



Photo by Fred Seligman, MD

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Owl Jokes

Jokes submitted from Martin Drell, MD

Q: What do you call an Owl get together?

A: A HOO-tenanny

Q: What is a bird's favorite Beatles song?

A: Owl you need is love

Q: What do you call an Owl with armor?

A: A Knight Owl

Q: What do you call an Owl mystery?

A: A hoot-dunit

Q: What does an Owl say when he leaves?

A: Owl be seeing you

Q: What do you call an Owl magician?

A: Hoooo-dini

Q: What do you call a baby Owl swimming?

A: A moist-owlette

Q: What's more amazing than a talking Owl?

A: A spelling bee

Q: What do you call Owl gang violence?

A: Drive by hootings

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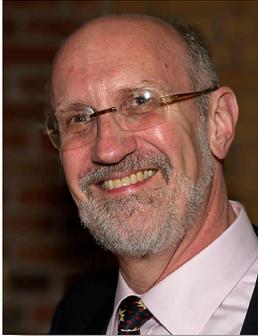
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Get involved - submit articles for the Owl Newsletter! We want to hear from you! Let us know what you are up to, how you're doing, and more! Please send materials to mdrell@lsuhsc.edu. The deadline for the next issue is **March 15**.

Martin Drell, MD



Burnout



Martin Drell, MD

It is clear that things in medicine have been changing for some time, that the pace of change appears to be intensifying, and that change will continue. Despite change being ever-present, it is clear that many doctors do not like what's happening, nor how it makes them feel and act.

Studies tend to confirm this

overall. Stress levels are up, along with burnout and suicide. If the studies are to be believed (and I believe them), up to 50% of physicians and two out of five psychiatrists suffer from burnout, which is defined by Izau, Kirch, and Nasca as a syndrome characterized by emotional exhaustion (which includes negativity, cynicism, and the inability to express empathy or grief), a feeling of reduced personal accomplishment, loss of work fulfillment, and reduced effectiveness.

Burnout, which can be measured by the Maslach Burnout Inventory which consists of three major components: physical exhaustion, depersonalization (which manifests in being cynical and sarcastic towards patients), and lack of efficacy with a loss of meaning and purpose.

High Maslach scores have been correlated with decreased job satisfaction, system inefficiency, increased medical errors, decreased patient safety, and increased malpractice lawsuits. It seems logical to wonder if it is also correlated with statistics indicating an increase in suicide in doctors.

The statistics for such suicides are estimated at 400 per year, which is equivalent to eliminating the graduating classes of seven medical schools each year. This does not help the well-known doctor shortage.

A Mayo Clinic handout on burnout lists the following stressful contributing factors:

Lack of control - An inability to influence decisions that affect your job — such as your schedule, assignments, or workload — could lead to job burnout, as could a lack of the resources you need to do your work.

Unclear job expectations - If you're unclear about the degree of authority you have or what your supervisor or others expect from you, you're not likely to feel comfortable at work.

Dysfunctional workplace dynamics - Perhaps you work with an office bully, or you feel undermined by colleagues, or your boss micromanages your work. These dynamics can contribute to job stress.

Mismatch in values - If your values differ from the way your employer does business or handles grievances, the mismatch can eventually take a toll.

Poor job fit - If your job doesn't fit your interests and skills, it might become increasingly stressful over time.

Extremes of activity - When a job is monotonous or chaotic, you need constant energy to remain focused — which can lead to fatigue and job burnout.

Lack of social support - If you feel isolated at work and in your personal life, you might feel more stressed.

Work-life imbalance - If your work takes up so much of your time and effort that you don't have the energy to spend time with your family and friends, you might burn out quickly.

To this list, I would add being incessantly exposed to the pain and suffering of our patients. How many people upon hearing you are a child psychiatrist, come up to you and say, "I don't know how you do what you do?" Burnout is when you have a hard time answering this question.



Burnout

In summary, people who are “burnt out” are not “happy campers” and are cynical and critical about what they do. They are often involved in downward escalating cycles of grief and woe. When at work, they are irritable, impatient, and/or withdrawn.

Their productivity is usually decreased. They can have somatic complaints and may compensate with poor lifestyle choices (drugs, alcohol, eating disorders) that have subsequent physical consequences (diabetes mellitus, obesity, heart disease, high blood pressure), and emotional consequences (adjustment disorders, depression, anxiety, suicide, etc.). Their feelings can impact their interpersonal relations both at work and outside of work.

It is noted that that the Accreditation Council for Graduate Medical Education (ACGME) has evolved over the years to an increased focus on protecting trainees. It has focused on work hours with more prescriptive requirements and more monitoring, etc.

In my estimation, these actions have subsequently increased the stresses on faculty. I believe the ACGME now agrees with this and now thinks that something needs to be done. They probably will not admit that their well-meaning past non-systemic actions may have played a part in effectively creating a problem of burnout in the faculty.

The ACGME has now announced systemic initiatives that put the medical schools in charge of the wellness of their faculty and staff in addition to the wellness of trainees and patients. This will force the medical schools to figure out how to enhance the wellness of their faculty. I cynically (n.b., one of the signs of burnout) await my orders on how to become “well,” starting with mandated computer-based training modules on wellness,

burnout, relaxation, and mindfulness that will come with warnings that failure to complete them in a timely manner will potentially lead to dire consequences for myself, my school, and the human race in general.

I have been struck in my readings on the subject that the burn out articles are often population-based and stay away from the uniqueness of the individuals involved. Many do not mention developmental, biological, and psychological issues in those they are doing research on.

To me, the devil is in the details. I suspect, for instance, that mental illness does not improve one’s stress tolerance nor resilience in the face of a problematic workplace.

In my own case, I have a long running personalized battle with electronic medical records that seem to have been invented to show how stupid I am. The fact that research shows that I am not alone in my “EMR phobia,” as judged by the surveys that show that 20% of psychiatrists feel that EMRs contribute to their burnout, does not make one whit of difference to my individual anguish.

The same survey shows that 60% of psychiatrists indicate that the main contributor to their burnout was having too many bureaucratic tasks, which includes EMRs, which have added 20% more work for doctors. A recent talk I heard mentioned that this extra work translates into added hours of work time at home which has been lovingly referred to as “pajama time.”

The fact that I currently have a different EMR for each of the two clinics I work at, and may have a third EMR in my future, does not reduce my stress levels.



Burnout

At one of the clinics, I found myself not wanting to go to work. After some soul searching, I realized it was not the clinic, nor its patient load, nor the short appointment times, but my slow mastery of the prescription writing portion of the EMR that I was suddenly forced to use. One gets used to one's prescription pad after 40 years.

Things are better now that I have all but mastered this completely non-intuitive prescription writing program, except for how to write two months worth of stimulant scripts for stabilized patients. When asked what all this anxiety is about, I liken it to being an immigrant (n.b., digital immigrant) lost in a foreign city where no one speaks my language. It is nothing rational, but who said things need to be rational?

Another recent example of the need to identify individual variables came from a recent "sensitivity" group I attended which talked about the ever trendy work/life balance. One of the members of the group mentioned that she liked to go to work on weekends.

This precipitated another well-meaning member of the "wellness police" to chide her for doing so. This apparently was a work-life balance violation. This irritated me so much that I broke in to say that I also liked to work on the weekends, as I love the quiet and have access to all the resources I need for what I'm working on. I championed the "different strokes for different folks" philosophy and mentioned that I can work endlessly if I can change activities and have not been ordered to do the work in the first place.

An article by Siva seems to back me up. It notes that work-life balance is "gobbledygook" in that it "artificially and deliberately compartmentalizes work and life with life being equated to fun and

work as "not fun." He quotes an article by Dr. Ronald on mindful practice that indicates that those physicians who find meaning in their work, if only for 20% of their work, are much less prone to burnout. We certainly all know friends who prefer work to their less than happy lives outside of work.

While writing this column, which focuses on the Owls, my mind wondered to thinking of my own future retirement with a modicum of anxiety. I certainly heard of similar anxieties in persons at all points along the continuum of activities, from being fully employed to being fully retired.

The question arises as to whether one can be burned out with retirement, which seems, with a few major changes in context, to involve many, if not all, of the factors from the Mayo Clinic handout listed in the beginning of the column. Surely, retirement can be a shock to one's work/life balance, or should I say one's work/life/death balance.

In truth, different people respond to stresses differently based on developmental, bio, psycho, social determinants. This would seem to lead to a continuum of first degree, second degree, and third degree burnout. This continuum, which can be mitigated by a contralateral strength-based and resiliency continuum with specific interventions that I will address in a future column.



Burnout

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Chair Column



Richard L. Gross, MD

Due to health reasons (I am doing very well now), I missed AACAP's Annual Meeting in Seattle. It was the first meeting I missed in the past 36 years, and I felt it. I missed running into or having lunch or dinner with old friends and colleagues.

I missed the comradery. I missed the Life Members Reception and Dinner, which I understand was a huge success. It points out the importance AACAP has for me, and I hope not to miss any more. I look forward to seeing all of you in Chicago.

Speaking of the Seattle meeting, the feedback I've gotten from Cynthia Pfeffer, MD, my co-chair, is that it was a great achievement. The Life Member contributions were very successful. The dinner and reception, especially the brief talk by Cordelia Ross, MD, of how being a grantee of a Life Member Award impacted her. It is why we ask all of you to continue with your donations.

The mentoring program was greatly attended by medical students, residents, and fellows. The Wisdom Lecture was well attended and received many kudos and compliments. Doug Kramer, MD, MS, has already planned an outstanding Wisdom Lecture for Chicago on Physician-Patient Relationships in Child Psychiatry.

All of you should be proud of your financial support for AACAP and the Life Members Fund. It has significantly increased over past years. Keep it up!

The more funds raised, the more grants we can give to the trainees and impact their education. There has also been a significant increase in the number of Life Members in AACAP. We are now over 1,080 strong!

Besides the Wisdom Clinical Perspectives Lecture for the Chicago meeting, the dinner and reception will also be continuing. The Mentoring Program will also continue under the astute direction of Joe Jankowski, MD, and Ellen Sholevar, MD.

Please continue all of your contributions in money, time, and wisdom. It all helps. We Life Members are often retirees like me and members who are still very active in their practice, academics, or other venues. WE are diverse and that keeps us vibrant. All of us need to remain active in AACAP and as Life Members.

“Grow old along with me! The best is yet to be” – Rabbi Ben Ezra by Robert Browning

Best regards and a happy new year to all,

A handwritten signature in cursive script, appearing to read 'Hick'.



Philippe Pinel: A Veritable Clinical Ancestor for Us



Kim J. Masters, MD

One of the functions of AACAP’s Owls is the conveyance of clinical experience and history, provided, for example, in the Mentor Seminar that Perry Bach, MD, had the wisdom to develop and offer at the Annual Meeting. We Owls are part of the chain of knowledge providers that stretch back to those experts whom Isaac Newton described in observation: “If we have seen further, it is by standing on the shoulders of Giants.”

With my obsession about seclusion and restraint issues, it was obvious that for me, Dr. Philippe Pinel (1745-1826) is one of those clinical giants, who focused attention on the suffering of the institutionalized mentally ill caused in part through the use of prolonged restraints in chains and lengthy isolation in prison-like cells. Furthermore, a review of his clinical experience shows that he was a leader in the reform of psychiatric practice from one of custom, to one based on diagnosis and treatment response. In this effort, he was a pioneer in keeping records about the course of treatment of his patients.

The Clinical Life of Phillippe Pinel



Picture: Pinel Statue in Paris, France, 2018. Courtesy of Christopher Bellonci, MD, with permission.

Although he earned a medical degree from both the University of Toulouse and Montpellier, as well as a master’s degree in mathematics, Pinel was largely shunned by the physicians of the Ancien Regime in Pre-Revolutionary Paris, France.

This was both because he was not trained there and because his practice was informed by the accumulation and analysis of data, rather than the preferred one of Cartesian deductions - deriving principles from general premises, and formulating medical theories and treatments based on untested philosophical formulations. For example, the treatment of blood letting was based on the humor theory of congestion in organs leading to disease.

Fortunately, the Revolution brought to power those who were sympathetic to data driven views. As a result, Pinel gained appointments to the Faculty of Medicine in Paris and that of Resident Physician at its two asylums - first the Bicetre and then the Salpetriere, both of which continue to treat patients today. Pinel went beyond experimenting with releasing those afflicted from their chains of bondage, as had his contemporaries, like Tuke in England and Chiarugi in Italy. He combined this humanizing element of treatment with onsite clinical observations of many patients to study the external manifestations (i.e., appearances) of mental illness.

He assumed that the study of specific symptoms, like speech patterns, somatic disturbances, usual actions, and “bizarre emotions” would lead to a classification of specific mental illnesses and their treatment. After observing patients pass through the stages of new onset psychiatric illness to recovery, he identified four diagnostic categories: melancholia, mania, dementia, and idiotism, which today might be described as affective disorders, psychotic disorders, organic disorders, and intellectual disability, although there are considerable overlap and misapplication of current diagnoses with his categories.

One could classify him as a phenomenologist rather than as a theoretician, an approach favored by many established psychiatrists of his day.



Philippe Pinel: A Veritable Clinical Ancestor for Us

According to the Davis translation of Pinel's 1801 Treatise on Insanity, 40% of patients at the Bicetre suffered from 'manie avec delire, [consequently lacking comprehension ability], 7.5% manie sans delire, [consequently retaining comprehension ability], 30% from idiotism, 13.5% from melancholia, 9% from dementia. Interestingly, the manie sans delire categorie appears best to resemble psychopathic conditions according to Kavka.

Pinel subsequently proposed two etiologies for these illnesses - predisposing, meaning heredity, prolonged environmental stresses, and extreme 'passions,' and occasional, meaning event-related like brain trauma, alcoholism, menopause, fevers, and skin diseases.

His observations led to the conclusion that a person's way of life and emotions were central to the presentation of their illnesses.

As a result, he studied the natural state and course of many mental illnesses, because he intended treatment to be based not on a general philosophic theory of illness but based on what his experience showed to be effective. In the end, this meant exchanging physiologic models of care like blood-letting as well as restraint and confinement, for psychological ones like compassion, kindness, and the granting of freedom, as the preferred alternative to restrictive interventions.

This included banning the indiscriminate use of medications because he thought that they could infringe on the health, freedom, and well-being of patients.

This was the foundation of what he and others labelled the Moral Treatment of Mental Illness. As he wrote in a speech to the French Revolutionary Council that governed Paris in 1794, during the height of the 'Terror,' and later in 1815:

□ "Public Asylums for Maniacs have been regarded as placements of confinement for such of its members as are become dangerous to the peace of society. The managers of these situations, who are frequently men of little knowledge and less humanity, have been permitted to exercise towards their innocent prisoners a most arbitrary system of cruelty and violence; which experience affords ample and daily proofs of the effects of a mild and conciliating treatment..."

□ "The general rule in well run hospices, is to watch all phases of their attacks closely, anticipate their termination, and generally speaking, grant as much freedom as possible to those madmen who content themselves with mere gesticulations, loud declamations, and acts of extravagance that hurt no one. To lock up this kind of madman on the pretext of maintaining order means to impose needless constraints that provoke his rebellion and violence and render his madness more inveterate and often incurable."

□ "Far from being sinful people who deserve to be punished, the insane are sick people whose unhappy state deserves all of the sympathy that is owed to suffering humanity."

Pinel developed a clinical rationale for the treatment of the insane, as 'the care of human beings.' In 1789, the French National Constituent Assembly issued a Declaration of Rights of Man, defining what being human meant to them. In a sense, Pinel was making this case for the mentally ill. In today's terms this Declaration can be summarized in the National Motto of France: *Liberte, Egalite, Fraternite*.

He furthered the integration of his hospitalized patients into the community by negotiating work opportunities in Paris for them with local merchants. This strategy prefigured the recovery goals of community based mental health today. However, he was not a saint.

There were cases that he felt were incurable and violence prone. With them, he sometimes resorted to 'in your face' verbal confrontations and the use of the straight jacket as treatment. Nonetheless, these cases were exceptions to his own predispositions and experience, both of which he described in "Traite Medico-Philosophic sur alienation mentale." With its insights and his enthusiasm, he attracted French physicians to psychiatry, the most famous being Jeane-Etienne-Dominique Esquirol, who trained a generation of psychiatrists in Pinel's principles.

Although he was not a child psychiatrist, he was familiar with and perhaps influenced Jean-Marc Gaspard Itard, whose famous contemporary humane treatment of the feral child, Victor of Aveyron, introduced us to the concepts of psychosis, abandonment, attachment, and a host of other issues that comprise the basis of child psychiatry even today.



Philippe Pinel: A Veritable Clinical Ancestor for Us

With all of these contributions, it is not surprising to find that a historiographic study of psychiatric textbooks over the years found ‘eminence qualification’ for 79 psychiatrists, with Freud being number one, Pinel number two, and Kraepelin number three.⁶ For me, however, Philippe Pinel’s greatest claims to a psychiatric gienthood are his perspicacious insights into the barriers to eliminating stigma, the validation of the rights of those with mental illness, and these individuals’ risk of abuse and death at the hands of their institutional carers. These remain a call to action for us all.

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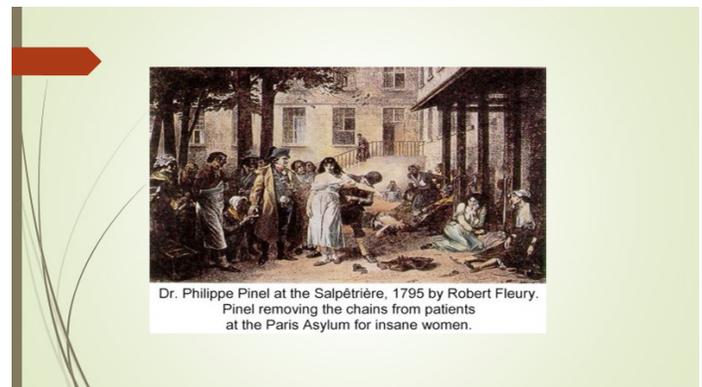
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Picture: Bicetre Hospital in the time of Pinel. Courtesy of the author.



Picture: Bicetre Hospital October 2018. Courtesy of the auhtor.



Picture: Pinel Painting from Presentation to SC Psychiatric Assn. 2019 by the author.



Looking Back on 40 Years of Adolescent Substance Abuse Treatment



Steve Jaffe, MD

In 1972, while I was a fellow in child psychiatry at Emory University, I consulted at a methadone program where heroin addiction and crack cocaine were an inner city African-American problem. In the mid-1980s, I became involved in substance abuse treatment as the director of an Atlanta adolescent inpatient program.

Half of my patients were involved in alcohol and drugs, and, at the time, I knew next to nothing about how to deal with this problem. My residency at the Massachusetts Mental Health Center (Harvard University) and my child and adolescent psychiatry fellowship at Emory University had done little to prepare me for work in this new field.

I decided to create a separate drug program for adolescents, hired an excellent counselor who was in good recovery, and we plunged ahead. Together we ran a substance-abuse group five days a week for four years.

Today, based on that experience, I advise fellows in child psychiatry at Emory University School of Medicine to pick a sub-specialty that few know anything about; one can become an expert if you know just a little bit and build upon it.

In the 1980s, the main drugs abused by teenagers were alcohol, marijuana, LSD, crack, and cocaine. My counselor took me to my first AA meeting, and we began to bring the adolescents in the program to meetings every week.

I studied the history of AA, and as we were trying to apply the steps to teens, I wrote *The Step Workbook for Adolescent Chemical Dependency Recovery: A Guide to the First Five Steps*. This workbook modified the steps to make them developmentally appropriate for adolescents. At that time, AACAP had a contract with APPI Press to publish recommended books.

I submitted the workbook for review by AACAP's committee. Two members of the committee approved it, and two others declined.

They thought that the AA steps, which were written in the late 1930s, were too religiously oriented and sexist ("God as we understand Him"). Fortunately for me, Mel Lewis, MD, chair of the committee, cast the deciding vote to publish.

Since it was published in 1990, 35,000 workbooks have been sold. I learned about addiction on a personal level during the early 1980s as I struggled to stop smoking.

Nicorette gum was very helpful, and I have not had a cigarette in over 35 years. Still, I continue to have using thoughts and urges which demonstrates the power of the addictive process. I believe that my understanding of addiction is confirmed by my own experience.

I regret to say that during that time period, people in the addiction field, including me, took a confrontational approach which we rationalized was necessary to break through denial.

While I never yelled at someone that s/he was an addict, I did take an aggressive position asking questions to have him/her admit how drugs and alcohol had negatively affected their life.

At the time I was directing daily community meetings for a hospital psychiatric program with 30 adolescents and staff. It was during that period that I was elected to be chair of AACAP's Nominating Committee. When I assertively chaired a meeting to choose a slate of national officers, one member supportively remarked, "Oh, Jaffe was just acting like he was running his adolescent community meeting." I directed that hospital program for 10 years with close to a 95% census and a relationship with Emory University School of Medicine in which we sponsored two residents/fellows every year.



Looking Back on 40 Years of Adolescent Substance Abuse Treatment

Shortly thereafter, there was a shake-up in the administration, and I was fired, and a few years later, the hospital closed.

I went on to direct another adolescent program in Atlanta, but that position was short-lived as the hospital was sold to an investor who wanted an immediate financial return and decided to cut staff. Then, in 1992, I went to a third hospital to direct their adolescent psychiatric program, and I again set up a separate substance abuse program.

Since hospital length of stays were now a few weeks instead of a few months, I developed The Adolescent Substance Abuse Intervention Workbook: Taking a First Step which was also published by APPI Press.

It solicits answers to short concrete questions as to the negative effects of alcohol/drugs on 12 areas of an adolescent user's life. The answers are presented and further explored in group therapy.

This process corresponds to the First Step of AA and helps subjects move from precontemplation to contemplation.

Unlike books on psychopharmacology, which quickly become out of date, these workbooks are still being used in a number of adolescent treatment programs.

After ten years at this hospital, with length of stays now reduced to only a few days, I was burnt out and left hospital psychiatry. I have continued to teach at Emory and Morehouse Medical Schools along with the private practice I had started in the 1970s.

In 1998 I was fortunate to connect with a creative, enthusiastic sobriety intensive outpatient adolescent/young adult substance abuse program known as the Insight Program.

A few years later I became their clinical director, and I continue in that position at the present time. This is a unique program of having fun without drugs and alcohol and consists of groups four hours a day, Monday to Friday.

Two evening groups where intensive outpatient program (IOP) patients connect with those in the aftercare program, and a weekly parents' group.

The uniqueness of the program lies in its provision of social activities every Friday and Saturday night. The IOP lasts 12-15 weeks and aftercare, where the adolescents attend evening groups and the weekend social activities, continues for two years.

Here I learned the importance of a loving empathic approach. The staff are cool, hip, young recovering drug addicts who clearly love what they do. They pay me a token amount, but my primary compensation is the love and good feelings of working with them.

While working in this modified 12-Step program, I became interested in understanding the spiritual (higher power) component. During the past several years, I have been interviewing young staff who are in good recovery, have completed the program, and were training in the program's counselor 12-week training program.

After interviewing 72 young staff members, I compiled their stories, realizations, and epiphanies in my recent book, Sacred Connections: Studies of Spirituality in Recovering Adolescent and Young Adult Substance Abusers (available from Amazon).

Like the AA booklet Came to Believe, which describes the variety of spiritual experiences in adult alcoholics working a 12-Step program, this book describes the spiritual struggles faced by substance abusing adolescents and young adults trying to seek a higher power. It is a tool for any program that uses or connects severe substance abusing youth to a 12-Step program.

Drugs of choice in the 1990s were alcohol and marijuana, but Ecstasy, Molly, Ritalin, and Adderall were added to the mix. The methamphetamine epidemic began in the late 1990s and continued in the 2000s.



Looking Back on 40 Years of Adolescent Substance Abuse Treatment

Then, during the 2000s, the perils of substance use became more severe as opiate and benzodiazepine pills became popular. Beginning in 2005, physical dependence to opiate pills was widespread and led into the present epidemic of heroin addiction in suburban middle- and upper-class Caucasian populations.

Marijuana strength has increased tenfold, increasing its negative effects on cognition, anxiety, and danger to driving. In addition, LSD and the use of research chemicals, including the synthetic cannabinoid Spice, is common.

While in previous decades death in adolescents and young adults attributed to drug use was uncommon, in the current opiate epidemic, in which fentanyl is added to heroin, death due to overdose is no longer a rare phenomenon.

For physicians and counselors, the stress of dealing with these patients has soared, as treatment becomes a daily life-and-death issue.

The high prevalence of drugs in the adolescent and young adult population makes it imperative for all child psychiatrists to become knowledgeable about substance abuse. I was delighted to see that at AACAP's Annual Meeting in Seattle, there were several presentations and an Institute on substance abuse and medical marijuana.

Still, there has been a relative paucity of child and adolescent psychiatrists entering this field of treatment. In addition, there are relatively few quality treatment programs for adolescents. Sending a teen to an expensive 30-day program without integrated intensive local follow-up treatment yields little success.

Child and adolescent fellowships need to provide more substance abuse treatment experience. I am especially pleased that Morehouse Medical School, which will begin a child and adolescent psychiatry fellowship in 2020, will have fellows spend two days a week for three months at the Enthusiastic Sobriety Program that I direct.

Working with severe substance abusing youth challenges the psychiatrist with unique issues. Young abusers love their drugs, frequently relapse, and are poorly motivated to change, making treatment especially difficult.

Treatment of dual disorders is hard to accomplish unless sobriety is achieved. Connection to a recovery community is extremely difficult to establish unless one networks and works with existing programs. In spite of these barriers, if one can handle the roller-coaster progress involved, each case of a successfully treated teen/young adult becomes especially gratifying as a life is saved.



Donors to AACAP's Life Members Fund

The Owls continue to demonstrate their long-term commitment to AACAP and to supporting the next generation of child and adolescent psychiatrists. Owls make a difference in the lives of other AACAP members as mentors, advisors, and friends. AACAP is thankful to the following Life Members for their generous donations.

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Paramjit T. Joshi, MD
Joan E. Kinlan, MD
Dr. Michael Maloney & Dr. Marta Pisarska
Jack and Sally McDermott
Patricia A. McKnight, MD
Scott M. Palyo, MD
The Frank A. Roberto, MD, Family
Diane H. Schetky, MD
Gabrielle Shapiro, MD
Diane K. Shrier, MD & Adam Louis Schrier, DEng, JD

Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org or 202.966.7300.

September 16, 2018, to December 31, 2018

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Harvey Feinberg, MD
Jo Ann Fineman, MD
Susan Fisher, MD
Arthur Gillman, MD
Robert Gluckman, MD
Mary Hagamen, MD
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Cyril Jones, MD
Saul Kapel, MD
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William Kirk, MD

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