NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

OCTOBER 2016

IN THIS ISSUE

NEXT ISSUE...

Disaster Response in Action

As *NCPA News* goes to press, a major category 4 hurricane is threatening the east coast. North Carolina is a state familiar with disasters natural and manmade—hurricanes, tornadoes, and gun violence.

NCPA Disaster Committee Chair *Allan Chrisman* deployed to Baton Rouge after a "once-in-a-millennium storm" devastated the region with floods in August. In the next issue of the *NCPA News*, Dr. Chrisman recounts the experience of a psychiatrist responding to disaster relief.

When disasters threaten our state, look to the NCPA website for resources and articles to assist you, your patients, and your community.

Science to Practice: Omega-3 Supplements

Chris Aiken, M.D., D.F.A.P.A.

Science to Practice

Top Ten Research Findings of 2015-2016

One of the most highly rated sessions at the NCPA Annual Meeting and Scientific Session is *Dr. Sy Saeed's* "Top Ten Research Findings." Begun in 2008 to rave reviews, NCPA has been fortunate to have Dr. Saeed continue to present this fascinating overview of the research findings from the previous year. But, as Dr. Saeed posited, there is a "gap between what we know and what we practice." How do NC psychiatrists adopt and embrace the research and put it into real-world practice?

At *Dr. Randy Grigg's* suggestion, this year, we are asking members for their thoughts—and their questions—about the research summarized in this presentation from September and to share their experiences in adapting science to practice. A link to the research studies from Dr. Saeed's presentation can be found on the NCPA website http://bit.do/SySaeed2016

Please contact us with your experience in adopting some of these practices.

In this issue's column, *Dr. Chris Aiken* describes his experience using Omega-3 supplements with patients.

At the 2016 NCPA meeting, ***Sy Saeed*** included two new findings for omega-3 fatty acids (a.k.a. fish oil) in his round-up of the year's top papers. In the first article, Amminger et al. demonstrated that a brief course of omega-3s significantly reduced the development of psychotic disorders in those showing early signs of the illness (average follow-up 6.7 years). The other paper brought clarity to the type of omega-3s needed to treat depression. In reviewing 35 studies, Hallahan et al. concluded that omega-3s treat depression only when they contain more EPA (ethyl eicosapentaenoic acid) than DHA (docosahexanoic acid).

Both these papers are supported by earlier studies, and both are practice changing. The challenge is finding an omega-3 product that fits these new specifications. I have used them in my practice for 15 years, but – thanks to this new research – this is the first year I've seen a noticeable difference with them. It turns out that most products on the shelf simply don't have enough EPA to treat depression.

Patients need not only the correct dose (1,000-3,000mg daily of EPA+DHA) but the right ratio of the two ingredients. Hallahan's paper argues for >50% EPA, and a more fine-combined analysis found that EPA ratios of at least 60% were ideal (Sublette, 2011). This means that EPA must be at least 1.5 times the amount of DHA. Bottles can be

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From the Editor

Drew Bridges, M.D., D.F.A.P.A

I began my psychiatry residency in the month that DSM II gave way to DSM III. My first rotation came at Dorothea Dix Hospital. One of the memorable learning experiences there was when ***Dr. Granville Tolley*** conducted a one-way mirror interview with a woman said to be suffering from multiple personality.

DSM II listed multiple personality as one of the possible presentations of hysterical neurosis, dissociative type. Later versions of DSM moved to the current terminology of Dissociative Identity Disorder.

As I pursued an interest in this disorder during my training, I found some faculty members held a withering skepticism that such a disorder existed. One professor suggested that multiple personality once existed but that humanity had evolved beyond this manifestation of a disordered life.

Through the rest of my residency, multiple personality by any name was rarely considered and never definitively encountered. During the 1980s, there was a revival of interest in the disorder, the argument being we are not finding it because we are not looking. Skeptics persist, some suggesting it is an iatrogenic phenomenon, or at least a cultural fad.

This brings me to my book recommendation, *A Fractured Mind: My Life With Multiple Personality Disorder*. The author is Robert Oxnam, a renowned Asian scholar who accompanied Bill Gates on his door opening business trip to China years ago.

Oxnam's description of his early trauma and his description of how he developed psychologically to contain the damage from such trauma is consistent with the best theory of how this disorder may develop and present. If one is mid-way between acceptance and skepticism about the validity of DID, this is a must read.

NORTH CAROLINA Psychiatric Association news

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Helping Members Transition

Tom Penders, M.D., D.L.F.A.P.A., President

A somewhat obscure new vocabulary has been introduced and is growing rapidly to describe the various complex ways in which providers of medical care, including psychiatrists, are being incentivized for the care they provide. It is challenging to describe the complexity of these changes, but they can be summarized, perhaps, as a shift away from the historical pay for patient encounter or "fee-for service" to one broadly described as "pay for performance" or "value-based payment" or "from volume to value"!

"Pay-for-performance" is an umbrella term for initiatives that are aimed at improving the quality, efficiency, and overall value of health care. Such compensation arrangements provide financial incentives to hospitals, physicians, and other health care providers to carry out these improvements. The overall aim has been articulated as the "Triple Aim," i.e. simultaneously enhancing health outcomes, improving the experience of patients and improving value by reducing the cost of care.

Pay-for-performance has become popular among policy makers and private and public payers, including Medicare and Medicaid. The Affordable Care Act has expanded the use of pay-for-performance approaches in Medicare and encourages identification of novel designs and programs that can be shown to be effective in aligning practice toward the overall goals of the triple aim.

The measures used for value-based payment generally fall into the four categories:

1. Process measures assess the effectiveness of activities demonstrated to contribute to positive health outcomes for patients. Examples include functional improvement associated with treatment of Major Depressive Disorder.

2. Outcome measures refer to the effects that care has had on patients, for example, whether or not a patient's diabetes or hypertension are well controlled by reference to accepted measures. The use of the PHQ9 to measure improvement during treatment of depressive illness would be another.

3. Patient experience measures patients' perception of their satisfaction with the care experience. An example would be how patients perceived the quality of communication with their doctors and nurses and whether their meetings with providers are timely.

4. Structure measures relate to the facilities, personnel, and equipment used in treatment. For example, many pay-for-performance programs offer incentives to providers to adopt health information technology.

A related objective of policy-makers attempting to improve patient care is a collection of initiatives identified by the phrase "population health." This phrase is used when policy makers focus their incentives to encourage health care providers to accept accountability for health outcome of the populations they serve. This perspective acknowledges that there are a myriad of factors beyond physician visits that affect the wellness of an identifiable group.

Recent legislation and regulations are now beginning to codify the rules for the transition of health care delivery that are the direct result of these policy changes. The staff and leadership at NCPA are quite aware of how these policy changes have and will continue to affect the psychiatric community and our members. After an evaluation of the implications of these changes on our membership, the Executive Council has approved a new multi-year strategic plan that will focus the efforts of NCPA to support our members in coping with the rapid changes in our treatment environment.

One major change being implemented is the consolidation of several NCPA committees that previously had narrow missions into a broader group known as the Practice Transformation Committee. We are most fortunate to have three NCPA members who are well-versed in the opportunities and challenges that are consequent to the changes described to share chairmanship of this critically important initiative--Immediate Past President ***Art Kelley,*** former Technology Chair ***Jennie Byrne***, and NCPA Secretary ***Sonia Tyutyulkova***. They will be provided with the resources and support from our parent organization, the APA, to begin to anticipate and respond proactively so that NCPA can assume a leadership role in informing and supporting you and advocating for appropriate involvement and reimbursement.

At this year's Annual Meeting we had an opportunity to spend two full days with Lori Raney, a recognized expert in the area of psychiatric care more closely integrated with primary care. The various evidence-based models being

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Benzodiazepines and the Substance Abuse Patient

Stephen Wyatt, D.O., Chair, Addictions Committee

This is the second in a series of articles by the NCPA Addictions Committee designed to address prescribing for patients with Substance Use Disorders.

On starting work at a new practice site a number of years ago I took over a caseload including a 47-year-old Caucasian single female with a history of chronic generalized anxiety. Her chief complaint was the persistence of her anxiety. She had a remote history of an alcohol use disorder, sober for five years, and was a 1.5 pack per day smoker. There was family history of both maternal and paternal alcoholism. She also had a history of multiple adverse childhood events.

On taking her current medication history it was determined she was taking alprazolam 1 mg two tablets four times a day. This prescription was being filled on a 90 day refill pattern resulting in her obtaining 720 of these pills at a time. Though this may be somewhat extreme, it is all too common. These can be challenging patients. However, with proper care there can also be significant reward for the provider in watching the possible stabilization following a reduction-- if not discontinuation-- of the benzodiazepine. This article will describe how frequently resisting the temptation to prescribe a benzodiazepine while establishing good medical and psychotherapeutic management can enhance the patient's internal resources and improve their mental and physical health.

Use of benzodiazepines in the substance disordered population is one of the most challenging clinical problems in the field of psychiatry. To sit with a patient troubled with anxiety asking for a benzodiazepine, knowing that the prescription may very well relieve the symptoms rapidly, yet resisting the temptation to prescribe this medication due to the understanding that these medications can lead to a poor outcome, particularly in the substance use disordered population, is very difficult. Prescribing these medications to the co-morbid patient can often open the door to significant problems for both the patient and the prescriber. Though it is outside the scope of this article, I would contend that the chronic use of these medications for any patient may not be the best practice.

For centuries humans have sought relief from anxiety by using various substances. Alcohol was one of the most commonly used drugs for this purpose up until the beginning of the 20th Century. Barbiturates were first released in 1903. They were used extensively for sleep and as an anxiolytic until chlordiazepoxide was introduced in 1957. Soon after, a variety of other benzodiazepines were made available and they quickly became the anxiolytic of choice by physicians secondary to the consideration of their effectiveness and improved safety profile compared to the barbiturates. By 1975, these anxiolytics accounted for 10% of all prescriptions written. The World Health Organization recommended scheduling of the benzodiazepines in the early 1980s. The prevalence has hovered around 13% of the US population having taken one of these drugs in the last year. Approximately 14% of those taking these medications have taken them for longer than 12 months. These medications have a significant role in the treatment of acute anxiety and in patients with severe and persistent mental illness. Most patients have a tendency to decrease anxiolytic doses over time.

There has been an established pattern of higher sales of the shorter acting agents. In initially becoming available, these agents like alprazolam, were marketed as being less addictive. There was consideration that they would be used only acutely. However, it was quickly determined that when used chronically they had a greater potential for abuse and dependence. The liability for this is greatest in patients with a substance use problem. By 2008, it was reported that alprazolam resulted in twice as many visits to the emergency department as the next most common benzodiazepine, clonazepam. In 2009, the New York City Department of Health identified that 30% of the city's overdoses included a benzodiazepine. These medications however continue to be commonly prescribed chronically for the treatment of a variety of what are often intermittent anxiety disorders and to the co-morbid patient. This is in part because the most common presenting psychiatric symptoms the patient with a substance use disorder presents with are depression and anxiety.

To better treat these patients, the initial evaluation should include a thorough history and physical exam. It is important to rule out medical reasons for development of an anxiety disorder, e.g. Mitral valve prolapse, hyperthyroidism, etc. The history can help to determine whether the patient's anxiety is a primary psychiatric disorder, secondary to their substance use, or a combination of both. It is important to take both a good family and developmental history. One can also better understand the involvement of the substance use on patient's anxiety by obtaining the

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Member Notes...

Debra Bolick, M.D., D.F.A.P.A. has been reappointed to the North Carolina Medical Board by Governor McCrory to serve a three year term.

Erica Herman, M.D. and ***Beverly Jones, III, M.D.*** represent psychiatry in the 2017 class of the North Carolina Medical Society Foundation's Leadership College. The elite program allows physicians and physician assistants to excel as leaders within organized medicine, hospitals, health care systems, medical staffs, group practices, and in the public policy arena.

Ureh "Nena" Lekwauwa, M.D., D.F.A.P.A. was awarded the Governor's highest honor – Order of the Long Leaf Pine – in June. The presentation was made during her retirement party as DMHDDSAS Medical Director/Chief of Clinical Policy.

Assad Meymandi, M.D., D.L.F.A.P.A. is the recipient of the State's highest honor – the North Carolina Award in Fine Arts. The award recognizes significant contribution to the state in the field of fine art, literature, public service and science.

Brian Sheitman, M.D. has been reappointed to North Carolina Commission for DMHDDSA to serve a three year term.

We want to hear from you... please don't be shy about sharing your news or your colleagues' news!

To submit an item for Member Notes, please email the NCPA member's name and details to info@ncpsychiatry.org.

...Omega 3's continued from cover

confusing, often listing the amount of "fish oil" or "total omega-3s" as 1,000mg, when the actual amount of EPA and DHA is much less. Further, many patients are understandably distrustful of supplements, especially with recent media stories including a Frontline episode about rancid omega-3 products.

To make to process easier, I maintain a list of products with the right specifications at:

www.moodtreatmentcenter.com/omega3.pdf

Products whose integrity has been verified by an independent lab are highlighted. Costs run from $4-25/month. It's best to direct patients to the product number, as many brands make products with similar labels but very different ingredients.

Patients often ask if they can get omega-3s from food or flax oil. While those sources have many health benefits, they are unlikely to treat depression because food sources tend to be higher in DHA than EPA, and only 10% of the omega-3s from flax enter the brain. There are vegetarian omega-3 capsules, but I have not identified any that are high in EPA. Because most fish are richer in DHA than EPA, I recommend that regular consumers of fish (e.g. salmon once a week or other fish daily) choose an omega-3 product with close to 100% EPA. Likewise, patients taking prescription omega-3s (e.g. Lovaza for high cholesterol) should steer towards a supplement that is 100% EPA because those prescriptions are also rich in DHA.

Omega-3s are among few treatments with benefits in both bipolar and unipolar depression. Their effect size for depression (0.53, Sublette, 2011) is higher than the average effect size for antidepressants derived from published (0.37) and unpublished (0.15) studies conducted since 1987 (Turner, 2008). Smaller studies suggest omega-3s can improve a wide range of mental health conditions including borderline personality disorder, autism, ADHD, and non-specific irritability; these studies used similar dosing strategies to those recommended for depression (Sinn, 2010). Omega-3s comprise 30% of the human brain, and their treatment effects have been associated with greater flexibility in brain cell membranes (Hirashima, 2004).

Their physical benefits include prevention of dyslipidemia, hypertension, cancer, stroke, psoriasis, osteoporosis, inflammatory bowel disease, macular degeneration, and asthma. The main side effects are increased bleeding time and fishy taste or gastrointestinal discomfort which can improve by changing the brand and storing in the refrigerator.

Note: Chris Aiken is the director of the Mood Treatment Center in Winston-Salem and Greensboro, and coauthor of the upcoming self-help book *Bipolar, Not So Much.*

To submit your Science to Practice feedback or experience, please email info@ncpsychiatry.org.

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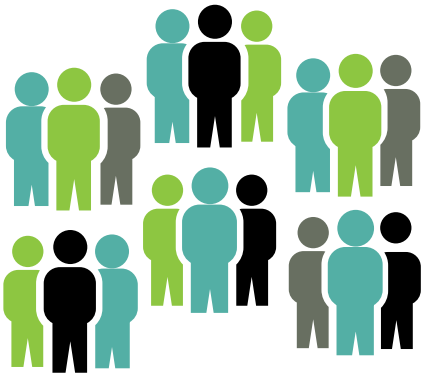
142 NCPA Members

36 Psychiatric Residents

7 Medical Students

68 First-Time Attendees



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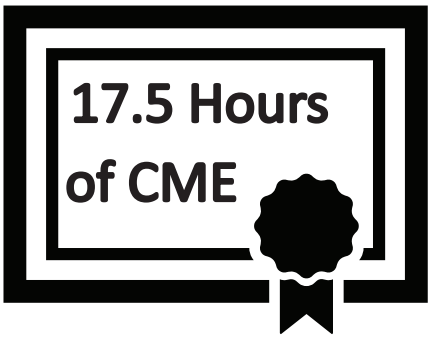

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Save the date for the 2017 Annual Meeting: September 13-17, 2017 at the Marriott Grande Dunes in Myrtle Beach, SC.

RESIDENT POSTER SESSIO

Each year, the Psychiatric Foundation of North Ca lina and the NC Council of Child and Adolescent Psychiatry sponsor a resident poster session duri the Annual Meeting. This year 14 posters were presented, and judges awarded four prizes:

First Place - ***Cornel Stanciu, M.D.*** (ECU), There's a Pill for That, but I am Not Comfortable Prescribin

Second Place - ***Kammarauche Asuzu, M.D., M.H.*** (Duke), Practices to Prevent and Treat Clozapine-Related Constipation: A Survey

Third Place - ***Samantha Gnanasegaram, M.D.*** (ECU), Novel Approaches for Treating Agitation In Demented Patients

Child and Adolescent Award, sponsored by NCCC - ***Laura Willing, M.D.*** (UNC), Integrated Mental Health Care in an Outpatient Pediatric Clinic: Res dency Education

Clockwise from top left: Poster Session winners Cornel Stanci Kammarauche Asuzu, M.D., M.H.S., Samantha Gnanasegaran Laura Willing, M.D. posing alongside John Diamond, M.D. as he the 2016 Poster Awards

MEMBERS HONORED

During Saturday evening's awards banquet, Immediate Past President ***Art Kelley*** and President ***Tom Penders*** presented awards to members who have made positive contributions that impact both NCPA and the mental health field in 2015-2016.

Top Left to Right: Philip Ninan, M.D., NCPA President Tom Penders, M.D., Michael Zarzar, M.D., with NCPA Executive Director Robin Huffman. Bottom Left to Right: Tom Penders, M.D. & Art Kelley, M.D., Art Kelley M.D. & Don Buckner, M.D., Art Kelley, M.D. and Burt Johnson, M.D. Winner not pictured Ted Zarzar, M.D.

PSYCHIATRIC FOUNDATION OF NORTH CAROLINA AWARDS

Foundation Board Member ***Debra Bolick, M.D.*** presented Samantha Meltzer-Brody, M.D. the 2016 Eugene A. Hargrove, M.D. Award for her extensive contributions to perinatal depression and mental health research.

The 2016 V. Sagar Sethi, M.D. Award was awarded to Helen Mayberg. M.D. for her research contributions to deep brain stimulation for treatment resistant depression.

What Psychiatrists Need to Know About... Supervising Requirements

Nurse Practitioners and Physician Assistants (NP/PA) have long played an important role in the provision of healthcare in North Carolina. NP/PAs have worked with psychiatrists in every practice setting—private practice, institutions, and particularly community mental health agencies. (The first formal approval by the Medical Board for a NP to work under the supervision of a psychiatrist came in 1984.)

The multi-disciplinary team approach of psychiatric care has instilled an appreciation for and reliance upon all clinicians in the care of this complex patient population, making the field uniquely situated to embrace the evolving health care delivery system of team-based care, collaborative care, accountable care, and shared savings. To that end, psychiatry's ability to work with other professionals, to assess skills, and to assist in their development will be even more crucial.

In our efforts to provide support and technical assistance to our members, NCPA has developed a resource for psychiatrists in their role as supervising physicians. At last month's Executive Council meeting, the Council approved the project developed by the NCPA Supervision Task Force--*A Psychiatrist's Toolkit: Supervising NPs and PAs.*

This toolkit was designed with two purposes in mind: to encourage more psychiatrists to consider providing supervision for NPs and PAs and to help psychiatrists provide effective oversight. This document collects and puts into one place the tools necessary to provide a strong supervision program—licensing board requirements, suggestions for structured clinical supervision meetings, templates for forms and agreements, and resources to make the supervisory experience a rich one that is mutually beneficial to the physician, the NP/PA, and the patients they care for together.

The NC Medical Board has stringent expectations that physicians who work in supervisory or collaborative arrangements with other licensed healthcare professionals maintain the ultimate responsibility to assure that high quality care is provided to every patient. There is the expectation that the physician provide adequate oversight. The Supervising Toolkit is designed to provide guidance, information, and suggestions for how to do that well.

The introduction of the toolkit is timely. NC's Division of Medical Assistance is currently considering requirements that nurse practitioners who provide psychiatric care in Medicaid must be certified as Psychiatric Mental Health Nurse Practitioners. Many NPs are opposed to this requirement. Having more psychiatrists who are willing and able to provide effective supervision to NPs is one solution to the issue.

The NCPA Task Force members have extensive experience working with NPs and PAs in various settings. The toolkit features vignettes from psychiatrists who work in various settings—solo practice, a major urban health care system, and a small community hospital. Task Force Chair ***Donald Buckner, M.D., D.F.A.P.A*** said "We couldn't have completed this document without the help of the NP and PA professionals we work with in our practices. They gave us guidance and feedback along the way. We are also grateful for the help we received from the attorneys from Allied World and the North Carolina Medical Board."

The toolkit can be found on the NCPA website at www.ncpsychiatry.org/supervising. Members of the task force are available to help answer any questions that the toolkit may not have addressed. They are: ***Don Buckner, M.D., Kim Dansie, M.D., Sid Hossieni, D.O., Ph.D.,*** and ***Rodney Villanueva, M.D.***

It is our belief is that psychiatrists are willing to meet the supervision needs of our NP/PA colleagues so that together we can provide excellent care to our patients. The solution to a physician shortage should not be substituting other professionals in their place. The solution to a shortage of psychiatrists is to embrace the opportunity to use our training and expertise to oversee and guide treatment by our NP/PA colleagues and improve patients' access to quality care.

...Substance Abuse continued from page 5

history of their level of anxiety in childhood and during periods of abstinence.

Most recreational use of benzodiazepines is in combination with other drugs. It is uncommon for it to be the patient's first drug of choice. The motivation to use these drugs in combination is often associated with increased euphoria and reduction in the untoward effects associated with other drug use. Alcohol and benzodiazepines augment each other in how they act on the GABA receptor resulting in more rapid and profound intoxication. Benzodiazepines work by increasing the frequency in opening the chloride ion channel and hyper polarization of the membrane, while alcohol increases the length of time in which this channel is open. This results in greater frequency of blackout drinking, which is in part dependent on the speed in which a person reaches high levels of intoxication. Thus the combination of benzodiazepines and alcohol is very dangerous. There is also significant potential for the development of tolerance to these medications and thus a need to prescribe more to have the same effect resulting in the escalation of dosing.

It is important for the clinician to understand the differences between various benzodiazepines as per their potency, lipophilicity, and elimination in consideration of prescribing one of these medications. It is also important to understand which of these medications are going to be identified in a specific urine drug-screening test. This is one of the incidences in which looking for a specific medication through confirmatory drug screening can be helpful.

In attempting to engage a patient in considering alternative medications it is helpful to determine some of the adverse effects they maybe experiencing associated with the benzodiazepine. One can then use these in motivating the patient to make change. These can include memory impairment and respiratory depression particularly in the already compromised patient. The most troubling symptoms the patient may describe are often associated with the increased anxiety due to withdrawal. Early-onset withdrawal symptoms are very similar to the patient's general feeling of anxiety, reinforcing the need for more benzodiazepine. All these adverse effects are made worse with concurrent substance use. On full discontinuation the withdrawal symptoms worsen considerably and can result in seizure and death. The withdrawal can be treated effectively with a slow taper of the benzodiazepines in the outpatient setting or a more rapid discontinuation often utilizing anti-epileptic drugs as an inpatient.

In recent years there has been a move towards the use of selective serotonin reuptake inhibitors, SSRIs, and selective norepinephrine reuptake inhibitors, SNRIs, and often in combination as first line treatment of what appears to be a chronic anxiety disorder. Buspirone and the tricyclic antidepressants are also effective in reducing some forms of anxiety. The choice often involves the constellation of symptoms the patient may be experiencing. It should also be kept in mind that patients will have the greatest improvement with concurrent utilization of medication and psychotherapeutic interventions. Cognitive behavioral therapy and exposure therapies have established evidence of efficacy. Abstinence of alcohol and other drugs is essential in moving people forward.

As you may have concluded, my patient did not get a three month supply of alprazolam on our first visit. I told her of my concern about the dosage of alprazolam. I described for her how tolerance and withdrawal where likely making the anxiety worse and pointed out her continued poorly controlled anxiety with her current management. Over time I was able to start a longer acting benzodiazepine and begin a slow taper. She was also started on venlafaxine XR and individual therapy. Over time, she was able to reduce her reliance on benzodiazepines. Her general presentation improved considerably and there was a palpable reduction in her anxiousness. This resulted in an improvement in her relationships and self care. These are complex patients and benzodiazepines are often not the answer.

...President's Column continued from page 3

developed within the Integrated Care movement promise to enhance the skills that are part of our psychiatric training and experience. The recognition of the particular skills possessed by psychiatrists can serve as the basis of a historical change in acknowledging psychiatry's unique contribution to meeting the objectives of the Triple Aim.

It is anticipated, as has always been the case at NCPA, that many volunteer members will play important roles in leading the constructive changes that promise to transform medical and psychiatric care over the next decade.

As always, your comments, questions and active involvement in the efforts that will make these initiatives successful are encouraged and welcomed.

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New Medical Director for NC Division of MH/DD/SA

Venkata "Amba" Jonnalagadda, M.D., F.A.PA was named Medical Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services effective October 3, 2016.

Dr. Jonnalagadda is the Medical Director for Eastpointe Human Services and is a partner in private practice with Greenville Psychiatric Association, P.A. She also serves on the adjunct teaching faculty in the Department of Pediatrics at East Carolina University's Brody School of Medicine. In addition, Dr. Jonnalagadda works as a clinical psychiatrist with the Veterans Administration.

Dr. Jonnalagadda is President of the Pitt County Medical Society and a member of the Ethical and Judicial Affairs Task Force for the North Carolina Medical Society. She was appointed by Governor Pat McCrory to the North Carolina Medical Board in January 2016. In 2015, Governor McCrory appointed her to a three-year term with the North Carolina Commission of Public Health.

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The Ethical Psychiatrist's Role in Public Elections

Claire Zilber, M.D., Colorado Psychiatric Society, Ethics Committee Chair

Presidential elections are intense and may lead some observers to speculate about the mental health of the candidates. People are curious about psychiatrists' diagnostic opinions of politicians and other public figures. This is a sufficiently common phenomenon that APA added an annotation to the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* in 1973, commonly referred to as the Goldwater Rule, prohibiting psychiatrists from offering public opinions about people they have not personally evaluated.

Section 7, Article 3, of the *Principles* states, "On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement."

Why is it called the Goldwater Rule? During the 1964 presidential election, *Fact* magazine published the results of a survey it had mailed to 12,356 psychiatrists. Of the 2,417 respondents, 1,189 replied that Sen. Barry Goldwater was not psychologically fit to be president. For a detailed account of the responses, see Henry Pinsker, M.D.'s "Goldwater Rule History" in *Psychiatric News*. Sen. Goldwater successfully sued *Fact* for libel and was awarded $75,000 in punitive damages.

APA responded to this very public ethical misstep by a large number of psychiatrists with the annotation above, and periodically the Goldwater Rule is recapped in APA publications ("Ethics Reminder Offered About Goldwater Rule on Talking to the Media") and in the national media ("Should Therapists Analyze Presidential Candidates?").

Beyond a reminder about the rule, it may be helpful to understand some of the ethical concepts behind it. Virtue ethics emphasizes the personal characteristics that society expects physicians to embody. Among these virtues are respect for others, humility, and adherence to diagnostic processes according to the standards of our field. If we venture a diagnostic impression about a person we have not examined, we trample upon these virtues.

In addition to inviting a lawsuit for libel or slander, a potential consequence of psychiatrists breaching these virtues is a diminution of public confidence in psychiatrists. If we will speak to the media about the possible psychiatric diagnosis of a person we have not evaluated, will we also reveal the identities and diagnoses of our patients? We must guard against undermining the protective cloak of confidentiality, without which people may refrain from seeking mental health treatment.

Political campaigns are brutal. Even a psychologically healthy person needs extra support if engaged as a candidate in an election. Because of stigma, that candidate needs to be assured of the utmost privacy and confidentiality if he or she is to enter treatment. If we are hazarding guesses about politicians' diagnoses in the media, we will lose the opportunity to provide treatment to our political leaders, which is perhaps one of the most effective ways to ensure a mentally healthy leadership while simultaneously eroding the stigma attached to our field.

Psychiatrists can play an important role in elections, but it is mostly silent.

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***David Gittelman, D.O., D.F.A.P.A.*, NCPA's Ethics Chair, reviewed and offered comments on this article:**

I'm certain you have noticed contentious presidential and gubernatorial campaigns have been underway for months. As experts on psychopathology it is likely you will formulate personal and professional opinions on the character of political candidates. You might be asked by neighbors, patients, or even by the media for your assessment of candidates based on their statements and activities portrayed on the Internet, TV, in print, etc.

Please be mindful of how you respond to such queries as a psychiatrist and NCPA member when asked for your professional opinion of a candidate.

My only difference with Dr. Zilber is with the final line of this otherwise fine article. You are free to express your views like any citizen, and you are not expected to remain silent about policies with which you agree or disagree (see the Code of Medical Ethics of the AMA, Principle VII and Opinion 9.0250).

However avoid analyzing politicians from afar and making public pronouncements on their possible psychiatric disorders, no matter how certain you are of the correctness of your opinions or risk civil suits and complaints to the NCPA Ethics Committee.

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