



July 2019

e-Newsletter



Photo by Rob Grant

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Dwight D. Eisenhower Quotes

Quotes submitted from Martin Drell, MD

“A sense of humor is part of the art of leadership of getting along with people of getting things done.”

Note: My search found few truly humorous quotes.

“How has retirement affected my golf game? A lot more people beat me now.” (An example of Ike’s humor.)

“What counts is not necessarily the size of the dog in the fight – it’s the size of the fight in the dog.”

“The opportunist thinks of me and today. The statesman thinks of us and tomorrow.”

“Pessimism never won any battle. I believe people in the future are going to do more to promote peace than our governments. Indeed, I think that people want peace so much that one of these days, governments had better get out of the way and let them have it.”

“Always take your job seriously, never yourself.”
“You don’t lead by hitting people over the head. That’s assault, not leadership.”

“I hate war as only a soldier who has lived it can, only as one who has seen its brutality, its futility, its stupidity.”
“Neither a wise man nor a brave man lies down on the tracks of history to wait for the train of the future to run him over.”

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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!

We’re looking for articles covering all topics - especially on doing therapy as one ages.

Please send materials to mdrell@lsuhsc.edu. The deadline for the next issue is **September 15**.



Fluffiness and Why This Follow-up Column to My Previous Column on Burnout Is Not on Wellness as was Promised

Martin Drell, MD



Martin Drell, MD

Writing about burnout was a “piece of cake.” It is a trendy topic complete with many data-based articles, statistics, many variables, and opinion pieces to learn from. It is a real problem that will be added to ICD II as an “occupational phenomenon” and not as a medical diagnosis, as reported in other stories (fake news?).

The new classification highlights the following 3 characteristics: 1) feeling of energy depletion or exhaustion, 2) increase mental distance from one’s job, or feelings of negativism, cynicism related to one’s job 3) reduced professional efficiency. Burnout is linked to job dissatisfaction, anger, frustration, depression, early retirement, and is considered a factor in the increasing physician suicide (400/year) rate.

When confronting the issue of what to do about burnout, things proved less easy. I had planned and promised a companion piece to my burnout article on the equally as trendy topic of wellness and its promotion. When I went to write the piece, however, I instantaneously encountered a problem, which I dubbed the “fluffiness” problem. I was not quite sure what this “fluffiness” problem was, but I viscerally knew I didn’t want my article to be “fluffy.” In thinking over my concerns, I realized that fluffiness was associated not only with wellness, but with resilience, as well as the Happiness Movement, with their near magical promises that if you do such and such activities, you will be well or resilient or “happy;” whatever that means. I see all these concepts as linked inexorably to Maslow’s “Hierarchy of Needs.” From the perspective of Maslow’s hierarchy I note that physician burnout seems to be very high up on the hierarchy?

After all, don’t those doctors with burnout all have well-paying jobs, financial security, and their basic physiological and safety needs met? Would not the billions of people in the world who still live on less than two dollars per day love to have such problems? My “tough guy” mother would call this “complaining with two loaves of bread under your arms.”

On a personal note, I might add that my mother frequently responded to my frequent litany of woes as a youth with her well-meaning “two loaves” retort. When she did, I felt horribly invalidated by her lack of empathy. She hurt my self-esteem, but may have set the stage for my concerns about “fluffiness.”

As a correlate, I often think that modern psychology, child psychiatry, and our culture have all conspired to raise the Maslowian bar so high with a commensurate raise in our psychological aspirations and expectations of parents and all caregivers that there have been many unintended and unfortunate consequences such as “helicopter parents,” “entitlement,” and paradoxical lower self-esteem.

My theory is seconded by Simon Sinek’s very popular TED talk on millennials in which he states that many of the problems with millennials are the product of “failed parenting strategies that told their kids they were special, that they could achieve whatever they wished, and were rewarded for participation regardless of their ranking (n.b., the trophies for all approach).

As further evidence of this tendency, I would point out that the Happiness Movement seems to have trouble with defining exactly what its goals are.

Martin Seligman, in his 2012 book: Flourish: A Visionary New Understanding of Happiness and Well-being, devotes a chapter in which he discusses being content vs. being happy.



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He seems to conclude that being content and happy may not be enough, that one's goal should actually be "to flourish." There is an oppositional part of me that resents that it is not ok for me to be merely content and that to settle for that is somehow not enough. Surely, such messages are a slippery slope to a sense of unease and failure and might perhaps even contribute to my becoming "burned out."

Remember the old adage that if you want a happy life, lower your standards.

As a psychiatrist who spends many a session with patient's chock full of various resistances who have troubles carrying out the simplest of suggestions, like taking a pill every day as prescribed, I distrust easy solutions, especially as I humbly see how hard it is for me to carry out my physician's seemingly simple orders to me, especially those to lose weight. The voice beckoning me to my refrigerator every night is far more powerful than my physician's sage and well-meaning suggestions every six months at our fifteen minute appointments. The beckoning siren like voice from my fridge also allows me to easily overlook the ever present and ever ignored sticky note on my refrigerator with the acronyms H.A.L.T. that details four potential etiologies of "night eating."

Having thought through my concerns involving fluffiness, I have therefore come to the conclusion that Wellness, Resilience, or the Happiness Movement are not so simple and that they are probably not the magical cure for burnout.

Having come to this conclusion, my problem with fluffiness has evaporated and I will now, after taking several deep, cleansing breaths, move onto some hopefully non-fluffy thoughts on how to deal with burnout.

I believe that burnout is the culmination of many complex variables that so varies from person to person that it can best be handled by a comprehensive model, such as George Engel's systems informed developmental biopsychosocial model. This model, I might add, is comprehensive enough that it would include wellness, resilience, and happiness however they are defined or however I may fluffily think about them.

They are definitely part of the solution, but certainly not all of it. Despite having taken such a strong stance with regards to wellness, resilience, and happiness, I have no problem with ACGME's recent initiative to promote wellness, especially now that it explicitly includes wellness as a goal for the faculty and not just the residents, which I took earlier to be too much of a "zero sum game."

After all, if the first year residents aren't on call, someone needs to take their place. I believe that burnout solutions should address faculty, trainees, and patients. This approach certainly makes things more difficult!

I will now return to a quote from the end of my previous Burnout column: "In truth, different people respond to stresses differently based on their individual developmental, bio, psycho, social determinants" (thank you George Engel).

Due to this reality, responses need to include a multitude of plans addressed at the level of the individual, his/her work environment, and the larger culture. At the level of the individual, we as psychiatrists, are wonderfully trained to assess, conceptualize, diagnose, and design treatment programs for those with "burnout," which seems more a syndrome ("a set of medical signs and symptoms") than a specific diagnosis.



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Are we not the experts at dealing with the symptoms/manifestations of burnout, such as stress, loneliness, rejection, fear of failure, sleep problems, depression, anxiety, attentional problems, perfectionism, poor self-esteem, problematic thought processes, self-defeating behavioral, interpersonal relationships, responses to trauma, masochism, attachment issues, exhaustion, sleep problems, lack of motivation, depersonalization, and lack of empathy that are listed as part of the syndrome of burnout in article after article.

If, in fact, it is a variant of depression, as some articles suggest, are we not the experts at its assessment and treatment?

From the standpoint of the workplace, the task would seem to be designing and redesigning work environments so that they address the list of problems listed in the Mayo Clinic handout that includes the following contributing factors: lack of control, unclear job expectations, dysfunction, workplace dynamics, mismatched values, poor job fit, extremes of activity, lack of social support and work-life balance.

Multifaceted and well designed programs addressed at these workplace problems will go far in reducing burnout if they are actually implemented.

Melissa Ashton's Perspective piece in the November 8, 2018 New England Journal of Medicine entitled "Getting Rid of Stupid Stuff," is a great short article that deals with several of the above listed factors. In this article, she details a program she implemented in which she involved and empowered staff to identify "stupid stuff" and to actions to eliminate and moderate some of the "stupid stuff," especially regarding the Electronic Medical Records.

I might add that her project is a brilliant example of CQI (Continuing Quality Improvement) which often involves small, focused, and achievable projects based on mutually identified real life problems. Such small projects, if successful, provide morale building opportunities. I caution the reader, however, to avoid the overwhelming tendency in CQI to do too many things at once, which I would add to the already long list of factors leading to burnout. The longest journey, as they say, begins with a single step. Start with one or two performable projects and go from there. I would also note from past experience, that such programs are seldom successful without true buy-in and cooperation of the staff and leadership in your Institutions.

At the Medical School level, programs to educate physicians as to the signs and symptoms and seriousness of burnout including lectures, handouts, Grand Rounds, Town Halls, articles, and computer modules, should be mandatory, but are only a beginning. More complicated efforts will need to be implemented, including resources regarding treatment and support (EAPs, student health services, and referral programs, including impaired physician programs). Stigma Abatement efforts will be crucial as physician's are still hesitant to seek treatment for varying reasons, two of which are the sense of failure and narcissistic injury in divulging one's weaknesses and fear of the consequences.

If one self-reports and seeks the referral programs that are available. Medical Schools should also provide education and access to wellness programs, yoga, fitness facilities, Balint groups, mindfulness programs, deep breathing exercises, relaxation techniques, as well as lectures/discussions/exercises on life-work balance (n.b., despite "life/work balance" being yet another "fluffy" subject in my estimation).



Fluffiness and Why This Follow-up Column to My Previous Column on Burnout Is Not on Wellness as was Promised

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The goals of the totality of these efforts will be to create a trauma informed and secure “attachment-based” medical school cultures that promote compassion, care, caring, self-care connections, resiliency, and remove barriers to the delivery of quality care to our patients which is what provides physicians with meaning and is why they became physicians in the first place.

Remember from my burnout article that physicians who find they are doing meaningful work, if only 20% of the time, are less prone to burnout.

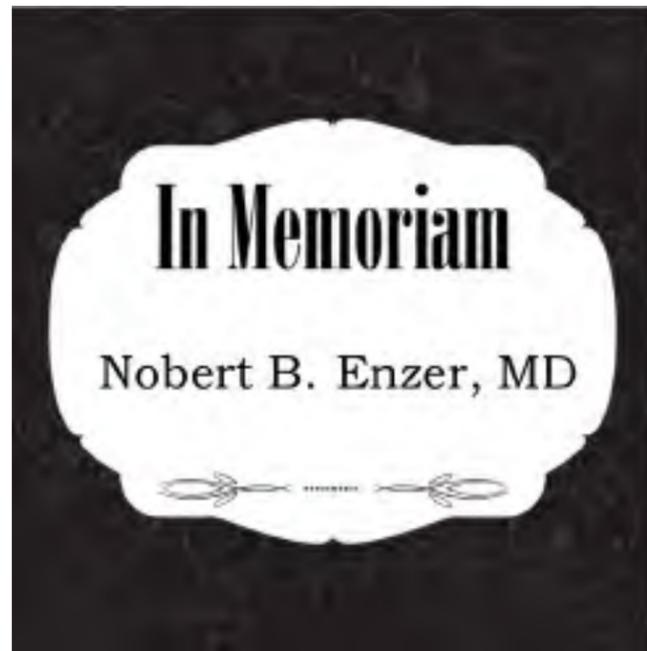
At still higher levels, we need to realize that parts of our society are broken or were never created, and press for social justice policies for not only physicians but for all citizens concerning adequate jobs and pay, appropriate medical and mental health insurance coverage and services, safety net programs; maternity, paternity, and family leave, quality daycare, and quality education for all throughout the life span.

As I list these aspirational programs, and wonder if they will ever occur, I am beginning, you guessed it, to feel fluffy again, so I will finish my suggestions and not proceed to still higher, perhaps ever more unrealistic levels of suggestions.

I hope to have made it clear that dealing with physician burnout is not a simple matter in which one solution will fit all.

I hope also that I will have suggested enough ideas that one can feel that they can easily play their part, whether big and small, in assisting in the amelioration of burnout.

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Should Psychiatry and Neurology Merge?

Co-Chair Committee Column

Dick Gross, MD



As I sat down to write my column, I learned that my good friend and colleague, Norb Enzer, MD, recently passed away. There will be eulogies written by many friends to follow, I'm sure.

Dick Gross MD.

I just want to comment here that I will miss him greatly, Norb was a wonderful human being, and a major figure in the history of AACAP.

My thesis for my July column has its origins from an article that a neurologist friend sent to me from an online newsletter (I think) called Neurology Advisor. The article was called, “A Neurology and Psychiatry Merger: Quest for the Inevitable?” by a person whose name is Tara Haelle.

I thought it quite interesting and provocative and wondered what all of you think about it.? I hope that you respond with letters to the Editor.

The author begins, “If a Martian with human like anatomy and physiology visited Earth, how would hu-mans explain why pulmonologists treat lungs, cardi-ologists treat hearts, and nephrologists treat kidneys, but neurologists treat some brain conditions and psychiatrists treat other brain conditions?”

It was a question posed by Thomas J. Reilly, of the University of Glasgow in the UK published in the B J Psych Bulletin.

It's pointed out that neurology “focuses on conditions with physical markers such as neuropathological lesions and psychiatry focuses on abnormal brain function determined through observable symptoms.”

The article goes on to describe that epilepsy was treated by psychiatrists until its neuropathology became clear and neurologists began treating it.

The same is true for tertiary syphilis, an infectious disease treated with antibiotics.

Many current modern tests are revealing “potential biomarkers for schizophrenia and autism.”

There are hallucinations in psychosis and Parkinson disease; depression in mood dis-orders and multiple sclerosis, and a variety of symptoms in different types of dementia.

Some forms of encephalitis are indistinguishable from early schizophrenia. Parkinson's, at one time was considered a psychiatric disorder until a specific treatment and a “reasonable hypothesis about its underlying mechanism” was found.

I learned from this article that conversion disorders for which there is no neuropathologic explanation is treated by neurologists in the U.K. and by psychiatrists in the U.S.

There's now a push for specialties like neuropsychiatry or behavioral neurology (especially the latter is most relevant to us child and adolescent psychiatrists).

Neuropsychiatry dominated the core of brain disease in the 19th century. Neurology and psychiatry began to diverge in the 1930's - 1960's with the advent of psychoanalysis.

Neurology sees little influence of the family and the environment and like experience in the symptoms they treat whereas psychiatry, especially child psychiatry, sees them as having a great influence in symptom formation and, indeed, by helping parents make changes in their par-enting methods which can be crucial to effective treatment.



Should Psychiatry and Neurology Merge?

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Neurologists depend on objective tests while psychiatrists depend on history and observation. Psychiatrists look for behavior being affected and identifying what causes that by behavior by clinical interview.

The article does point out that the distinctions between neurology and psychiatry vary across the world such as in the U.K. and Italy where psychia-try is under neurology.

Could the disciplines be merged in the U.S.?

Perhaps, but with GREAT difficulty! Academic politics and power issues would surely interfere. Should there be a third option such as neuropsychiatry or behavioral neurology? There already is at some of our academic institutions such as Johns Hopkins University.

“Psychiatry prides itself on its rich phenomenological descriptions, nuanced observation of behavior, highly sophisticated interviewing Neurology lays claim to its unabashed empiricism, rigorous clinical examination skills, and its pure objectivity.”

Shall the twain meet?

My big worry (among many) should a merger happen, is that the understanding of the significance of family, child development, and life experiences in the expression of behavioral symptoms would all be lost.

I also worry about a loss of empathy and sensitivity in treating children and their families. I worry about how the “Neuropsychiatrist” would treat PTSD, the Traumas of violence to children, the understanding of LD and DHD and its effects on the family, the understanding of how Tourette’s Syndrome effects the family and the psyche of the patient.

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Life Members Reception & Dinner

Mark your calendars and make plans to attend, **Thursday, October 17 at 6:30 pm.** at the elegant and lovely *University Club of Chicago*.

Enjoy the company of long-time friends, colleagues, and celebrate our young award winners! It’s not only a great night for nostalgia, but also plays a key role in moving our specialty forward

Tickets are required, and available for purchase when you register for the Annual Meeting.

You Don’t Want to Miss It!



Poop In The Proper Place Program - An Efficient Technique to Cure Encopresis

R. Larry Schmitt, MD



R. Larry Schmitt, MD

Dr. William Baak after experiencing years of frustrations using long-accepted practices to help children and families deal with encopresis created this effective program. I had the good fortune of clinically working with him in several locations for over twenty years.

His various clinical gifts were obvious to many. He often found novel solutions to common problems.

In the mid 1990s his unique approach to the common and typically difficult cases of encopresis proved surprisingly efficient.

Here I will attempt to detail that approach. The important points are the combination of light-heartedness, religious avoidance of the word “accident,” and a consistently positive attitude.

Pediatricians all agree on the absolute need to be certain that the colon is free of constipation and impaction before the training begins. (The majority of cases are functional, not due to anatomical abnormalities.) Once that is done, our practice deviates from the usual. Meeting the child with their parents throughout this program is essential. It is a process to correct family issues.

If not already stated to the parents in prior meetings during the clean out, it is important to empathically make clear that you appreciate the frustrations, shame and disappointments they and the child have experienced attempting to correct this problem. Acknowledge their doubts that this process will be successful while maintaining your professional optimism and confidence.

At the start of the first meeting after the colon has been cleared, we establish the family’s word for stool. That is the word we use for the duration of the case. We identify the child’s favorite oral treat to be used as the reward.

Candy, ice cream, and cookies are more powerful than stickers.

Next come the following questions to the child: Where do you put your poop? Where do your parents put theirs? Would you like to put yours in the toilet? Pause, and with a growing twinkle in your eye, where else might you put it?, the back yard?, the door step?, the kitchen floor?, your parent’s bed?, in your mother’s shoe? What would your parents say if they saw it in those places? What would they say if you put it in the toilet? This step promotes the absolute avoidance the word “accident” while enforcing the child’s control.

THE PLAN

Explain to parents and child the importance of taking advantage of the gastro-colic reflex that functions after each meal. The parents choose the meal, usually supper, after which the child will sit on the toilet for three to ten minutes depending on the child’s age. Generally, age 4, 3 minutes, increasing by a minute/year. Allowing the child to choose the length of sitting time may be helpful.

Pictures of child’s favorite reward are placed in rooms of the home including the bathroom, the kitchen and the child’s bedroom.

This reward must be immediately available for the duration of the program. It is to be given for any production of stool in the toilet after sitting, not for cleaning it out of pants.

The child is to let the parents know when he produces something in the toilet. The parents are to view with interest the production commenting about all aspects of it before letting the child flush and say bye-bye.

The reward is promptly provided to the child.



Poop In The Proper Place Program - An Efficient Technique to Cure Encopresis

R. Larry Schmitt, MD

If the sit time finds nothing in the toilet, parents stay optimistic mentioning the reward will be available next time.

If there is any production it will be recorded with a brown marker on a calendar drawn by the child, with parental help, and roughly inch square dates. The size of the brown mark is relative to the size of the production. Keep calendar in bathroom.

If the child puts stool in their pants during the program, insist the child help clean it up, including putting it in the toilet. No reward.

The next appointment is set within a week. The therapist welcomes phone contact for any issues. Sensing significant parental resistance, a wise therapist asks permission to phone them for a progress report. Emphasize the importance of bringing the calendar to future appointments.

Exploring grand-parent's attitudes and the parent's history of toilet training may identify sources of resistance. These may include: Certain the child has no control, parents/grand-parents experiences with their own toilet training, parental discomfort with their authority, stumped by the child's oppositional position, or certain there is a physical/anatomical explanation. The work up would have determined if any anatomical abnormalities presented alternate explanations for this problem.

In our experience, parents "catch on" to this process quickly. It evokes rapid results and stresses success rather than failure for both parents and child. With rare exceptions, our cases were cured within two months. That contrasts with the widely reported 12-18 months reported in the literature and on the net.

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"They Tried To Kill Me!" or How I Spent My Christmas Holiday

John T. McCarthy, MD



John T. McCarthy, MD

Just before Halloween, my wife and I chose to skip AACAP's Annual Meeting in Seattle. Instead, we took a 7-day Caribbean cruise. Although I had gotten my flu shot a month earlier, I developed an annoying non-productive spasmodic "Whiskey cough."

I thought for sure that the embarkation check-in crew would spot me a mile away and summarily yank me from boarding. As I smugly passed them, I figured maybe my cough wasn't that bad after all. I was wrong. I fell into serious denial.

Beside my cough, I was NOT my usual "energizer bunny" self. I picked at my food, lost weight, and often retreated to our stateroom fatigued.

Upon returning home, my health downswing continued to the point that I "begged off" going to my family's Thanksgiving celebration. My wife, a retired internist, urged me to go see my regular doctor. Shocked by my weight loss, sickly appearance, and physical exam, he sent me to get a chest x-ray.

It showed a distinct infiltrate in my lower left lobe as well as probable fluid in the plural space. He started me on Levaquin, an oral antibiotic for 7 days, "a bitter pill to swallow". I kept trying to reassure myself and others that it was "all for a good cause". BUNK! A seemingly good response to Levaquin didn't last.

When I began to spike temperatures of 103 degrees, my doctor sent me to the local ER for further evaluation. A CT scan of my chest showed a persistent enlarging infiltrate with a possible abscess and what they now suspected was an empyema in the adjacent plural space.

The pulmonologist opted to have a chest tube placed under CT guidance by the interventional radiologist using a posterior wire between my ribs on the left side.

For this procedure, I laid on my belly, under what was supposed to be a light sedation not requiring respiratory support. However, maybe because perhaps I'm a very "drug naïve" patient, I found myself barely able to lift my head when suddenly, blood gushed from my nose and mouth. I felt like I was drowning, and probably was.

I tried to yell for help but to no avail as the entire team was fixated on the tube placement going on behind me. That's when I began to believe that "They were trying to kill me!" After what seemed like hours of terror, the team noticed me in distress. Someone wiped up the blood as I was still unable to do it myself.

At this point, the growing number of professionals involved in my care, concluded that I needed a chest surgical evaluation not available at this facility and immediately (note: in Medical parlance this means 10 hours) shipped me to Rasputin Memorial Hospital* via ambulance for further evaluation and treatment.

Awaiting transfer gave me plenty of time to muse further about my future in this world. My thoughts went back to The Bronx, New York, Spring, 1955 when I was a lad of 12.

My mother asked me to go to the local bakery to pick up some pies she had pre-ordered. As I entered this deliciously aromatic bakery on 204th Street, for the first time I heard Tennessee Ernie Ford singing "Sixteen Tons," on the radio.



"They Tried To Kill Me!" or How I Spent My Christmas Holiday

John T. McCarthy, MD

I immediately fell in love with this tune especially the soulful chorus, "Saint Peter don't you call me cause I can't go, I owe my soul to the company store." (note: this became the #1 song for 1955 and earned its crooner high accolades.)

Anyhow, now at 75, as I lay in my bed in a private room on the 6th with a view and most importantly a bathroom. I found myself singing softly and/or humming this chorus as my own coping mantra. It worked. Thus, began my Christmas Holiday but I wasn't singing Christmas Carols yet.

Wait, there's more to come.

Now ensconced at Rasputin Memorial Hospital, the number of physicians involved in my care had expanded to six including a very personable chest surgeon and his PA, cardiologist, a "matinee idol" hospitalist, and infectious disease doctor etc.

Now, I lay heavily tethered to a constantly beeping monitor, Oxygen, two IV poles with pumps one for hydration the other for alternating powerful antibiotics, and a hefty chest tube emerging from my back. I had become a "captive audience" with virtually no traffic control day and night. The path to my bed felt and sounded like a major thoroughfare.

Weren't hospitals supposed to be quiet? Almost every encounter became an annoying "What's your name and birthday?" Using the toilet and other bathroom amenities became a nearly impossible iteration unless a certain energetic manic attendant, "Swiftly" * was on duty. She referred to us as "John & Jane Doe. It took her no more than a nano-second to free me up from all my tethers so I could get to the toilet just in the nick of time.

Occasionally, Swiftly, also found the time to take me on a stroll around the ward, as she made one crack after another. She also was the one who knew when to discontinue the oxygen, saying, "You don't need this anymore!"

The hordes, however, continued to invade my space and included doctors, nurses, aides, respiratory therapists (almost always when I was trying to eat my meal), and even kitchen staff whom we usually welcomed. The procession seemed endless.

"There's no rest for the wicked!" I thought. Once, there was even a team of carpenters in the room next to mine, noisily hammering on the other side of my wall, oblivious to us patients. What made the cacophony and chaos almost bearable was the "24/7" presence and QUIET interventions of my dear wife. Her highlight each day became the sweet shy kitchen guy who delivered our meals daily.

She raved about the tastiness of everything in contrast to me barely eating anything. My appetite normalized only after discharge.

Each day, my chest surgeon arrived and greeted me with, "So how are you doing today, Doctor?" He stressed the positive pleased with my progress. He hoped for better drainage from my chest tube, however. On Christmas Eve, his team recommended that we "goose" the system by injecting a substance known as Tissue Plasminogen Activator (tPA), used most often with patients with an acute stroke, designed to dissolve a clot and save the patient from a more disabling stroke or worse, death.



"They Tried To Kill Me!" or How I Spent My Christmas Holiday

John T. McCarthy, MD

For someone like me, there were no large control studies on tPA use to break up an empyema to further enhance drainage of thick plural exudate like I had. Despite my concerns about what I considered as an "off label" use of tPA, the team talked it up like "it was the next best thing since sliced bread". They tried to reassure me, but I was skeptical. They claimed the procedure itself was easy "as pie".

All I had to do was sit up and "take it like a man" as they injected the full dose of tPA into my chest tube. No test doses allowed for real men. The next thing I knew, I'm again drowning in my own red blood, hypoxic, hypotensive, confused, delusional, frightened, and angry. Suddenly, according to my wife, a "cast of thousands" had arrived in my room to save me and whip me to Rasputin Memorial's Critical Care Unit. What a stark place that was as I slowly emerged from my fog.

Noisy, and run by the nurse from hell who told my wife that that she could stay with me but could NOT sleep. How ironic. I was lucky, however, to have other family members as visitors to help keep me sane. That and of course, my "Saint Peter don't you call me" mantra to sing or hum.

Thankfully, the next day, Christmas Eve, the treatment team felt I was stable enough to be transferred back to my private room on the 6th floor where I could "celebrate" Christmas properly. I thought, "All I want for Christmas is to get rid of my IV, chest tube and other tethers, and of course, GO HOME! Santa must have been listening as the next day, Christmas, my attending physician, arrived to tell me that he wanted to DC the IV antibiotics and start me on a powerful oral antibiotic. IF tolerated, he would set me free, but I would have to continue that antibiotic for a month.

(Note: all cultures and biopsies during and after my hospitalization were negative)

I then sweet talked him into discharging me early on December 27th because that was my wife's birthday and I didn't want her to miss her "surprise" party.

I'm very happy that Saint Peter didn't call me because he knew that I had more living to do starting with my wife's "surprise" birthday party. Believe me, she deserved it!

names of the hospital and persons were fictitious to preserve confidentiality

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The Curious Case of the Ambivalent Psychiatrist

Peter R. Cohen, MD



Peter R. Cohen MD

You are about to read the tale of a psychiatrist who struggles with retiring for good. What follows is fiction—not personal confession or memoir—but it may serve as a touchstone for colleagues who have experienced or are thinking about giving up the ship.

Keep in mind that there are only a few archetypal tales. The critic Christopher Booker proposed seven: rags to riches; overcoming the monster; the quest; voyage and return; comedy; tragedy, and rebirth. I would posit two additional factors needed to grab hold of us strong enough to want to hear a story through or to stay awake reading past bedtime. One is the developmental crisis of the main character. Two is the trick of how to tell the tale.

This story will include some of the 7 archetypes. The developmental crisis is self-evident: the dynamics of aging. And the trick? It's somewhat unconventional, the depiction of the main character in large part through his psychiatric examination, by what he says and what his examiner observes.

And now, The Curious Case of the Ambivalent Psychiatrist.

Call me Jack, adrift in an ocean of indecision, suffering from mental seasickness, unable to choose whether or not to retire from my practice. My first impulse to fix this quandary was to ask for professional advice from someone I trusted. Why not my great uncle and steadfast mentor, the British-raised, American-trained emeritus psychiatrist, Reginald Shropshire M.D. Uncle Reg's clinical virtuosity has been legendary. He could move willing and unwilling participants towards unexpected insights and change through the uncovering of conflicts afflicting the heart, mind and soul.

Having grown up in his shadow, I wondered, would he agree to examine my motives for metaphorically sailing into uncharted waters—in essence, leaving my lifework behind?

Some additional background is required about my great uncle: Not only my family but his confidants have described him as the most understated creature they ever encountered. He was so understated, he could remain completely mute while conducting a case discussion, consultation or therapy session, limiting his inquiries and responses to body language and facial expressions. During his ninth decade and following the death of his dear wife Helen, his understatement took on a curiously concrete turn, when he traveled south from Boston to the farthest end of Florida Keys—literally under the other forty-nine United States.

I visited Uncle Reg at his retirement community, the Arthur “Groucho” Marx Estates, comfortably sequestered in the Keys. I was surprised by his warm embrace, considering his reputation for being more reserved than a statue of Buddha. He then guided me on a tour of his new abode while explaining why he settled there. “It’s the perfect locale for newly minted pariahs, adventurers and upstarts, all willing to shed a lifetime of catering to conventional societal expectations, yet with all the desired comforts and amenities. I can even take my catamaran out and sail all day.

Ah, there’s nothing as refreshing as shoving off the pier with a new-found paramour and riding the trade winds to an uninhabited island. We could maroon ourselves for a day or two until the estate’s overseers decided enough was enough, then hunted us down and towed us back to safely. But enough of that. Would you care to join me for afternoon tea?”



The Curious Case of the Ambivalent Psychiatrist

Peter R. Cohen, MD

I already knew there was a risk in asking for Reg’s guidance. His farewell letter to his faculty emphatically stated he would never again subject himself to tend to the woes of his contemporaries or supervisees. A lifetime of devoted, concentrated, empathic listening about their travails had worn him down, resulting in unremitting headaches and surging blood sugar concentrations. Despite his quite understandable grumbling, I decided to dash it all and ask anyway. He might refuse but still send me off with a few crumbs of advice.

Reg considered my plea in his sunlit parlor room, while we feasted on oolong tea and surprisingly tasty low-carb blueberry scones. Behind the nonagenarian were photos of his departed wife, their three children and countless grand- and great-grandchildren. He had affixed to each photo a post-it note reminding him of the date each living progeny was coming to visit for an afternoon of sandwiches, cribbage and developmentally appropriate hi-jinx.

Reg was tastefully dressed in a fine cotton teal polo shirt, white Bermuda shorts and leather sandals. I was struck by his pale gray eyes, bushy eyebrows, prominent lips and well-coiffed though thinning silvery locks. His precise, tasteful, professional manner did not seem to extend, however, to the rites of eating. One could detect what he had consumed for breakfast or lunch by the Jackson Pollock-like dribs and drabs of food and liquid stains dotting his clothing. Nevertheless, he listened to my plea while staring off at the clouds couched on the horizon and allowing crumbs and drops of tea to escape from his mouth at a rate of a slow dripping faucet. After finally dabbing his mouth with a fine cotton napkin, he proceeded to break his vow of refusing administration to the emotional quandaries of familiar persons and to grant my request.

He set, however, the following conditions:

- 1) Over one week we would meet for three one-hour sessions to discuss in succession my complaints, past history, and my considered plans of action.
- 2) He would promptly submit a written report after the first two meetings for my consideration. At the third meeting he would offer his conclusions and discuss his findings. A formal report would follow in the mail.
- 3) He left the distribution of his “notations and musings” to my discretion, just as long as family and professional colleagues would respect his privacy and refrain from contacting him to argue his findings. “I have better things to do than explain myself.”
- 4) Payment for his services upon completion of the three sessions required my smuggling into his chambers at the final meeting “a reasonably ample slice of Death-by-Chocolate Ice Cream Cake.”

I agreed whole-heartedly to his terms, to which he mumbled under his breath, “Diabetes be damned, full speed ahead!”

Those words over afternoon tea were close to the last ones Reg uttered in my presence. Over our time together, he scribbled notes while I rambled on. He expected that I would verbally fill in the blanks of a standard psychiatric interview.



With that lengthy though necessary introduction complete, I now submit for your perusal the first of my great uncle’s three reports. I shall offer neither comments, rejoinders nor retorts. I leave that task to the reader to consider, analyze, speculate, and opine. I will say this. I did almost all of the talking—he said little to nothing. Uncle Reg’s report then corresponded to how the session proceeded, as an exact replication of my confessions with his contributing a sprinkling of transitional phrases. Indeed, the ratio of his sentences to mine was exactly 10 to 69.

SESSION ONE: INTRODUCTION & PRESENT HISTORY

Patient: Jack B. Gilliam MD Age: 70

Chief Complaint: “I can’t decide if this is the right time to move on.”

History of Presenting Illness:

This married, Jewish, heterosexual male child and adolescent psychiatrist presented in crisis. In short, he wished to retire and felt besieged by ambivalence. “For the last 42 years, I’ve loved or at least more than tolerated my profession. I’m also basically content with what I could accomplish. But recently, something’s been insidiously gnawing at me, like a squirrel hell-bent on gnawing his way into an attic.”

One week before this appointment, the subject had announced to his family his wish to conclude his career. The declaration was embraced with elation, quickly followed by confusion and irritation. His adult son spoke first: “Dad, you announced that ‘monumental decision’ TWO years ago—here, at the restaurant. You even ordered your favorite, the chicken pizzaiola. Yes, we’re still happy for you, but check yourself in a mirror. You look like your garden upped and died.”

Dr. Gilliam attempted to defend himself. “I told them I had entered into something that felt close to retirement. I thought I was acting quite nobly. They didn’t buy it. I couldn’t get one mote of admiration. So I backed off and agreed that I only cut back.”

The patient’s wife, whom he has relied upon as his chief navigator on the roads and highways, as well as his helpmate for life, piped in: “Don’t try to get away with this. Your ‘cut back’ has been nothing but a slow roll around the corner. Let’s give it another year to see if you try to use the brakes.” The celebratory evening proceeded with another round of familial harassment and ribbing.

For the past two years of his “slow-rolling” semi-retirement, he worked twice a week, treating children and adolescents in an outpatient office. He had originally planned to retire fully by age 75. Yet, during the most recent winter holiday break, his crisis emerged, as the following complaints rose to his awareness:

- “I’m starting to lose my stamina. Six to seven hours of treating patients means another two hours of documenting in the electronic health record (EHR). By the next day I feel like a worn-out battery. That’s a warning shot across the bow. A lack of stamina can make you sloppy about medical care. I don’t want to be the butt of an old joke—maybe you’ve heard it. ‘What’s the difference between a kid and his psychiatrist? The kid gets better.’”



- “One more beef about the EHR. It’s like a guy you have to invite to your birthday party for professional reasons. He bores you all night with the details of his life, and what’s worse, he scarfs down all your guacamole.”
- “I know I hyper-obsess, but I think I’m detecting the first tremors of a personal cognitive-auditory mudslide. For example, I must be getting distracted when I drive to Costco while listening to an audiobook. Four weeks later, a ticket arrives in the mail demanding \$100, because the traffic camera clocked me 9 miles over the speed limit. You need more evidence? I’m a compulsive task-lister, but since I’m more tired at the end of a day, I don’t look at the list as often as I should. Recently my very forgiving patients and their parents are gently reminding me about things I still need to do. Wait—here’s the clincher. Last week, my pre-teen granddaughter greeted me enthusiastically and said, ‘I just aced all my tests!’ Here’s what my \$3000 hearing aids heard. ‘I just ate all my cats!’ It took me a minute to remember she doesn’t have any cats.”
- “So, who am I fooling? Trying to soldier on in the face of inevitable decline isn’t fair to patients or families.”
- “I think I’ve become a better psychiatrist by learning to coexist with an ‘internal image’ that haunts me—it’s a dour, humorless, impatient, pedantic, task-mastering academic psychiatrist. The sex of this ‘specter’ is irrelevant, it changes from day to day. It expects my specifying the names and functions of critical cortical areas including their receptors and connectivity to be followed by a comprehensive bio-psycho-social formulation to halt all debate. Four decades of this carping superego is really getting on my nerves.”
- “I spent the last two years finally ‘getting it right’ as a psychiatrist. You know, the things they taught you in Year 1.
- Cap your anxiety about helping a kid and family in distress. Shut up and listen without judgement. Hear yourself think as clear as a bell. Recognize your countertransference and don’t play it out. Kick your narcissism to the curb—it’s about them, not you. And keep your sense of humor. So now that I’m finally humming along, why give it up? Plus, there are not enough child and adolescent psychiatrists around to fill the need and I hate to see needy children on a waiting list.
- “But the problems of kids and families never end. It’s the human condition. And the nature of this work can wear you down till there’s no wind left in your sails.”
- “When I aggravate my wife, you know, by being forgetful, too preoccupied to pay attention, and so on, she shakes her head in exasperation, points her finger at me and says, ‘No jury of my peers would convict me of murder.’ I want to make her happy, but recently I’m pressing my luck. It seems smarter to retire with a thick enough cushion of functional years before she or the kids put me in assisted living.”
- “It’s not like I’m a tragic figure at a crisis point, doomed beyond repair in an indifferent universe. I’m no Hamlet troubled by ghosts, a murderous uncle, and an adulterous mother. Or name any of the characters in Game of Thrones. Winter isn’t coming, the white walkers aren’t at my door, and I don’t have to dodge fire-and-ice breathing dragons or walk naked through the streets to be shamed by the populace of King’s Landing.”
- “What really worries me? One word. Malpractice. It’s this nimbus cloud that’s been threatening to downpour over the last 40 years. I’ve been more and more careful, even after being cleared from two malpractice suits, but who knows when my luck will run out and the rains come down?”

Peter R. Cohen MD
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Letter to the Editor:

Assembly Line Medicine Is Burnout Medicine: The Loss of Physician Autonomy



Doug Kramer, MD, MS

DSM5: Other specified trauma- and stressor-related disorder I learned from you that physician burnout is a syndrome, akin to congestive heart failure, and that the Maslach Burnout Inventory, is a tool to help diagnose physician burnout.

That sounds very familiar to me.

What happened? Corporate medicine happened, not just in private practice but just as pervasively in academic medicine. Physicians lost all of their autonomy . . . except to “walk out” as did most of Ford’s skilled craftsmen.

Up until approximately 1990, every medical group and hospital with whom I was even loosely affiliated was physician led. The CFO and the COO worked for the physicians. Physicians naturally designed systems that facilitated good patient care. Physicians knew that ultimately the patient was the boss — the patient was the employer.

Physician Autonomy: Physician-Designed Systems

Colleagues of mine, including Peter M. Lake, MD, and I were recruited in 1993 by a physician-owned multi-speciality group (230 physicians) in Madison, Wisconsin to 1) begin a psychiatry department, and 2) design and implement a cost-effective mental health program for their physician-owned HMO (120,000 members).

After a year of planning, we recommended systems for both our new department and the HMO based on the hypothesis, “High quality care is cost-effective care.”

The boards of directors of both the medical group and the HMO, each comprised primarily of physicians, literally said, “Okay, go do that.” They were high quality physicians and understood the premise through their own experience practicing medicine.

We implemented clinical policies such as, 1) early psychiatric consultation, 2) encouraging psychiatrists to practice combined psychotherapy

I assert that physician burnout easily meets criteria for the DSM5 diagnosis (309.89), “Other Specified Trauma- and Stressor-Related Disorder.” Thus we have a syndrome, a diagnostic inventory, and an applicable DSM5 diagnosis!

Yet, as I casually survey the literature, discuss the situation with colleagues and my personal physicians, and observe other physicians at work, it seems to me that the physician himself or herself is expected to “deal with it.” Isn’t that like blaming the patient? The contributing factors that you reported from the Mayo Clinic all come under the heading of corporate control and the associated loss of physician autonomy. I propose that physician burnout is inversely proportional to physician autonomy (b = k/a), where b = burnout, a = autonomy, and k = a constant of proportionality.

Assembly Line Medicine

Does this sound familiar? Crawford (2006) describes the implementation of the assembly line by Henry Ford, and the effect on the skilled craftsmen who previously had been building his automobiles:

“Given their likely acquaintance with such a cognitively rich world of work, it is hardly surprising that when Henry Ford introduced the assembly line in 1913, workers simply walked out.”

One of Ford’s biographers wrote, ‘So great was labor’s distaste for the new machine system that toward the close of 1913 every time the company wanted to add 100 men to its factory personnel, it was necessary to hire 963.’”



Letter to the Editor:

Assembly Line Medicine Is Burnout Medicine: The Loss of Physician Autonomy

and medication management, 3) bimonthly coordination of care and peer supervision meetings with non-physician providers, 4) a 15% bonus for seeing children age 12 and under, 5) a 50% fee reduction for medication checks, and 6) encouraging child psychiatrists and all non-physician providers to treat whole families.

These and similar policies reduced the pmpm, a comparative measure of HMO costs used by health plans, from \$5.05 to \$3.25.

We maintained this “quality bonus” for 15 years until we were replaced by a corporate model claiming they “could do it better.” It never came close. Fewer patients were seen, waits were longer, and patient satisfaction fell.

We demonstrated what physician leadership, in management and in clinical care, can do when the focus is on high quality care. We had the autonomy to do it the right way and we did. It was cost effective the entire 15 years we operated.

Physician Autonomy: A Personal Example

A few years earlier, I had seen my new general internist for the first time. I had a whole list of things in my head that I wanted to be sure we covered.

I was sitting on the end of the exam table rattling on as he went through his physical. He stopped, while showing me his left wrist, and said, “Doug, I don’t wear a watch.” What a message! And it was true.

Jack Brandabur always had time but somehow saw all his patients by 5:00 PM. He was the perfect example of the “person-of-the-physician”™ being the connection to the “person-of-the-patient.”™ What corporate model today would allow such a philosophy of practice?

Compare his approach with that of many corporate doctors now, working with virtually no autonomy, and for whom, for all I can tell, the patient only exists in the computer — the patient isn’t a person. The patient is literally the X-Ray image in the computer. They rarely even touch the human patient, but they love touching that keyboard.

Conclusion

The assembly line model of medical care is disastrous for the physician, the patient, and the health of our citizenry. The assembly line model sees physicians as cost centers and interchangeable parts, and greatly restricts their ability to form healthy physician-patient relationships, to provide thoughtful care, or even to compose thoughtful progress notes. Why haven’t the patients revolted? More incredibly, why haven’t the physicians revolted? At least we physicians know it’s not only bad for our health, but bad for the health of our patients? Henry Ford just kept hiring workers to find sufficient numbers who would put up with the boredom, or at least would do so for \$5 per day (after three years). Is that who we becoming? Or are we already there?

Doug Kramer, MD, MS dakrame1@wisc.edu





Virginia Q. Anthony on Norb Enzer



My friend Norb was simply superb.

In real life a father, grandfather, raconteur, history buff, fly fisherman, gourmand, chef, and watercolorist. Moreover, he was a first-class gentleman.

In child psychiatry he was an extraordinary leader, visionary, conceptualizer and at the heart of many giant leaps for the Academy.

In the early '70s Norb became a main thinker in manpower development, serving on the governments National Advisory Committee on Graduate Medical Education.

Using every conceivable equation about meeting the needs of the country's children with mental illnesses, the group found that by 1980, the country would need 30,000 child psychiatrists, way more than the 3,000 at the time- so the group divided its projections by 3, and recommended. 10,000, almost reachable today. Norb knew the 30,000 figure was true but would diminish the report. At the time (and maybe still) 300 residents/fellows completed training each year.

He served in several more commissions, and politically balanced the needs with the reality. He finished his last major role in AACAP co-chairing the Manpower Committee with his good friend, Wun Jung Kim, MD. So, when you look at the distribution maps, think of these two, and manpower development, and Norb's passion on public health.

In AACAP, Norb served as an officer, a tri-chair of Project Future which set the plan for the coming decades emphasizing science and clinical treatments.

He chaired the Program Committee, introducing so many younger colleagues to AACAP, including

Bennett Leventhal, MD and David Shaffer, MD.

Although, he moved the program to a more science base, Norb added the dimension of childhood. In San Diego, he recruited the head of the zoo to talk about "mothering problems at the zoo." We had children's authors, and even a casino in our Chicago meeting.

It occurred to him that the specialty needed a code of ethics, so along with others, Norb mostly wrote it. And then he wrote its annotations. He was clear and cogent writer of vision always based in reality. This was a landmark achievement for our members and part of the center of any specialties' development.

Many knew Norb because of his enjoyments, either meals or wrapping up the evening in the bar. He loved the congeniality and the give and take, no more so than at the Professors. Norb epitomized the Professors, and was always ready for a walk, poolside, or lobby consultation. Because he had held every academic position, he understood the layers, complexity, and the players of academia. Upon news of his death, so many wrote in about Norb helping them in their careers, development of divisions, funding issues, dealing with problems either paranoid chairs, deans, residents. We will never know how extensive the measure of these consultations were and how far-reaching his influence has been.

I met Norb before the Academy in 1972. I was in New Orleans at the founding meeting of the State Mental Health Directors of Children and Youth. The representatives were talking very grandiosely about clout and influence. Yet one thing saved me. Norb, across the room, rolled his eyes, and I caught it, a kindred spirit with a grasp of the possible and the real in policy development.

We became friends, loved our friends together, shared the growing up of our kids, the ups and downs of leadership, his chairmanship and planning for the AACAP's 25th and 50th anniversaries . . . *always true, always great, simply superb.*



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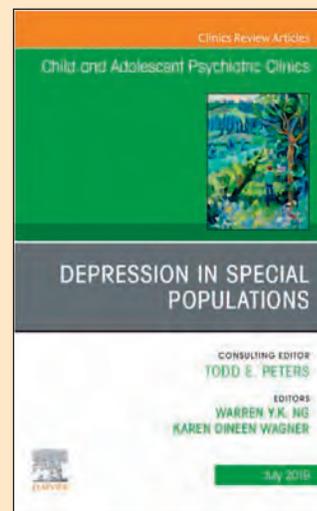
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The release of these important resources coincides with the current Presidential Initiative on **Depression Awareness and Screening in Children and Adolescents** of Karen Dineen Wagner, MD, PhD.

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