

THE MARYLAND PSYCHIATRIST

Spring 2016

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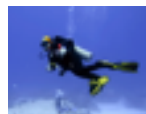
Welcome to the Spring 2016 Edition of The Maryland Psychiatrist

This edition features Brian Zimnitzky, our President for this 2015-16 year, and Jeff Janofsky, who is Medical Director for the American Association of Psychiatry and the Law.

Mark Komrad has written a timely article. While editing this edition, I happened upon a television documentary that included the lethal injection of an older German woman-- mother of two adult children-- with a diagnosis of borderline personality disorder. The "euthanasia" occurred after two interviews of the woman with a psychiatrist, who later performed the injection in the woman's home...

Neil Sandson provides the first in a series of articles addressing psycho-pharmacologic issues common in routine clinical work-- in this issue, serotonin syndrome risks, serotonin withdrawal syndromes, and of course some drug-drug interaction commentary.

Bruce Hershfield provides a string of pearls from his many years of practice. John Buckley has written an op-ed mourning the state of the Medicare system, viewed from the perspective of his decades of experience.



Nancy Wahls, MD, Editor

What I've Learned...

Bruce Hershfield, MD

Now that I'm getting ready to turn 70, I thought I'd summarize what I've learned since I finished my residency at the University North Carolina, when I was 28. Of course, I didn't learn all this only by being a psychiatrist since I would hope that most folks have also learned lots in the last 41 years. But our field has really changed, and so have I. This is what I tell the residents, when I get a chance to meet them in a group.



1 Psychotherapy is important, particularly if the patient is on the right medication. I won't do "med checks" since I would not want them if I was a patient. I figure if it's simple enough to do in a few minutes, my family doctor can probably handle it or learn how to do it. If it's complicated, it's going to take me more than a few minutes. I knew when I was a resident that psychotherapy was important. I realize now, if you have a severe psychiatric disorder like schizophrenia or bipolar disorder and you are not on the right medicines, you're in a lot of trouble, no matter how skilled your therapist-- psychiatrist or non-psychiatrist-- is.

2 Splitting the treatment, which was tried at least as far back as the '70s, is a serious matter, only to be used when both treaters know and trust each other and are

able to communicate easily. You just don't know what the other treating professional is actually saying to the patient. Splitting the treatment puts a psychiatrist at great risk of a suit, with little reward.

3 Try to get along with colleagues, even when they are being provocative. You may need to walk away, and you

probably will need to apologize and also to forgive at times. Never fight with secretaries; learn from their observations. I should have read *How to Win Friends & Influence people* long before I turned 60.

4 Try to have as few bosses as possible. If everybody loves the boss, he or she probably isn't effective. Never have more than one boss to whom you are reporting. All people--not just patients-- have transferences, and they usually complicate relationships with bosses.

5 If you're always agreeing with the general wisdom, particularly if money is involved, you will eventually be dead wrong on something. Atypical antipsychotics helping the negative symptoms of schizophrenia is a good example of conventional wisdom that turned out to be wrong. Beware of fads; don't trust ads; don't take professors or studies too seriously.

6 The more we know, the less magic is associated with us and the less respect we receive. It's part of our attempt to climb out of the Middle Ages.

7 Psychotherapy is more about healing, which usually occurs in-between sessions, than about insight. Patients who are asking for insight are usually unwilling to change their behaviors. Patients who don't do the homework probably will not learn new ways of handling problems.

8 You can't tell who is going to be a good patient. Some people with little education and little command of the language can change and get well. People who have addiction problems are the hardest to predict. You probably should give them a chance if they ask. Even after seven years of chronic depression, for example, some patients recover.

9 People will pay for good medical care, particularly for their children. It is not an accident most psychiatrists are now practicing outside the managed-care system. Don't allow managed-care companies to tell you how to practice. It doesn't look good ethically, and it doesn't impress juries. Do what is right, even if it costs you in the short run. You still may get in trouble, for example with administrators, but someone may be impressed and maybe you'll be rewarded. At least be kind if you can't do any more than that.

10 Stay out of court, if possible. Don't sue people, don't dismiss the possibility that anyone can sue you, and be sympathetic when your patients get involved in proceedings. Lincoln was right when he advised a group of lawyers to "eschew litigation".



11 Join societies and ask for advice from other members. If you're willing to ask for a consultation, you are almost certainly not negligent. Patients are reluctant to get them. Arrange for consultations with someone whose advice you'll almost automatically take. Don't criticize colleagues to others, including to patients.

12 Don't steal other people's patients. Ask potential patients if they have ever seen a psychiatrist, when they first call. If it's in the recent past, ask to have their psychiatrist refer them to you, and say you'll get back to them if that happens. Clarify beforehand if it's for a one-time consultation or for ongoing treatment. If patients don't show up for the first visit for any reason, or give you a hard time on the phone, you will eventually regret taking them into your practice.

13 Be available. Return calls. Have a call hour. Answer letters. Encourage patients to call you if they need you. Find someone to substitute for you whom you can trust when you're away from the office for any significant time. Be very careful about prescribing for the patients of others when you cover for colleagues. Don't charge for phone time. Most people won't abuse it. If patients call too much, you probably need to see them more often. Don't let patients go for more than 90 days without seeing them.

14 Document. Too much is better than too little. There's more paperwork each year--more work in general. Real earnings have been going down since the '70s. Follow up on lab tests. Write legibly. Your reputation may depend on the quality of your notes.



15 Be cheerful, even optimistic. It turns out it wasn't Lincoln, but someone else, who said that he reckoned people are as happy as they allow themselves to be. You can't expect depressed patients to be optimistic, and someone has to be, at least to balance their pessimism. If you are a psychiatrist, chances are that most people, and virtually all of your patients, have it worse than you do. Don't complain.

16 Keep learning. Read books, acquire new skills. I've heard that almost everything we know we've learned since 1950. Accept that what you know will probably turn out to be wrong or useless. They call that progress. Beware of people who tell you they know the answers. Your training will probably turn out to be a small fraction of your career.

17 Patients are probably right about side effects. Be suspicious about claims made by drug companies, including maximum recommended doses. Ask patients about drinking and about

caffeine, not just about illegal drugs. Check with families. Be suspicious if patients forbid you to contact their families or the professionals who used to treat them.

18 Get to know families. It's crucial if something like a suicide occurs. Get a family history. I understand the average person carries the genes for 20 disorders, of which four are lethal.

19 Don't treat members of the same family, or close friends, if you can help it. Don't write prescriptions for your friends or coworkers. You can't successfully treat everybody. Somebody else may be a better match. Sometimes, patients return after they drop out.

20 You work for the patient, not the other way around. Dress accordingly, use honorifics like Ms. or Mr., and ask what the patient wants. Set up a valid treatment contract, early on. Be wary of double agency, like working for the patient and the hospital, or for the patient and the managed-care company.

21 Use "we" interpretations. This is not Europe; people expect to be treated as equals, and they aren't as tied to their traditions and their families as in other places. Sometimes a story or a fairytale can illustrate a point. Be careful about using your own life as the example. Patients can sometimes change if they are laughing, but be careful. If you offend someone, apologize. Patients don't expect their psychiatrists to be perfect, but they do expect them to display good manners, like holding the door for them or offering them a tissue when they cry. Psychiatric disorders are common and chances are that someone you know, or even you, will get one.

22 If you're going to work for yourself, you have to stay healthy. Take frequent vacations. Learn how many patients you can safely see in a row and what your personal clock tells you. If you are sleepy, excuse yourself and get some coffee. If you bring it into the session, offer the patient a cup.

23 Make sure you get paid. If you get cheated, learn from it. Don't pursue it too hard; there are too many ways that disgruntled ex-patients can make you miserable. Be careful to document when patients pay you in cash.

24 When patients miss an appointment the first time, don't charge. Make sure you call to find out what happened. If they can come later that day, let them. Patients tend to resent paying for missed appointments.

25 Be on time, or at least apologize if you're not. Try to give extra time if people need it. They rarely abuse it and often appreciate it. Give plenty of warning before you raise your fees.

26 You will like some patients more than others. Some patients will like you more than others. You are neither as good or as bad as your admirers or detractors say you are.

27 Things go wrong. Admit it when you make a mistake. We are always on the verge of disorganizing, as is everything else in the universe according to the second theory of thermodynamics.

28 Diagnoses can be important. Hand the patient the DSM-V if you think that a personality disorder is present. That book has its limitations, but at least it uses a common language we've had

since 1980. Watch out for indications of learning disorders. You may not want to make a diagnosis of a personality disorder, but it may be present anyhow and completely ignoring it may complicate or destroy the treatment.

29 The public system is in worse shape than the private, since government is not in the business of building reserves and sooner or later finds itself in a financial crisis. Also, there are too many bosses and too many political influences affecting patient care for it to be very good for very long.



I hope I haven't finished learning. It is upsetting to realize how little we still know about what causes psychiatric problems. Our patients live better lives now than they did 41 years ago, and I'm optimistic that we can help them live still better lives in the future. I used to think that I would retire when I turned 70, but I decided not to do that. There's too much going on for me to quit now. 🙄



Brian Zimnitzky

MPS President 2015-16

Bruce Hershfield, MD



Dr. Brian Zimnitzky, our MPS President, has a rich background and is able to make use of many of his prior experiences in handling issues for us. Currently in private practice in Annapolis, where he treats patients and performs forensic psychiatric evaluations, he has also been Clinical Director for Adolescent Services at the Crownsville Hospital Center, Medical Director at the Woodbourne Center, and Assistant Clinical Professor at Johns Hopkins.



BRIAN AND KURT ON THE GREAT WALL OF CHINA

Educated in chemistry at the University of Delaware, in Medicine at the University of Maryland, and in Psychiatry at Tufts, he later spent several years in California, where he worked in community mental health and at the Langley Porter Psychiatric Institute and at Kaiser Permanente. He then returned to the East Coast, where he did a forensic psychiatric fellowship at the University of Maryland.

Licensed in three states and in DC, he is board certified in General Psychiatry, Child and Adolescent Psychiatry, and Forensic Psychiatry.

A member of the faculties at both Johns Hopkins and the University of Maryland, he is also a member of the American Academy of Child and Adolescent Psychiatry and the American Association of Psychiatry and the Law. He is the author or co-author of eight publications, including contributions on Child and Adolescent psychopharmacology, death associated with desipramine, and autism.

He now lives in Washington, DC, with his husband, Kurt, their adorable little girl, Emily Rose, and an English bulldog, Nigel, whom he describes as “very handsome”. In the little spare time that he has, he enjoys playing the piano, traveling, and speaking German. He has enjoyed being our President— getting to know his psychiatric colleagues and learning how important our organization is to psychiatrists and to the people we treat. He expects to be very active in the next couple of months, now that the



NIGEL AND EMILY ROSE

legislative season has begun. As he has mentioned in one of his President’s columns, he anticipates that physician-assisted suicide will be a major focus in this year’s session.

... he enjoys playing the piano, traveling, and speaking German...

Dr. Zimnitzky has been an important leader for the MPS for quite a few years. We are fortunate indeed to have someone with his clinical and political skills helping us not only during this session, but in so many other years when psychiatric issues have been important to our members and our patients. 🐼



AT LAST YEAR'S MPS ANNUAL DINNER AT MARTIN'S WEST IN BALTIMORE: KURT, BRIAN, HEIDI, MEAGAN, EMILY ROSE

How do you keep balance in your life?

Share your story with other members! Do you volunteer? Are you a visual artist? A musician? Are you in a band or symphony? Are you a writer? Are you an athlete?

Want to comment about anything in this edition?

Send your comments, letters to the Editor, or article submissions to:

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An Impending Ethics Tsunami

Euthanasia for the Mentally Ill

Mark S. Komrad, MD

It's not often in one's career that one can say there has been a development that could be one of the most significant in the history of one's field. I had that sensation regarding my field of psychiatric ethics when the following headline came across my email this summer:

Right to die: Belgian doctors rule depressed 24-year-old woman has right to end her life
[The Independent, 7/18/15]

Actually, I had been wondering when we would get here—ever since I saw the roll-out of state-sponsored laws in the United States giving people the right to physician-assisted euthanasia. As of fall 2015, physician-assisted suicide is permitted by statute in Oregon, Washington, Vermont, Montana and most recently California. Countries where it is permitted are: Belgium, the Netherlands, Colombia, Germany, Japan, and Albania. In the United States, these statutes are limited to “terminal illnesses.” However, countries like Belgium and the Netherlands have expanded access in recent years to those who have “untreatable” and “hopeless” chronic suffering, but who are not necessarily “terminal.” Those who are advocates of these laws, do not use the term “assisted-suicide,” but “aid-in-dying.” U.S. laws require totally autonomous actions by the patient, who is provided the means by physician prescription. In Belgium, there are centers, where the agents are administered to the patient by “professionals.”

In a strange twist on the concepts of “stigma,” and “discrimination,” people with mental illness are now beginning to say that they should not suffer

discrimination in accessing physician assistance to end their severe pain, their “hopeless” and “untreatable” situations as can patients with other severe and chronic medical illnesses. This is a strange example indeed of the contemporary quest for “parity” in law and policy for those with mental illness. The argument is gaining traction in places, like Belgium, where the laws are not confined to “terminal” illnesses, but include “chronic suffering.” That of course describes many with mental illnesses. Although illegal, there are some physicians, like Lawrence Egbert M.D. (founder of the Final Exit Network) who has provided “physician-assisted suicide” for a few here in Maryland.

To say that this goes against the grain of most psychiatrists is an understatement.

As clinicians we recognize that “hopeless” and “untreatable” are vague concepts. The lack of progress in some cases may come down to a lack of resources to obtain potentially more effective treatments like Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), residential rehabilitation, intensive psychotherapy, family therapy, et cetera. Sometimes, the distinction between what we traditionally call “treatment-resistant” conditions and “untreatable” is unclear and debatable. Perhaps more complex or aggressive medication trials have not been conducted because they haven't been considered or because they have been resisted by the patient due to the very illness we are trying to treat— or perhaps because of insurance limitations on formulary access to newer agents. Most psychiatrists have had experience with patients who

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come to us after years of suffering, who have been treated by non-physician mental health professionals with psychotherapies, only to finally be referred for medication which turns their case around. Alternatively, many “medication-resistant” patients turn around when finally engaged in robust psychotherapies.

The potential conflicts of interest surrounding these “choices” by patients abound. Consider who might also have an influential role on the patient: the insurance company which stands to save on the cost of continued treatment; overwhelmed and exhausted families who would have relief; even exhausted clinicians and the staff working the revolving door hospitalizations.

One of the core roots of medical ethics is the value of life, a moral rule that drives much of our activities as physicians. Assisted-suicide is difficult for all physicians. However, permitting—let alone helping—a patient commit suicide is a particular anathema for psychiatrists. One of the most basic activities in our everyday work is scanning for and trying to prevent suicidal behavior. One of the ways we do this is to see, on behalf of our patients, numerous paths to a better future, multiple ways to lower and cope with suffering. We help patients to elaborate options for finding meaning, empowering

choices, and creating change. We may hold those visions on behalf of the patient for awhile until they are ready to embrace them and deploy a path to a better future. In this sense, I see psychiatry, of all specialties in medicine, as having the most robust skill set in helping instill hope in patients for a better future, and working relentlessly to sustain that hope. This is not an easy endeavor. To do this, we typically encounter our patients in sessions of longer duration, more frequency and over a longer period of time than other specialists. Delivering hope and taking the journey with patients out of their suicidal thinking and other sufferings, hacking our way through the under-bush of disease, resistance, family dynamics, insurance denials, and all the other obstacles, is what we do.

Though Belgium requires a second-opinion psychiatrist to verify that a mentally ill person is truly psychiatrically “untreatable,” it does not require another attempt at treatment with a different psychiatrist by an applicant. That government is willing to underwrite the cost of the euthanasia, but not necessarily other treatments that might not have been accessible to the “untreatable” patient. Nor is there any provision, even here in the U.S., for non-psychiatric patients who are choosing assisted-suicide to be evaluated

**Dr. Annette Hanson
and I are bringing an Action
Paper...asking the APA to resolve:
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by psychiatrists, not necessarily for mental competency, but to have a trial of treatment, to do what we of all health care professionals are the most trained to do—deal with suicidality.

I think that this issue is inevitably on its way to the U.S. It will enter under the umbrella of combatting stigma and non-discrimination against the mentally ill, potentially turning on its head these tropes that we have long used to advocate for our patients' lives and recovery. We will have to revisit some very fundamental ideas about the ethos of our profession and our mission as psychiatrists. Psychiatrists will have to determine whether to work with or resist this approaching ethics tsunami that I predict will rattle practitioners both seasoned and new.

As representatives to the APA Assembly, Dr. Annette Hanson and I are bringing an Action Paper to the May Assembly asking the APA to resolve:

The American Psychiatric Association holds that a psychiatrist should not deliberately prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death.

Many prominent colleagues have signed on in support of this paper. 🌱



Dr. Komrad, M.D., is Ethicist-in-Residence at Sheppard Pratt; member of the APA Ethics Committee; and author of [You Need Help: A Step-by-Step Plan to Convince a Loved One to Get Counseling](#). Dr. Komrad's opinions are his own and not necessarily representative of Sheppard Pratt, the APA, or the MPS.

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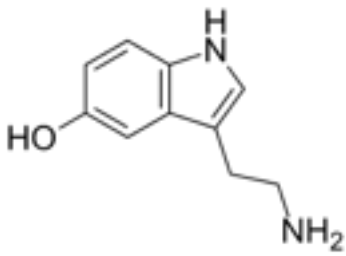


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Hopefully soon the full edition will also be accessible on The MPS website, but currently there are still some technical limitations preventing this.



SEROTONIN

A recurring headache...

Neil Sandson, MD

For the next few installments of this column, I'll explore some recurring psychopharmacologic issues and concerns that seem to arise with some frequency in routine clinical work. My treatments of each issue will mix what little we actually know (the evidence base) with what many hope and believe to be the case (lore, conjecture, and what passes for "expert consensus"). If readers have further input, please feel free to contact me at Neil.Sandson@va.gov.

The first group of these issues will deal with concerns encountered when using serotonergically active agents, which of course most commonly applies to SSRIs.



Serotonin Syndrome

It is hypothetically possible for any recipient of any serotonergically-active drug to experience a central serotonin syndrome. Of course everyone understands that the more serotonergically-active agents one prescribes, and the higher the dosages of those agents, the more likely a recipient is to experience serotonin syndrome (SS). Beyond that, however, there is little consensus regarding risk-benefit calculations. With no hard evidence to back me up, I offer the following guidelines.

One agent

Although serotonin syndrome is a theoretical possibility, I wouldn't ever hesitate. This is obvious.

Two agents

This is virtually ubiquitous. The clear likelihood is that, within standard dosing parameters, this will not produce serotonin syndrome. That being said, I wouldn't be cavalier; and, unless I'm specifically treating OCD, I would lean more toward neurotransmitter synergy than redundancy when possible. But, for instance, I would never let this stop me from dispensing 50 mg qHS of trazodone to help address insomnia in someone on fluoxetine.

Three agents

This is the biggest functional change. The legitimate need for three such agents to be given concurrently will occasionally arise. Let's imagine a scenario in which someone with depression or OCD also has chronic pain issues and/or migraine headaches. In this situation, it is my conjectural belief that the probability of SS has gone from "almost negligibly remote" to "improbable but quite possible and even plausible." Unless truly compelled by circumstances, I will generally try to avoid this but not to the point of sacrificing the quest for efficacy. Definitely coach the recipient explicitly about what to look for, warning signs, what to do, et cetera, when entering this territory. Provided you have a coherent rationale and you've had this risk-benefit discussion, you're still within the standard of care, IMHO.

Four agents

I believe that the risks are now appreciably greater: “still unlikely, but not by much.” This is rarely necessary, and the onus for demonstrating clinical necessity, should that need arise, is correspondingly much greater. Strive mightily to avoid this state of affairs!

Five or more agents

Whether true or not, “one would be defenseless against the allegation that SS is now a reasonable probability.” Unless one is fond of being a defendant in malpractice proceedings, this should be categorically avoided.



Tramadol and SSRIs

I get asked about this one a lot. The concerns are threefold:

- *serotonin syndrome (see above),
- *seizure risk,
- *and loss of tramadol’s analgesic efficacy.

With regard to the seizure risk, while tramadol is one of our more seizure-genic drugs, there is nothing special about the combination with an SSRI (all of which only modestly lower seizure threshold) that creates more inherent pharmacodynamic risk than combinations with more seizure-prone drugs, such as bupropion or clozapine (or maprotiline, for any world-travellers).

As for the analgesic efficacy, the concern is that tramadol is, at least on some level, a pro-drug. It undergoes transformation via cytochrome P450 2D6 into O-desmethyltramadol (or M1), which is a

much more potent mu agonist than parent tramadol. However, parent tramadol has both serotonin and norepinephrine reuptake-blockade capabilities— not unlike (in vivo) tertiary-amine TCAs, such as imipramine or amitriptyline. I used to maintain that co-administration of tramadol with a potent inhibitor of 2D6, such as fluoxetine, paroxetine, or bupropion, would greatly diminish tramadol’s analgesic potency. While that may be true, and some animal studies support that, I’ve encountered any number of patients who report perfectly intact analgesic efficacy with tramadol while taking one of those aforementioned drugs. This may be due to the neurotransmitter profile that I’ve just described, in which case metabolic conversion might augment but would not be essential to preserving tramadol’s analgesic efficacy. This would also explain why tramadol, in my experience, seems to work in folks taking suboxone, even though it’s not supposed to work in this combination.



Serotonin withdrawal syndrome

This seems to be a particular problem with venlafaxine. Getting off that last 25 mg/day or 37.5 mg/day seems especially difficult. Paroxetine is also more problematic than other SSRIs. One reason why these two drugs pose more difficulties in this regard is that they have quite short half-lives. Pharmacodynamically, the reason why that last bit is so hard to discontinue tolerably is that the 37.5 mg of venlafaxine from 0 to 37.5 mg accounts for a LOT of serotonin reuptake-blockade, whereas the 37.5 mg that makes the difference between

188.5 mg/day and 225 mg/day accounts for a lot less blockade. So the latter transition is easy, but the drop from *low-dosage but NOT minimal reuptake blockade* to *non-existent reuptake blockade* is jarring to the system.

So how to get around this? Well, for paroxetine, one could resort to elixir and give ever-decreasing amounts in a protracted taper that would be tolerable, if lengthy. Venlafaxine does not have a liquid formulation; I get the willies reading the self-help websites as folks cheerfully describe opening capsules and deciding how many venlafaxine “beads” they will consume on any given day. Mind-boggling. Anyhow, Scott Aaronson gave me this core idea for an efficient and tolerable way to taper off of these medications, which I’ve modified slightly.

Step 1: On day 1, add fluoxetine, 10 mg/day.

Step 2: On day 4, stop the venlafaxine or paroxetine.

Step 3: On day 8, stop the fluoxetine.

The fluoxetine should then auto-taper in a gradual and easily tolerated manner. This won’t work for everyone, but it should work for a lot of folks who have otherwise been unable comfortably to stop these drugs.

Next time, I’ll continue with SSRI-induced sexual dysfunction, inhibition of platelet adhesion, and a revisiting of some classic drug-drug interactions. In later installments, I’ll explore other drug classes.



*Dr. Sandson is Clinical Associate Professor for the University of Maryland Medical System and Medical Director of the Baltimore VA Hospital’s Acute Inpatient Psychiatric Unit. He is also author of two books: **Drug Interactions’ Casebook: The Cytochrome P450 System and Beyond** (APPI - 2003) and **Drug-Drug Interaction Primer: A Compendium of Case Vignettes for the Practicing Clinician** (APPI - 2006).*



“M & M” Medicare and Me...

John Buckley, MD

In July 1965, Medicare legislation passed into law. I was about to begin my third year of medical school. The news meant little to me then: too distant, no personal impact. There were cries of “socialized medicine,” but the traditionalists were out-voted.

I paid a lot more attention in the late 1970’s and 1980’s when, as a full-fledged psychiatrist, I had a part time office practice and spent many hours in the general hospitals of Towson. Medicare was just a fact of life. Reimbursements were low but consistent, and they were without the debates common with commercial insurers. Who covered what and where? There was a slow increase in government rules and “T”-crossing, but everyone seemed to adapt to the creeping bureaucracy.

The local CMS contractor was a group from Texas who worked from an office in Timonium. They responded to calls, explained the rules clearly, and made fewer mistakes than their “Blue” cousins.

As I spent more time in my office and less in hospitals, I saw more patients with Medicare and saw no increases in Medicare payments. Then I changed my status to “non-par”, followed the rules, submitted the detailed

forms on behalf of my patients, and lost a few of them after the decision.

The requirements continued to creep up, the payment schedules lagged, and the Texas group was replaced by a Pennsylvania insurance company. I guess that they promised more service at lower cost to the government. I floated with the tide, but the new contractors were less efficient and harder to contact. The tone of communication had shifted from patient explanations to an adversarial “do it our way or else” attitude.

In early 2009, the mail arrived with a copy of the 1099 form which Medicare had sent to the IRS. I was surprised to learn that Medicare reported having sent me checks in 2008 that totaled \$270,183.01. A quick and nervous review of my records revealed direct Medicare payments of \$148.17. (As non-par, I had accepted assignment of benefits for two nursing home residents with Medicare and Medicaid.)

I called the CMS contractor and eventually spoke with “Jimmy”... no last names... and was promised a corrected 1099. I asked for the name and address of the CEO so that I, as CEO of my own business, could send a written complaint. “We are not allowed to do that... you can look it up on the internet”. I tried the

internet for a few minutes with no success, and then I set the matter aside once the revised form arrived.

My next encounter with Medicare arrived in the spring of 2009. It was an inquiry about two out-patient visits for an individual earlier that year. They demanded copies of my records for those dates. I responded with a letter to the inquiring “team” (no names of individuals) asking for the reasons and for the qualifications of the reviewers.



The case was straightforward: a 78 year old retired man was referred by his PCP for management of dysphoria and preoccupation with family relationships. There was no history of mental health treatment, and there were no vegetative changes. I saw him for evaluation in December 2008, followed by four visits, each 50 to 60 minutes, from January to March 2009. His intense distress had subsided, and he reported a return to his usual comfort level— with a plan to lower his expectations of his errant grandchildren and to relax his role as paterfamilias. He returned to his PCP and paid for his treatment at the Medicare rates, and all was positive.

In response to my letter of inquiry, a Medicare representative called with reassurance that there was no problem with my practice, that the reviewers were specially trained nurses and that they had reviewed the

submitted statements because of the atypical combination of 90807 and 309.9 codes. Their review revealed a deficiency: that in spite of the 90807 definition and the clearly-marked progress notes, I had not written down the actual minutes spent face to face with the patient.

I promised to resubmit the edited progress notes with the exact minutes as best as I could recall. I did that (and never mentioned the other two visits with the same codes, which had escaped detection), then waited for some decision, and waited...

The situation was awkward. The brief intervention was done and paid for. The patient had now been notified that his check from Medicare was delayed by an investigation of his treatment. His wife had pooh-poohed the idea of a psychiatrist in the first place. I sent him a note of explanation but never heard from him or from Medicare...until I asked Medicare, a few months later, for an outcome of their investigation. They answered! A form letter from a team announced that anything beyond six months was not reviewable unless I wished to file a formal appeal.

The medical associations to which I have paid dues for four decades were not helpful. I was on my own.

It was then that I began the arduous process of “opting out”. Patients with Medicare must now sign a contract every two years. With a copy of

this and a copy of the CMS acknowledgement letter, they can submit bills to their secondary insurance for a small reimbursement.

I still get calls from people with Medicare who describe a need which I am well-qualified to manage, but the opt-out is all-or-nothing. I cannot treat anyone with Medicare even if I agree to accept assignment for a given case.

It was slow to dawn on me that Medicare had hired a large group of technicians (for the lowest bid?) to review records in a search for outliers. They have no way of judging outcomes, efficiency, or mutual trust. There is no incentive to do so. They are rewarded for finding cheaters. Discovery of government fraud can be lucrative. These technicians are trained to find irregularities from another state, work decent hours, take no night call and never use their last name. In a future model of efficiency with standardized EHRs, one can picture plug-in humanoids doing the same job.

Now that I am “free”, I am certainly not happy. After practicing in the same community for 41 years, the climate for the medical cultural community is permanent cloud-cover.

When I was a resident circa 1970, I met a 60-year-old woman in an outpatient clinic. She was chronically depressed but determined to work hard and function in society. She had a number tattooed on her forearm. After surviving the war, she had returned to Poland to live in the Soviet environment before escaping to the west in the 1950’s.

In her accented English, she explained the differences from past to present cultures with a story of her bus rides. On buses in Eastern Europe, she could talk freely with her fellow passengers, sharing pleasantries and also complaints about a harsh existence. If a policeman boarded the bus, the passengers became quiet, guarded in their communication and avoided eye contact. (The police worked for the state and were always looking for dissent [“outliers?”].) The passengers no longer felt safe. Here in the United States, she used the bus to get to work, speaking freely with the other riders... until some rowdy youth or threatening character caused the same reaction as in Poland... but now if a policeman boarded the bus, the passengers could again be safe and conversational because the policeman was there to protect them...unlike the false protection in a closely regulated state.

With all the advances in safeguards and protection from illness and from doctors who aren’t comfortable with the regulatory supervision, I feel less safe. This is in spite of my belief in the common good, in pooling our resources to serve all levels of society. Now, I am not sure which bus is the right one.

Years back, I felt that as a qualified physician, I was honored and respected by my peers, by the government, and by most of society. I was confident and hopeful for the future.

Today, not so much. 🚗

Interview with Jeffrey Janofsky, MD

Bruce Hershfield, MD



shoes. The Medical Director maintains the long-term integrity of the organization. My job is to help the President and the other officers maintain the stability of the organization.

Q: How long do the officers serve?

Dr. J: The President serves one year as President-elect, one year as President and then one year as Immediate Past President, so really it is a three year term. We have really good people in the organization. We have a deep bench of Past Presidents and rising stars, many of whom are from Maryland.

Q: Why is Maryland such a hotbed of forensic psychiatry?

Dr. J: Around the turn of the 20th century, the Baltimore City Court was the second jurisdiction in the United States to appoint a psychiatrist to help judges evaluate cases. Before modern forensic psychiatry started with AAPL in 1969, when forensic psychiatry was not yet a recognized subspecialty, psychiatrists who practiced what we would now call forensic psychiatry, at least initially, worked in the courts directly. Some people developed private practice interests. Then, a small



group developed a forensic psychiatry interest group in the APA, and that morphed into APPL. AAPL's first meeting was in a hotel near what was then Friendship Airport. Since then, the organization has grown to more than 1500 members. AAPL members must be psychiatrists who are members of the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, or an APA equivalent Canadian or foreign organization.

Q: I remember when you represented the organization in the APA Assembly.

Dr. J: Yes, I was AAPL's representative to the Assembly for more than 10 years. We have strong participation in the

Q: I understand that you're the Medical Director of the American Association of Psychiatry & the Law (AAPL) now.

Dr. J: I've been Medical Director for two years. AAPL is the leading professional association for forensic psychiatry in the United States. AAPL is dedicated to excellence in practice, teaching, and research in forensic psychiatry. It was founded by our own Jonas Rappoport, who was AAPL's first President and its first Medical Director. I'm proud to be stepping into his

Assembly. Many forensic psychiatrists are interested in public policy issues, and many are very involved in the APA Assembly as well in various capacities.

Q: Would you tell us a little bit more about what AAPL actually does?

Dr. J: Our major function is to

resource documents to help our members in the field. We have a well-regarded journal, the “Journal of the American Academy of Psychiatry and the Law”, which is edited by Ezra Griffith from Yale. It’s a peer-reviewed publication, and that’s another way we foster scientific excellence. We also have a newsletter, which is not peer-

Q: How else does AAPL help?

Dr. J: At times, forensic psychiatrists may be perceived as controversial. That’s sometimes based on perceptions that are not accurate. For example, when John Hinckley tried to assassinate Pres. Reagan, the public and legislators’ perspective was, ‘How could he be found not guilty?’ We all saw him do it on TV’. There was a lot of rhetoric that many people are found insane and that there were frequent ‘battles of the experts’ in insanity cases. That actually prompted me to do one of the first scientific papers I ever wrote. Jonas and I looked at all the people pleading insanity in Baltimore City and found that in fact insanity pleas were extremely rare; they were rarely successful; and most of the time both sides agreed on the outcome. So doing some research to counter public misconceptions—it’s one thing I’ve been very interested in during my whole career.

The [AAPL] Journal and Newsletter are available free on-line at:

<http://www.JAAPL.org>
and
<http://www.aapl.org/newsltr.htm>

have an annual scientific meeting, which happens every October. AAPL’s upcoming annual meeting program can be found on-line at <http://www.aapl.org>. Every 10 years the meeting is held in Baltimore, and we will be here again in October 2019. We’re also interested in broader public policy issues. We have developed a number of practice guidelines, including criminal responsibility, competency to stand trial, and disability; and we’re also working on other

reviewed; but it’s more practical. We’re primarily an educational organization.”

Q: Do non-members have access to these publications?

Dr. J: The Journal and the Newsletter are available free on-line at: at <http://www.JAAPL.org>” and <http://www.aapl.org/newsltr.htm>

Q: What is likely to be an important forensic issue in the next few years?

Dr. J: I think that privacy is going to be a big issue. I think that there is a tension right now with the violence in France. Should security agencies have access to people’s medical records? That’s a major issue for us, as American citizens, not just as psychiatrists.

Q: Would you tell us a little about yourself? How did you first get interested in forensic psychiatry?

Dr. J: I was a medical student at Hopkins, and I had decided to go into psychiatry. I had some elective time, and I looked at Hopkins's elective booklet, and I saw forensic psychiatry—"Treat the criminally insane at the Circuit Court." Jonas was running it, and he was involved in the Hinckley case at the time. What could be more interesting than that? I've been interested ever since.

My primary interests have centered on looking at populations in various ways-- violence prediction, confidentiality, but most lately its inpatient suicide risk mitigation. How can we make inpatient psychiatric units safer? I spend most of my clinical time as a general inpatient psychiatrist at Johns Hopkins.

Q: Who has influenced you the most?

Dr. J: I think Jonas, and Paul Appelbaum, along with clinical people at Hopkins. I've had the pleasure of working with many excellent clinicians at Hopkins, like Paul McHugh and Ray DePaulo.

Q: What would you do differently, if you had a chance to do it over again?

Dr. J: I didn't know anything when I was first entering the field. I think I've had some tremendous

on these issues because the standard of care is evolving. I would read the APA guidelines on

"For most of us, the issues we are going to be dealing with on a daily basis are suicide risk assessment and violence risk assessment... It's important to participate in CME on these issues because the standard of care is evolving."

opportunities.

I mean, to be a good forensic psychiatrist you have to be a good clinician. I've always put my clinical roles first. I started out getting COSTAR together, with Annelle Primm. We had to figure out how to do ACT teams in urban settings together. I've been doing inpatient work ever since. It gets a little harder every year. The patients seem to be getting more violent for some reason."

Q: How do you think we could practice better, as psychiatrists in the community?

Dr. J: For most of us, the issues we are going to be dealing with on a daily basis are suicide risk assessment and violence risk assessment. I think it's important to participate in CME

suicide risk assessment. The AAPL Journal has many papers on suicide and violence risk assessment. I would recommend that, when AAPL comes here for its annual meeting, readers might want to attend. It's a good idea to also go to the APA annual meeting, where they have good courses on suicide and violence assessment. 🌟





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Happy year of the monkey!