrists kept up their learning afterwards. We think it would be preferable if our professional associations, for example, the APA and the MPS, set standards for our members to reach throughout our careers, particularly in ways that are relevant to our practices.

There have been many problems with Maintenance of Certification. The first was the way it was imposed on us, rather than being devised with the cooperation of the APA's Assembly, Components, and Board. We know that the policy was instituted by the umbrella organization – – the American Board of Medical Specialties – – that governs all 24 of the specialty boards, not by Psychiatry/ Neurology. The concept is based on the idea that the longer one practices the worse one does it. There's almost no data at all supporting that this is true in Psychiatry (unlike in Surgery). If it was true, patients would be clamoring to see psychiatrists who have just finished their training. This just about never happens; they clearly

prefer to see experienced ones. It also means that the Residents we supervise should be supervising *us*, since they are only a few months away from graduating.

The ABPN has an obligation to show the scientific basis for the determinations it makes; we believe that this is an obligation of “gown” when it dictates to “town”. This is particularly true because MOC is expensive, at a time when so many young psychiatrists are heavily in debt, their patients are struggling to pay reasonable fees, and so many members of the public simply cannot afford to see us.

There is a desperate shortage of psychiatrists. Patients who choose to go through their insurance networks are routinely being asked to wait several months. Even those who willing to pay are having trouble getting appointments. It is about to get worse, since half of psychiatrists are either at retirement age or within 10 years of reaching it. Rather than being replaced by people who know a great deal because they have just finished excellent psychiatric training, we're really being replaced by nurse practitioners, non – medical therapists who don't *know* any psychiatrists, and family doctors who cannot be expected to be experts in our field. We believe it would be better if the APA and our other organizations, working in collaboration with the ABPN, figures out a way for us to learn effectively, so that we practice better and so that more medical students want to become psychiatrists. We need to avoid afflicting our younger colleagues with even more paperwork, expense, and time away from not only their work and their families, but also the leisure time they need in order to be healthy.

The latest accommodation from the ABPN looks like a step in the right direction. We believe that the APA should see what else can be done. This would strengthen not only our natural desire to continue learning more about our profession, but also our faith that we are well-served by the organizations we join and support.



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