American Academy of Child & Adolescent Psychiatry
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LifeMember

Owl Newsletter

April 2015 e-Newsletter

Inside...

Thoughts from the Editors

Dick & Carol Gross

As we sit watching the snow come down in our backyard we hope that we are watching the last blast of winter. It is beautiful but in our hearts we hope that Spring is not far behind! Certainly, those of you in the northeast, you have the right to REALLY want to see green with crocuses and snowdrops!!

Thanks to those of you who sent in articles, all of which will be ready for publication in the next Newsletter. Each one is different, interesting and provocative...

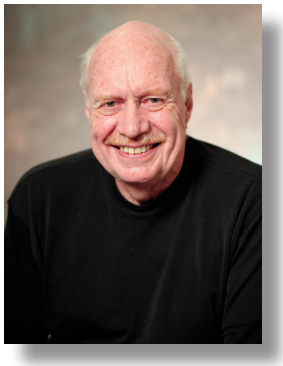
....Keep them coming!

Many thanks to all of you who have written the current articles: Diane Shrier, who writes, "Semi-Retirement: An Alternative Choice"; Joe Jankowski, on "The Value of Joining a State Medical Society"; Michelle Horner, Editor-in Chief of JAACAP Connect, who tells us about this new, wonderful online extension journal of *JAACAP*. (GO online; *JAACAP*'s Connect IS really good); and finally, John Schowalter's reminiscences about E. James Anthony.

"Thanks to those of you who sent in articles, all of which will be ready for publication in the next Newsletter.... Keep them coming!"

Send articles, likes, or suggestions to: rlgrossmd@gmail.com.

King James



John Showalter, MD

When Christians today hear the name King James, the more learned may associate to the classic translation of their bible. The so-called "King James Version" is the most famous English bible translation and was published in 1611. It was, unsurprisingly, commissioned by King James I, whom its translators in a praise-laden forward addressed not only as "King of Great Britain, France, and Ireland," but "Most High and Mighty Defender of the Faith," plus much, much more.

However, within the American Academy of Child & Adolescent Psychiatry, reference to another Brit is more likely to come to mind.

Although we today in the 21st Century are less flowery in our speech, I will use this Newsletter space to comment on the AACAP Past-President and famous Owl, E. James Anthony, who died recently at the regal age of 98. Before coming to America, James was an English citizen and he did attend medical school at Kings College. Although I think of him as an AACAP King, he was typically addressed only as James, and sometimes as E. James, but you would never call him Jim or Jimmy. That was simply not done and would not have been right. In an upcoming *JAACAP* tribute and at our Annual Meeting in San Antonio there will be much said about E. James' scholarly contributions. As a scholar, James was undoubtedly a philosopher king.

Years ago I was once described by a supposed friend and a fellow academic as "one of the best of the minor poets." Faint praise, indeed, and I hoped he was kidding. James also had a very dry sense of humor, and I was sometimes not sure whether James' muted responses to my hoped-for witticisms were British compliments, signs of boredom, or both. I will here strive to be a good-enough poet to describe accurately some snippets of our casual conversations over the years. I believe that these show James to also be a regal kind of friend.

James and I had known each other before, but we became friends through the loss of the three AACAP Presidents whose terms of office were between ours. At the Academy Annual Meeting's Plenary Session, past presidents sit across a row on the raised dais behind the presiding President in the order of their dates of service. About 15 years ago, the space between our two chairs disappeared, and we were now sitting next to each other . James' chair was at the very end of the row and closely abutted a 20 foot drop to the ballroom floor below. Since I enjoy humorous quotes, and as we both leaned to peek down at the drop beside us, I repeated the deathbed words of the 19th century British tragedian, Edmund Kean: "Dying is easy. It's comedy that's hard." James looked back at me with no facial expression and replied drolly, "Why, yes. I can see that for myself." Was his response a put-down, a compliment, or a simple acknowledgement that he realized he was very close to breaking his neck? This moment began an enjoyable

habit of mannered banter between us. I was the active one, and James was the one with restraint. It must be added that James' wife and then AACAP Executive Director, Ginger Anthony, made sure that past president seating from that year forth placed the most senior of us at the safe center of the dais and not at the drop-off side.

James tended to be quiet. It was not an uncomfortable quiet. It felt pensive or perhaps like waiting. He once told me that he had learned more in life by listening than by speaking. In our relationship, I was delighted to be the talker. When he would then smile, I kept going. When he instead would gaze into the distance and "ahem," I shut up. Even would-be comedians know that timing is everything.

James would occasionally ask whether I had read any new quotes. He particularly liked ones about aging. As with one's King or one's psychoanalyst, I then tried hard to please him by telling a quote or two. If I tried to tell a joke, my percentage of success was only in the single digits. So, I stopped. Of the many quotes I shared with James about aging, I would judge his five favorites were: 5) Getting old is nothing new. 4) Life is a loan; not a purchase. 3) It's better to be over the hill than under it. 2) Old professors don't retire. They just lose their faculties, and 1) The best thing about getting very old is the lack of peer pressure.

The other situation that could trigger communication between James and me was more evenly initiated between us. It occurred during the senior officers' or staff members' reports either at the Plenary Session or at the Business Meeting. In fact, James and I were often among the very few persons who voluntarily attended the Business Meeting. There were always plenty of empty chairs, and here it was our personal choice to sit together. Not only was our back and forth communication here more equal in its initiation, but it was also usually non-verbal. We didn't want to seem as though we were dissing the speakers, because we remembered all too well having to give reports that were not perfectly phrased or had to acknowledge bumps in the Academy's or our functioning. Every Executive Director, President, or Treasurer must at times do this. It's part of the job. We felt empathy and relief but we still enjoyed showing each other our reactions to awkward statements. This might be to nod our head to the side, give a couple of blinks, raise an eyebrow, or some-such. I occasionally passed a forefinger across my throat, but this was never James' style. I must admit, however, that Great Stone Faced James had the very best "Look." I cannot do it justice, but as I remember he seemed able to roll and widen his eyes simultaneously. I asked him to show me how, but he said he couldn't. Was it that he couldn't teach me or he knew I couldn't learn? He didn't say. Perhaps you had to be British. Finally, there is no doubt that our ultimate display of facial and bodily twitches erupted during the Business Meeting when James' wife declared that all those present "must" join her in a Group Hug. We thought this was an awful idea. We looked at each other and went into high gear.

After all of these years it's a blur, but I do remember thinking at the time that we might look like a couple of geriatric deaf mutes in status epilepticus.

Well, as promised, above are some snippets of casual conversations that over the years I had sitting next to E. James Anthony. Recalling them has been important to me, and this essay is obviously part of my grieving process. Probably also important for our relationship is the fact that James was born within a few years of my major mentor and fellow Academy President, Al Solnit. Al was killed when a passenger in an auto accident at the same time that James and I were getting to know each other better.

Finally, while writing this essay, a Dr. Seuss quote came repeatedly to my mind. I do not remember quoting it to King James, but I believe it would come when I recalled his relatively rare, but radiant, smile.

Don't cry because life is over.
Smile because it happened.

Smile,

Successful New Mentoring Program

Perry B. Bach, MD

A different approach to mentoring medical students and residents was tried at the 2014 AACAP Meeting in San Diego. The approach was both new and old, challenging and fun, organized and informal.

Remember your first Academy meetings when you met and had a chance to talk in person with the pioneers and leaders in child psychiatry? Since the total attendance at each meeting ranged between 200 and 800 in the 1970s, it was relatively easy. Now, with over 3500 attendees at each of the recent meetings, the opportunities for medical students, residents, and early career child and adolescent psychiatrists to informally meet and talk directly with senior psychiatrists is more difficult.

Recalling our own experiences, we tried to provide a taste of that for the Medical Students, Residents, and Fellows at the 2014 AACAP meeting. The Life Members Committee took the lead on this new mentoring program, and it was co-sponsored by the Committee on Medical Students & Residents and the Membership Committee. The co-chairs were Life Member Perry Bach and Psychiatric Resident Aaron Roberto. We invited students, residents, and Life Members to be in one room at the same time without any presentations or formal program, just the suggestion that they talk with each other, ask and answer questions, and get to know each other. We asked Life Members who were on the Committee to attend and invited several other Life Members who had different career trajectories so the students and residents might meet and talk with people who had a broad range of experiences.

Over 130 students and residents showed up! In spite of the room being too small for the number of people who came, we received positive feedback from the students and residents as well as the Life Members. Everyone enjoyed being able to meet with each other informally and without any agenda. Not only were many questions answered and suggestions made, several of the students and residents have remained in contact with the Life Members they talked with. As a result, we're planning to have a similar event at the San Antonio meeting. In addition to having basic information about each of the mentors so the students could determine who they wanted to talk with , this fall we will add a picture and e-mail address for each of the mentors.

To ensure that we have enough Life Members present to serve as mentors and provide students with that information, we are again designating about twenty Life Members (almost all of whom participated last year) to be the Life Member Mentors for this event in the fall. While other Life Members should feel free to attend, you should also consider participating in other mentoring activities. At the annual meeting, there are two breakout sessions under the auspices of the Committee on Residents and Residents where groups of 10-12 medical students and residents meet with two mentors to discuss career and practice issues twice during the annual meeting. Also, throughout the year, there is an opportunity to participate in the AACAP Mentorship Network. More information can be found on AACAP's Mentorship Matters webpage.

If you have any questions or thoughts about mentoring, feel free to contact Perry Bach at perrybbach@aol.com.

Semi-Retirement: An Alternative Choice

Diane K. Shrier, MD

Distinguished Life Fellows, whose eligibility for membership is solely that age and number of years in the Academy equal 99 (plus qualifications for Distinguished status), spend their time in a variety of ways. Some are fully retired but still doing volunteer work related (or unrelated) to their profession. Others continue to work full-time as academics, clinicians, or in other professional roles. Richard Gross, editor of The Owl has asked that I describe my own choice as another option: semi-retirement.

I graduated Yale Medical School in 1964 at the nadir for women in medicine nine years before the Supreme Court supported the 1964 Civil Rights Act banning discrimination on the basis of race or gender and mandated in 1973 that institutions that accepted federal funding were required to accept applicants on the basis of merit. There were four other women in my graduating class of 80: two never married, one married but did not have children, the fourth had two children after completion of training as an oncologist . Now, half of entering medical students are women though many still struggle with combining career and a personal/family life.

In hindsight, my husband and I were pioneers trying to "do it all": two career professionals supportive of one another's careers and family life at a time when women were expected to stay home after having children and where the husband's career was sole or primary. For reasons related to our families of origin, we decided to marry early (20 and 23) as did our peers and we were aiming for 6 children before Iturned 30 (then considered as elderly for childbearing). We came close with four children in 9 years (last year medical school, in between internship and psychiatry residency when husband did a post doc in Cambridge England in Chemical Engineering,two weeks before starting child psychiatry fellowship, and five years later after completion of residency during which husband did four years of law school at night while working full time). After the fourth baby, I had a postpartum hemorrhage, surgery, and a lengthy recovery and then chose to work parttime for five years in a community mental health center and consulting to a day care center in New Jersey. I got a lot of grief from other at-home moms for having a career and multiple children until the Supreme Court decision and the second wave of feminism, at which point I became "a role model."

Having always wanted to be an academic, when a new Chief of Child and Adolescent Psychiatry was hired at a nearby medical school (UMDNJ-New Jersey Medical School in Newark NJ), I accepted a half time position running the outpatient program. Within three years the Chief had left for a managed care position and I was offered the full-time job as Division Director. By the time I left 14 years later we had expanded the program to include: 7 full time and 3 part time child psychiatrists,as well as psychologists, social workers, and trainees in child psychiatry, child psychology,and social work and medical student teaching. We had established an infant mental health program with ten staff, a large multi-disciplinary, multi-racial, multi-ethnic outpatient program, emergency psychiatric services, a therapeutic

nursery, and a day school program. Every child psychiatrist and psychologist faculty member and child psychiatry trainee was expected to attend a monthly research program in which each attendee took a turn presenting their work for constructive criticism plus lectures on doing clinical research. I met with the child psychiatry faculty individually on a regular basis to provide ongoing supervision on their research. While primarily being a clinical and educational program, we all did some level of academically focused mostly unfunded research whether reviews of the literature or IRB approved clinical studies relevant to our clinical work and presented same at professional meetings. I myself did research primarily in two major areas: boy victims of child sexual abuse (with the head of adolescent medicine Robert Lee Johnson) and divorce and custody: sole and joint custody with several other social work and psychiatric colleagues. In addition, I continued a small private practice in my home office, and was active in local professional societies.

By the late 1980s managed care had arrived and increasingly interfered with doing the kind of work that our indigent patients and their families required. Simultaneously our youngest son left for college. As city people who had lived in the New Jersey suburbs for 24 years while raising our four children, we wanted to be in a city convenient to airports for my husband's international consulting work and our own travels. We began looking to relocate anywhere between Philadelphia and the Research Triangle, ultimately arriving in Washington DC with the encouragement of Jerry Wiener, then Chair of Psychiatry at GWUMC. I accepted a position as Vice-Chair and Director of Clinical Services at Children's National Medical Center under the then new Chair, David Mrazek. By the time I left full-time academic medicine two years later in 1994 I had served also as Acting Director of Training, Acting Director of Outpatient Services, ran a mock board, and did the bulk of medical student teaching. I found myself constrained from doing the kind of clinical work I wanted to do, nor was there adequate time for training and teaching and even less for research and writing. Simultaneously, my parents (then living in New Jersey) were both dealing with serious medical illnesses requiring my active involvement especially after they were relocated to the DC area. I had thought I would be a full-time academic for the rest of my working life, but the changes wrought by managed care led me to make a decision to leave.

Thus, in 1994, I decided to open a half-time private practice in Washington DC, ten minutes away from where we lived and initially worked an additional ten hours a week doing outpatient clinical and supervisory work in the Department of Psychiatry at GWUMC until I could establish the outpatient practice. I also continued my academic endeavors as an "independent scholar," doing research,writing, and teaching/supervising/mentoring. I have maintained my primary academic affiliation with GWUMC to the present and until recently also had academic affiliations with Children's National Medical Center (where I taught for several years an elective called Classics) and with Walter Reed Army Medical Center psychiatry and child psychiatry (where I taught, supervised, and saw housestaff for training psychotherapy) until WRAMC closed and relocated to Bethesda Naval Center.

I loved the flexibility of working for myself. I re-trained myself through reading and taking courses to be able to do a range of short-term focused episodic treatments in addition to the

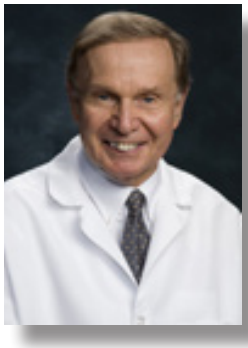
Semi-Retirement: An Alternative Choice

long term psychodynamic therapy I had been trained to do. This re-training and my interests in cultural differences made my practice of interest to the World Bank and International Monetary Fund mental health services staff and soon I had a steady stream of referrals. American Psychiatric Press invited me to write an edited book on Sexual Harassment in the Workplace and Academia, a topic I had become interested in and written and taught about with other members of the New Jersey Psychiatric Association Committee on Women. Other papers and book chapters on other topics of interest to me followed and I found time to consistent ly have one to three publications a year. I soon became more active in AACAP and the local CAPSGW. In AACAP I served on the Council for two years,on numerous committees, the Assembly. I soon was invited by Marty Drell (then Editor of AACAP News) to serve as Associate Editor and subsequently have continued to serve as Contributing Editor writing and soliciting articles for AACAP News as part of an expanded Editorial Board. In 2000, I was searching for a new research topic and my older daughter (a physician specializing in adolescent medicine on faculty at Boston Children's Hospital) and Idecided it would be fun to study mother-daughter physicians. I was able to obtain IRB approval for the study through GWUMC under the sponsorship of the Department of Psychiatry. In addition to my daughter, I recruited two pre-med women students to help with the 450 mailings of the 11page questionnaire to physician mothers and their physician daughters recruited through county medical societies,academic institutions, and by word of mouth. We had approximately a 95% rate of return and several publications. A psychology faculty member and several doctoral level students became part of the research team, helping with data analysis in exchange for getting their names on a paper.

Over the past few years I have gradually reduced the number of patients Isee by half and the number of days and hours in my office. Every year as more of my colleagues fully retire or retire to do volunteer activities or became incapacitated or die, my husband and Ire-evaluate whether we want to continue to do what we are doing. He is now teaching graduate students as an adjunct in two universities in the energy field and loves it plus takes classes, attends professional meetings and continues to travel (sometimes for work, often with me for pleasure). I have concluded that Istill cannot think of anything Iwould love to do more than the work I am doing now, albeit at a lower pace. Besides, it keeps me from the unpleasant task of clearing out our apartment, going through books, papers,photographs, and so forth!

We continue to travel extensively all over the world, attend professional meetings,exercise, socia lize with friends and children and grandchildren and to be active in our Co-op apartment complex and in our nearby synagogue. A few years ago I co-autho red a commentary for Pediatrics with 3 pediatricians called: Integrating Career and Family/Personal Life Over the Life Cycle. We postulated that pediatricians (and Iwould add child,adolescent, and adult psychiatrists) could work full-time early in their careers prior to having children, then reduce to part time during the peak of their child bearing and child rearing years, and then (rather than retire fully) continue to work on a part time basis for as long as they want to do so. Semi-retirement has been a good choice for me.

The Value of Joining a State Medical Society



Joining a state medical society can be an interesting and valuable option for child/adolescent psychiatrists. They can become a member of an influential medical organization that complements the work of AACAP.

Joseph J. Jankowski, MD

This is an especially positive step for life members who may be partially or fully retired and are provided with more opportunities to use their knowledge and experience as an advocate for helping children and adolescents with mental health problems. It allows one to work on local and national issues as a participant of a strong physician organization in one's own state. State medical societies provide learned input into problems that all physicians deal with and can have considerable influence on local and national issues.

In the past, CAPs were not inclined to join state medical societies because they felt their aims were primarily to serve medical/surgical and not psychiatric physicians. However, with the onset of current medical care reforms, we are being asked to join our physician colleagues in assuming MD leadership roles within integrated clinical teams. This is especially relevant as we begin to function within Accountable Care Organizations.

State medical societies are generally larger, better funded, have considerable advocacy power within state legislatures and provide input to AMA on national clinical and political issues. At this time in our history, physicians need each other to help maintain health care reform moving in an acceptable direction for our patients and the field of medicine generally, including psychiatry. They operate in a specified administrative manner while providing local and national representation within the AMA. Members are recomwmended to join the AMA, but it is not mandatory.

The state medical society is divided into district branches representing local physicians who live and/or practice in a defined geographic area. These district branches function semi-autonomously by obtaining input from local members while abiding by the general rules and expectations of the state medical society.

Within each district branch, delegates are nominated and appointed to create and review resolutions within the district to be brought forward to the state society. Resolutions include the history of a defined problem with recommendations for action. All district delegates from the state convene as a House of Delegates (HOD) twice per year where statewide resolutions are presented for discussion and voted upon. The vote may be for immediate action or referred to the state medical society board of trustees, state or local committees, tabled or voted down. The Board of Trustees will decide which issues need to be presented to the AMA.

Since the state medical society has a great deal of manpower and resources to fully vet a major medical issue, it carries a great deal of influence and power within the state legislatures. As a result, state adult psychiatric and child/adolescent psychiatric societies themselves should become closely allied to and encourage their members to also join their state medical society.The resolutions presented at the state

medical society include issues of great interest to adult and child/adolescent psychiatrists, e.g., health care reform, scope of practice, billing, third party insurance, malpractice, licensure, EMRs, and HIPPA rules. Other topics of interest include medical marijuana, opiate overdoses, increased occurrence of unintentional suicide with prescription medications (ages 20-40 years), end of life, and substance abuse. Others include medical/psychiatric care in correctional institutions, forensic issues, violence in families, schools and communities.

Disaster planning is provided in terms of education and planning for future disasters. Currently it is expected that physicians obtain training in disaster work and sign up to be on a multi-disciplinary team if they want to volunteer for a disaster response. If you are not on such a team, you are discouraged from providing disaster care outside of such an organization. Additionally, volunteer opportunities are available to teach medical students and provide direct services in a number of individual medical, surgical and psychiatric clinics.

An example of how you might be helpful while a member of your state medical society includes helping with scope of service legislative bills. Many of our current AACAP colleagues representing a multitude of states in the AACAP Assembly repeatedly complain and are frustrated by not being able to receive positive support on this topic from their state legislatures. It would help greatly if AACAP Regional Council members could work together with their state medical societies on these bills. They need to join their state medical society colleagues to help with all scope of service bills regarding all medical/surgical specialties not only psychiatry psychiatry. As you can see, becoming an effective advocate requires joining forces with the state medical society and working with all physicians on similar problems. State psychiatric or child/adolescent societies are too small to do this by themselves. They need to join forces with a stronger better-connected organization to get the legislative changes they need.

Currently, I am a member of the MA Medical Society (MMS) where I was on the Interspecialty Committee representing the MA Psychiatric Society (MPS). I am now a delegate of the Charles River District Branch, attend House of Delegates Meetings biannually, and attend meetings and conferences while dealing with pressing problems, e.g., opiate addiction, medical marijuana, and prescription control. This Medical Society has a strong voice in Massachusetts as well as in the AMA. Most recently they strongly supported measures to be certain that a physician-led team based model of health care is developed to insure optimal patient care and patient safety. Fortunately, the State Legislature tends to seriously consider and support the majority of issues brought up by this State Medical Society. It's clear that their respect and influence is directly related to the large number of members (24,500) and the wide range of physician involvement. I am certain that your local state medical society would welcome your membership and involvement and offer you many opportunities to be active and helpful. It is a great way to continue to use your knowledge and experience to advocate for and help the types of patients you had been treating when in practice. It moves you from treating individual patients to dealing with state and national issues which is an ideal path for someone contemplating retirement or in retirement.

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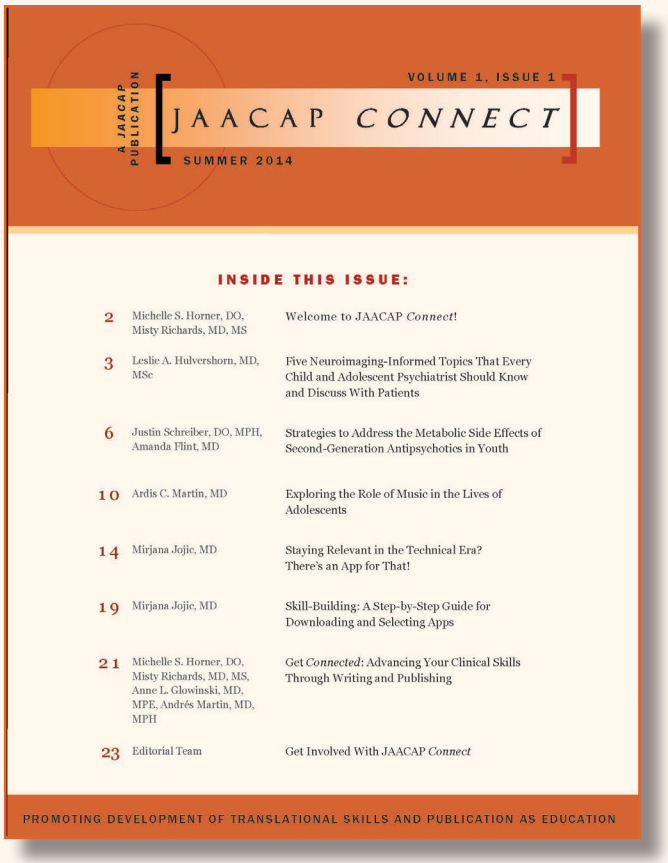
We welcome you to *JAACAP* Connect, the new online extension journal of the *Journal of the American Academy of Child and Adolescent Psychiatry* (*JAACAP*)! The field of child and adolescent psychiatry is rapidly changing, and translating scientific literature into clinical practice is a vital skillset that takes years to develop. *JAACAP* Connect engages clinicians in this process by offering brief, practical articles based on trending observations by peers. We also offer unique opportunity for authorship and becoming engaged in the editorial process. We will work directly with students, trainees, early career, and seasoned physicians, regardless of previous publication experience, to help develop brief science based and skill-building articles. We also welcome guest-editors, and will guide editors through the process. *JAACAP* Connect is interested in any topic relevant to pediatric mental health that bridges scientific findings with clinical reality, or connects the reader to important topics in the field. As evidenced by our current issues, the topic and format can vary widely, from neuroscience to teen music choices. We invite each of you to read and write for *JAACAP* Connect. The content is freely available at http://www.jaacap.com/content/connect.

Interested in authorship? If you've always wanted to author an article, now is the time! We will help guide you through the process, including assistance with editing and crafting the content. We can pair authors with mentors. What trends have you observed that deserve a closer look? Can you envision reframing key research findings into clinical care? Do you want to educate others on a broader scale, thereby improving the health of children around the country, the world? We encourage all levels of practitioners and researchers, from students to attendings, to join in and participate. All are welcome and you are invited.


A JAACAP PUBLICATION

VOLUME 1, ISSUE 1

JAACAP CONNECT

SUMMER 2014

INSIDE THIS ISSUE:

PROMOTING DEVELOPMENT OF TRANSLATIONAL SKILLS AND PUBLICATION AS EDUCATION

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Throughout the Years...